**KARADENİZ TECHNICAL UNIVERSITY * INSTITUTE OF SOCIAL SCIENCES**

**DEPARTMENT OF INTERNATIONAL RELATIONS**

**PHD PROGRAM**

# MULTILATERALISM AS IMPLEMENTED IN THE NEWLY INDEPENDENT COUNTRIES.

# CASE OF THE WORLD HEALTH ORGANIZATION AND THE HEALTH SECURITY IN CAMEROON FROM 2008 TO MID-2020.

**PHD THESIS**

**John MADI MADI**

**MAY-2022**

**TRABZON**

**KARADENİZ TECHNICAL UNIVERSITY * INSTITUTE OF SOCIAL SCIENCES**

**DEPARTMENT OF INTERNATIONAL RELATIONS**

**PHD PROGRAM**

# MULTILATERALISM AS IMPLEMENTED IN THE NEWLY INDEPENDENT COUNTRIES.

# CASE OF THE WORLD HEALTH ORGANIZATION AND THE HEALTH SECURITY IN CAMEROON FROM 2008 TO MID-2020.

**PHD THESIS**

**John MADI MADI**

**Supervisor: Dr. Erol KALKAN**

**MAY-2022**

**TRABZON**

**APPROVAL**

Upon the submission of the dissertation, **John MADI MADI** has defended the study "**Multilateralism as Implemented in The Newly Independent Countries. Case of The World Health Organization and The Health Security in Cameroon from 2008 To Mid-2020**" in partial fulfilment of the requirements for the degree of Doctor of Philosophy in International Relations at Karadeniz Technical University, and the study has been found fully adequate in scope and quality as a thesis by **unanimous/ majority** vote on **07/7/2022.**

| **Committee Member** | | **Decision** | | **Signature** |
|---|---|---|---|---|
| **Title - Name and SURNAME** | **Mission** | **Accept** | **Refuse** | |
| Dr. Öğr. Üyesi Erol KALKAN | Supervisor | ☐ | ☐ | |
| Prof. Dr. Tülay İLHAN NAS | Member | ☐ | ☐ | |
| Doç. Dr. Murat ÜLGÜL | Member | ☐ | ☐ | |
| Doç. Burak HERGÜNER | Member | ☐ | ☐ | |
| Doç. Hüsrev TABAK | Member | ☐ | ☐ | |

Approval of the Graduate School of Social Sciences.

Prof. Dr. Tülay İLHAN NAS

Director

## DECLARATION OF ORIGINALITY

I, John Madi Madi, hereby confirm and certify that;

- I am the sole author of this study and I have fully acknowledged and documented in my thesis all sources of ideas and words, including digital resources, which have been produced or published by another person or institution,
- This study contains no material that has been submitted or accepted for a degree or diploma in any other university or institution,
- All data and findings in the study have not been falsified or embellished.
- This is a true copy of the study approved by my advisor and thesis committee at Karadeniz Technical University, including final revisions required by them.
- I understand that my study may be electronically checked for plagiarism by the use of plagiarism detection software and stored on a third party's server for eventual future comparison.
- I take full responsibility in case of non-compliance with the above statements in respect of this study.

John MADI MADI

25.07.2022

**ACKNOWLEDGMENT**

While compiling data and capital information to produce this analysis, we have been helped, encouraged, and boosted by some people that I wish to thank particularly.

It is the case of my Dad, the late Colonel Madi Dodo who has always tried his best to grow us with the expectation that later we will be double useful individuals. Useful individuals for ourselves and useful individuals to others and the community.

It is also the case with my Supervisor, Dr. Erol Kalkan. He has been more than a lecturer and a supervisor to me. He has been an elder brother permanently available and always willing to find solutions to the various situations I faced in Turkey. I wish him to feel warmly thanked.

I wish to thank Prof Dr Tülay Ilhan Nas. Through her questions, suggestions, and orientations she has given to the present thesis a wider scientific content and a stronger analysis perspective. May she feel sincerely thanked and warmly respected.

I wish to thank Doç. Dr. Murat Ülgül. He has been available to be one of the examiners of this research. As same as the impact of Prof Dr. Tülay Ilhan Nas on this present research, his questions, suggestions, and various advice have deepened our analysis and strengthened our research options.

I wish to warmly thank Madam Yüksel Kara, one of my dear friends in Turkey who has tried to make me feel at home despite the distance from my home country. She did everything like a mother, like a sister, like an aunt to protect somebody they are caring of. She helped me in all the domains in Turkey and if the academic side was perfectly filled by the above-mentioned lecturers, the psychological side has been entirely fulfilled by her. Many thanks to you Yüksel Kara.

May, 2022 John MADI MADI

## CONTENTS

## CHAPTER FOUR



## CHAPTER FIVE



## THESIS CONCLUSION

## ABSTRACT

With the advances in transportation and communication technologies, the interaction and integration among nations have replaced the classic self-sufficiency of nations around the world. The modernization of society has driven a dual reality. On one side, it has eased global cooperation, bringing closer nations worldwide. On another side, the said modernization has erected an international society where the issues and challenges are more complex. To face the said complexity of the international society, countries worldwide have decided to federate their prerogatives to pool their efforts to deal collectively with any sectoral eventuality. Hence, the creation of international organizations and so doing, the advent of multilateralism. Presented as a pledge at the service of international development, this idea of multilateralism has been strengthened to cover various sectors such as the economy, culture, politics, military, and health. Within the framework of this research, it will be highlighted the question of health multilateralism and more precisely, the World Health Organization's impact on Cameroon. Through the research question formulated as *what is the impact of the World Health Organization on the Cameroonian health security*, the theme **"Multilateralism as implemented in the newly independent countries. Case of the World Health Organization and the Health Security in Cameroon from 2008 to mid-2020",** pursue a specific target. The target is to outline the impact, the importance, and the concrete value of the WHO on the Cameroonian Health system. Seconded by the subsidiary research question interrogating whether health multilateralism is still helpful for Cameroon, the concrete observations of facts in the country rather paint a disillusion with the multilateralism. Analyzed through the yardstick of postcolonial theory, and the methodology of the comparative, qualitative, and quantitative methods, three key facts emerge from this study. The precariousness of the Cameroonian health system is a reality. There is a mismatch and a gap, between the projects initially announced by the WHO and the concrete achievement in the field. It is time to create an international, post-multilateral environment, conducive to the real development of States.



Key Words: ***Inter-Governmental Organization, World Health Organization, Cameroon, multilateralism, Post-colonialism***.

## ÖZET

Ulaştırma ve iletişim teknolojilerindeki gelişmelerle birlikte, uluslar arasındaki etkileşim ve entegrasyon, dünyadaki ulusların klasik kendi kendine yeterliliklerinin yerini almıştır. Toplumun modernleşmesi ikili bir gerçekliğe yol açtı. Bir yandan, küresel işbirliğini kolaylaştırarak dünya çapındaki ulusları birbirine yaklaştırdı. Öte yandan, söz konusu modernleşme, sorunların ve zorlukların daha karmaşık olduğu bir uluslararası toplum inşa etmiştir. Uluslararası toplumun söz konusu karmaşıklığıyla yüzleşmek için, dünya çapındaki ülkeler, herhangi bir sektörel olayla toplu olarak başa çıkmak için çabalarını bir havuzda toplamak amacıyla ayrıcalıklarını birleştirmeye karar verdiler. Bu nedenle, uluslararası örgütlerin yaratılması ve böylece çok taraflılığın ortaya çıkması. Uluslararası kalkınmanın hizmetinde bir taahhüt olarak sunulan bu çok taraflılık fikri, ekonomi, kültür, politika, askeri veya sağlık gibi çeşitli sektörleri kapsayacak şekilde güçlendirildi. Bu araştırma çerçevesinde, sağlık çok taraflılığı ve daha doğrusu, Dünya Sağlık Örgütü'nün Kamerun'daki etkisi söz konusu olacaktır. ***Yeni bağımsız ülkelerde uygulanan çok taraflılık. 2008'den 2020'nin ortasına kadar Kamerun'daki Dünya Sağlık Örgütü ve Sağlık Güvenliği Örneği***, DSÖ'nün Kamerun Sağlık sistemi üzerindeki etkisini ana hatlarıyla belirtmek için belirli bir hedef izlemektedir. Sağlık çok taraflılığının Kamerun için hala yararlı olup olmadığını bilmek için araştırma sorusuna dayanarak, ülkedeki gerçeklerin somut gözlemleri, daha ziyade çok taraflılığın bir hayal kırıklığını resmediyor. Post kolonyal teorinin kıstası ve karşılaştırmalı, nitel ve nicel yöntemlerin metodolojisi aracılığıyla analiz edilen bu çalışmadan üç anahtar gerçek ortaya çıkıyor. Kamerun sağlık sisteminin istikrarsızlığı bir gerçektir. DSÖ tarafından başlangıçta açıklanan projeler ile sahadaki somut başarı arasında bir uyumsuzluk ve boşluk bulunmaktadır. Devletlerin gerçek gelişimine elverişli, uluslararası, çok taraflı bir ortam yaratmanın zamanı geldi.



Anahtar Kelimeler: ***Hükümetler arası Örgüt, Dünya Sağlık Örgütü, Kamerun, çok taraflılık, Post-kolonyalizm.***

## LIST OF TABLES

## LIST OF FIGURES



## LIST OF ANNEXES

## LIST OF ABBREVIATIONS

| | |
|---|---|
| AIDS | : Acquired Immune Deficiency Syndrome |
| AL | : Artemether Luthefantrine |
| AMRO | : American Regional Office |
| AMU | : Arab Maghreb Union |
| ASAQ | : Artesunate Amodiaquine |
| ASEAN | : Association of Southeast Asian Nations |
| AU | : African Union |
| CAD | : coronary heart disease |
| CCS | : Canadian Cardiovascular Society |
| CDC | : Centres for Diseases Control and Prevention |
| CEN-SAD | : Community of Sahel-Saharian States presented as the |
| CHD | : Coronary Heart Disease |
| CHW | : Community Health Worker |
| CNR | : Centre National de Resources |
| CNTP | : Cameroonian National Tuberculosis Program |
| COMESA | : Common Market for Eastern and Southern Africa |
| Covid19 | : Corona Virus 2019 |
| EAC | : East African Community |
| EC | : European Council |
| ECCAS | : Economic Community of Central African States |
| ECOWAS | : Economic Community of West African States |
| EMRO | : Eastern Meridional Regional Office |
| EOC | : Emergency Operation Centre |
| EU | : European Union |

GDP : Gross Domestic Product

GGC : Gulf of Guinea Cooperation

GRESAC : Group on Human Resources for Health in Cameroon

HERO : The Health Educational and Health Organization

HHA : Harmonisation for Health in Africa

HIV : Human Immune Virus

HO : Health Organization

HOLN : Health Organization of the League of Nations

HRH : Human Resources in Hospital

ICCM : Integrated Community Case Management

ICD : International Classification of Diseases

ICJ : International Court of Justice

IDSR : Integrated Disease Surveillance and Response

IGAD : Intergovernmental Authority on Development

IGO : Inter-Governmental Organization

IHR : International Health Regulations

IIC : International Islamic Conference

IMF : International Monetary Fund

IO : International Organization

IPT : International Partnerships for Health and Similar

IPTP2 : Intermittent Preventative Treatment of Malaria in Pregnancy

ISC : International Sanitary Conference

LOF : League of Nations

LTBI : Latent Tuberculosis Infection

MCEE : Maternal and Child Epidemiology Estimation

MDR TB : Multi Drug Resistant Tuberculosis

MERCOSUR : Southern Common Market

MI : Myocardial Infarction

NATO : North Atlantic Treaty Organization

NCD : National Coordination Department

NHDP : National Health Development Program

NHRDP : National Human Resource Development Plan

NMCP : National Malaria Control Program

OAU : Organization of African Union

OIF : Organisation Internationale de la Francophonie

OIHP : Office International Hygiene Publique

OPCW : Organization for the Prohibition of Chemical Weapons

OTSC : Collective Security Treaty Organization

PAHO : Pan American Health Organization

PASB : Pan American Sanitary Bureau

PED : Potentially Epidemiological Diseases

PERSAN : Populations et Espaces a Risque Sanitaire

PROGRESS : Perindopril Protection against Recurrent Stroke Study

REC : Regional Economic Community

SAARC : South Asian Association for Regional Cooperation

SABC : Societe Anonyme des Brasseries du Cameroun

SADC : Southern African Development Community having as acronyms

SCC : Strategy of Cooperation with countries

SEARO : South East Asian Regional Office

SMC : Seasonal Malaria Chemoprevention

UHC : Universal Health Care

UK : United Kingdom

UN : United Nations

UNDAF : United Nations Development Assistance Framework

UNHCR : United Nations

UNOCHA : United Nations Office for the Coordination of Humanitarian Affairs

USA : United States of America

USAID : United States Agency for International Development

VRU : Vulnerable Road Users

WB : World Bank

WHA : World Health Assembly

WHO : World Health Organization

WLO : World Labour Organization

WPRO : Western Pacific Regional Office

WSCC : World Strategy of Cooperation with Countries

WTO : World Trade Organization

XDR TB : Extensively Drug-Resistant Tuberculosis

YUTH : Yaoundé University Teaching Hospital

# CHAPTER ONE

## 1. RESEARCH QUESTIONS, HYPOTHESES, MULTILATERALISM AND OUTLINE OF CHAPTERS

### 1.1. Introduction

The ongoing war in Ukraine, qualified by the European Union and its international partners as the *2022 Russian invasion of Ukraine*, that started on the 24th of February 2022 is one of the most evident situations pointing out the role that the international organizations and so doing, the multilateralism, are supposed to play in the international context. More precisely, this war that started with a military operation and that is being presented as the most important military attack and operation on the European continent since the end of the second world war, can easily be considered as a case study on the concrete impact and usefulness of intergovernmental organizations on the stability of a country. From the perceptions of Ukrainians citizens, it is expected from Intergovernmental Organizations such as the European Union on a political and diplomatic side and NATO on a strategic side, some specific and dissuasive actions to put an end to the said war that is causing uncountable human and material loses and forcing not less than three millions of Ukrainians to leave their home or their country to feel secure. This is, on a first side, to mention the expected impact nourished by these populations from the various European institutions that, according to them, could have developed some drastically enacted measures such as negotiations, sanctions, embargos, and all the other diplomatic and economic pressures against the Federal Republic of Russia to force the Russian authorities to withdraw from the war. On another side, it was expected from NATO, known as the North Atlantic Treaty Organization, which is a strategic and operational organization, to a military intervention on the Ukrainian field to stop the evolution of the Russian tanks and troops. But, arrived at the 20th day of battle on the field, not only the diplomatic apparel developed by the European Union institutions and its international s partners such as the United States of America does not bear the expected results and the war is still ongoing but also, the expected intervention of the NATO will not be operational. Officially, despite the informal promise of assistance formulated to Kyiv's authorities before the beginning of the war by this military organization, the fact that Ukraine is not an official member of the Alliance does not oblige an intervention of this Organization besides the Ukrainian forces on the field. Taking into consideration this reality, the multilateralism on a Ukrainian citizen's basis and angle of view, who are daily assisting powerless to the destruction of their country, the international community's incapacity to protect them might be considered as a

disillusion of the multilateralism and the necessity to think about the usefulness of intergovernmental organizations.

The global health crisis caused by the pandemic of the Covid19 outbreak is one of the most recent factors providing significant insight into intergovernmental organizations. It rises the interest in the use, impacts, and more specifically the importance of multilateralism in the resolution of transnational crises. In fact, from the end of November 2019 till the end of this research, the world is under the pressure of a virus, identified by US President Trump as *China's virus*. This virus is causing significant economic and financial losses, paralyzing the entire world and obliging more than a quarter of humanity to stay at home. It is in this context that normally, the World Health Organization, in brief, WHO, this organization in charge of the health security of humanity should have been proactive. On the contrary, as same as the regional organizations such as the European Union or the African Union, this global health institution has not been able to propose a concrete and consensual solution to the critical situation. It is every country that tried its best to cope with the pandemic and protect its populations against the said virus. It was the case in Africa of countries such as Madagascar, Benin, or Cameroon, offering to their population local medicines made by traditional local practisers. While this is the most recent and visible element, the critics and debates on the real impact and assistance provided by the Intergovernmental Organisation in the promotion of the well-being of nations around the world, critics have always been part of the history of international organizations. At some point in the evolution of humanity and nations, some States have found it useful to transfer a substantial part of their sovereignty to autonomous supra-state organizations with legal personality and based on an international treaty that will act on their behalf. The first-ever recorded forms of this multilateralism have been done and implemented in the military field. It has been materialized by the signature of a treaty related to peace enforcement to ensure a harmonious relationship between the signatories' parties. Established in 2400 Before Christ, this first treaty set a peace agreement between Slow from Lagash and Lugal Kinishe from Dudu a Sumer in the former Near East region (Gondoin, 2005).

Perceived as a quasi-homogeneous entity whose primary mission and ultimate ambition is to unite States around the world and so doing, build an integrated set of nations around the world under the label of the international community, the IGO has multiple perceptions. They are understood in sociology, legal and political terms as an association of states that have kindly transferred a symbolic part of their sovereignty to a supranational entity that acts in their interest. The said supra entity acts in the development of international policies in the various aspects of international cooperation such as humanitarian, economic, political, cultural, security or health. The creation of these transnational institutions promoted the advent of a harmonious and peaceful common destiny where each member would be equal in decision-making. However, what happens, in reality, is what Bertrand Badie

(Badie, 2013) describes by using the words diplomacy of connivance or a pentarchic system, where only five countries decide the future, the evolution, and the general orientation of the entire world. So doing, these five superpowers, permanent members of the Security Council of the United Nations, drive the international system in the sense of their interest, regardless of the concrete needs and expectations of all the other state members of the United Nations galaxy. This international conduct of global affairs, resulting in a well identifiable gap between the initial presented and projected politics and the final realizations on the field, drags a sort of disillusion and affects the credibility accorded to globalization and the role supposed to be played by the multilateralism. It is the case of the World Health organization in Cameroon. Hence the research theme of this doctoral thesis is entitled ***Multilateralism as implemented in the newly independent countries. Case of the World Health Organization and the Health Security in Cameroon from 2008 to mid-2020.***

This research is framed in the period from 2008 till 2020, including some significant crises and needs, expressed worldwide in general and in Cameroon in particular but that have not witnessed the concrete and decisive implication, importance, and incidences of these international organizations. Focused on the Cameroonian health system concerning the impact of the World Health Organization, this research is important because it finds its roots in the observation of the impact of the WHO on the Cameroonian health security system. At a time when the Governmental International Organisations are demonstrating their weaknesses and their incapacities to resolve the international crisis as expected, the main objective of this research is to examine the basis of the re-emergence of the state as the main actor in the international environment, as the main responsible of its foreign policy by demonstrating the obsolescence of the multilateralism. It is a sort of demonstration of the emergency for the governments to take back the power they conferred to international organizations and strengthen their position in the international context in favor of the said re-emergence of the Sovereign State, the main responsible for the future of its citizens. The ambitions raised by this analysis are to put an end to the Cameroonian collaboration with the World Health Organization and with the other Governmental International Organizations in all forms and draw the post-multilateralism era by bringing back the form that has led in the past to the well-being of nations which is the bilateralism. In the Post multilateralism cooperation system, states will set a cooperation system free from international treaties that most of the time, are not benefiting them. Whether at the global level with the International Monetary Fund, the World Bank, or the United Nations that French President Charles de Gaulle already described in his early days as a *thing*, recriminations are been raised against international organizations. Those critics are related to the functioning, missions, and real purposes of these transnational institutions in the well-being of the member States that constitute them. Our research finds its originality and foundation and importance, in the fact that it goes beyond the simple reformist ambition of the Intergovernmental Organizations. This research aims to be a precursor to the formulation of the post-multilateral era. Indeed, this research is interesting and

important because it questions the usefulness of the World Health Organization in its participation in the health security of Cameroon. So doing, are also questioned the value of international organizations and thus the importance of multilateralism.

### 1.2. Research questions and hypotheses

To have an overview and a better understanding of the objectives of this research, some key questions will be developed, outlining the steps and motivations of this thesis. For a country planning to be emergent by 2035, how can be evaluated the impact of the World Health Organization on the health security of Cameroon? This main question drags some other related sub-questions. More precisely, concerning the above-questioned impacts, which credits should be granted to this IGO in the health improvement process of Cameroon (a)? Are the said credits in favor of maintaining the ties between the country and the World Health Organization (b)? Is multilateralism still helpful for Cameroon (c)?

This research will be built on a dual-based hypothesis of analysis. The World Health Organization has been created to enhance, promote and strengthen the global and so doing, Cameroonians Health Security System. Based on a well-shaped agenda and planning of activities, the WHO has identifiable actions and realizations in Cameroon (1). However, the deep and concrete observations of the Health situation of the country drag out, not only the World Health Organization limits in Cameroon but also raises the question of the finality of the philosophy and the conduct of worldwide multilateralism. These, command a reflection on another model of international cooperation based in a post-multilateral era (2).

### 1.3. Arguments

We do not want to silence the fact that the international organizations since their creation have been of some use to the future of humanity. However, and that is where our research is based, we proceed by a scaled assessment, more precisely, by a comparison between what has been declared and officially presented as the general health politic that should be implemented in the country, what should be done and what is concretely being done on the field. That is to outline, an ideological opposition, a neutral and objective scientific opposition between all the normative mechanisms informing about the ambitions, missions, and objectives of these various international organizations. This will be done concerning our case study the World Health Organization and the actual practice, the concrete deployment in the theatre of operations in Cameroon more specifically but also in the international society, the globalized society. In other words, certain gratitude must be shown to these international institutions, such as the Central African Economic and Monetary Community, the Organization of African Unity, which later became the African Union in 2002, through its Bank of

African Development is doing to reduce the poverty and strengthen the Peace and Security in Africa. There is no question for us to ignore that the European Union is born through Robert Schuman's (Schirmann, 2008) declaration, on 9th May 1950 for the integration of European countries. There is no question for us to systematically refute the fact that the United Nations, which succeeded the United Nations in 1945, was forced to make the world space a space where international peace and security reign. However, and this is the neck point of our analyses, the figures, statistics, and realities of the Cameroonian health system and of the questionable impact of the World Health Organization in its ambition to curb positively the rates figures and incidences of illnesses in Cameroon, rather drive out and present weaknesses from this transnational institution and so doing, plead against the maintenance of the participation and the membership of the country to this international health-based organization. It is in short the exposition of the failure of the global health international organization in the Cameroonian context this failure is identified as the disillusion of the multilateralism pleading in favor of the erection of a post-multilateral era based on the reinforcement of the sovereignty of countries worldwide. In this sense, our research stipulates that if Cameroon withdraws itself from the World Health Organization by taking back from the IOs this substantial part of the power the country as same as the other State members transferred to the said WHO, the international society may be more structured and more integrated. More precisely, the debate is being raised due to the apparent fact that the current system is rather in favor of keeping certain countries in a position of wait-and-see, followers and being merely receptacles of general norms, principles, and laws that are almost imposed on them with no certitudes and guarantees that they will always understand or master the ins and outs of those principles. This is the case for example of the draft European Constitutional Treaty (Jean Louis Clergerie Gilbert Wassermann, 2005) which was in some way imposed on the French people by the fact that despite having a majority vote on 29 May 2005 against the said project with 54.67 percent of votes (L'Humanité, 2008). An almost identical text, the Lisbon Treaty, was ratified by Parliament two years later in 2017 (Nicolas Sauger, 2007). This means that the population if consulted, may have positions that could run counter to positions taken by officials and governments that often do not adhere to these International Organizations for the well-being of the people they are representing but with a principle of a globalized vision of global governance that is not always in favor of the concerned beneficiary population.

### 1.4. Theoretical framework

The main theory that will be mobilized to understand the above-mentioned disillusion of multilateralism will be the post-colonial theory with a stopover on a referent notion that is domination. It will be a question to analyze the mismatch of the WHO global interventions and the specific case of Cameroon's health system expectations. Being identified as a critical theory that

develops the trajectories of the former European superpower in their legacies to humanity. It is the theory taking colonialism and imperialism as key and central points of analysis.

The post-colonial theory has been scientifically studied by authors such as the psychiatrist Franz Fanon (Fanon, 1961) who, through his concept of subjugation has presented colonialism and imperialism as an essentially destructive policy for the colonized people. It is what the author has identified as "the imposition of a subjugation colonial identity". Fanon by so doing presents colonialism as a politic that changes the mentality of the colonized people. It transforms them into something else that is stranger to them. It is destroying their essence, their culture, in short, it is destroying their original identity (Fanon, Black Skins, White Masks, 1967). Colonialism, according to Franz Fanon, is a decided politic having as its principal aim to dehumanize individuals and is a "systematic denial of all attributes of humanity". As same as described by Lenin (Lenin, 1917), the idea surrounding the notion of colonialism is perceived as a higher level of imperialism. It gives details related to the political, economic, cultural, and social sides of the presence of the former European superpowers in the administration and cooperation system with their former foreign territories. It is in a simple line the short explanation of the aftermath of western colonialism as explained by the Palestinian critic Edward Said. Concerning our research topic, the post-colonial theory will guide us in seeking of understanding why the international rules and global cooperation are still not benefiting African countries and particularly Cameroon. The said theory will orient our analyses in the will to understand why despite years of cooperation the Cameroon health security system is still in demand, why some basic illnesses are still prevalent, and why the country is still facing some diseases that should have been completely cured many years ago. Under the principles developed by Said, we will demonstrate that through the actual form of international cooperation built by former colonizing superpowers, a former colony can't develop itself except a new system of diplomacy is set up. Understanding the importance of postcolonialism in this research drags the necessity to develop what can be qualified as a mismatch between the WHO international policies and the Cameroonian health realities under some specific points that symbolize the post-colonial studies the principle of postcolonialism the method employed and the finality of the said method.

The main principle of neo-colonialism lies in the fact that the said notion is basing itself on another approach to international relations which contrary to the traditional hard power is the diplomatic approach known under the concept of soft power. As theorized by Robert Keohane or Joseph Nye, the main principle of soft power used through postcolonialism is the attraction, the opposition with the coerce and physical strength, appeal to the attention of others through the attraction. In this system, there is no longer a need to use hard power through the intervention of weapons soldiers, and other physical means of demonstration of power as was the case during the colonization and the invasion of foreign territories by possessing superpowers. Seduction and

attraction which are the main founding principles of soft power are the same principles structuring post-colonialism. The said principles target to attract through the cooperation the other countries to invite them or convey them to adhere to a project by presenting them the advantages of their participation and the potential gains they will realize by joining the raided idea. The method requires the interference of a superpower country in the destiny of the formerly colonized entity by presenting itself as the guarantor of the future of the said territory. As developed by Wenda Bauchspies (Bauchspies, 2008), the subordination of the global policy to the willingness of the main countries to guide international relations is a subject of concern and worry. A club of countries sharing common interests, cultures, and values regrouping themselves in an international organization that is conveyed the other countries around the world. At the same, a club where there is no necessary expressed impression to take into consideration their expectations and concrete need for their respective populations. All the member states of the World Health Organization must refer themselves to the annual policy prescript to them by the WHO. They should refer themselves to the said document as the guide to their health politic. The objective and aim of postcolonialism are to maintain the former possessed territories under a stage of permanent and renewed expectations of foreign investments, foreign assistance, and foreign dependency. The said objectives will be more understood by developing some notions that are revolving around this concept of postcolonialism and that at their level of explanation give an overview of the goals, ambitions, and perspectives of the cooperation between the World Health Organization and the health security of Cameroon. It requires a reference to domination, a reference to imperialism, another reference to unilateralism, and finally a reference to colonialism. It is important at this stage to outline the gradation, linking these four concepts. Starting with the ambition to dominate a specific territory, the domination itself gives the possibility to the dominated entity to free itself. This is the first step. After the domination, comes imperialism which is a step higher than the domination. Under imperialism, the dominator imposes on the dominated entity the general principle that will govern its evolution. But still at this level of imperialism, even though the possibilities are fewer than the ones in the domination, it remains some options for the dominated territory. The third level of alienation of a population is unilateralism. By unilateralism, there is only one option, the option of the imperial dominating superpower. In the history of international relations, there have been some imperial nations that despite the fact of dominating other nations, didn’t use unilateralism in their foreign politics. It has been the case of the Ottoman Empire which rather used to give the possibility to its conquered territory, the possibility to freely administrate themselves. Concerning the present research on the WHO impact on Cameroon, the domination, imperialism, unilateralism, and colonialism can be explained in these terms. Cameroon's health system is dependent on the international policies of the WHO. It is the WHO that decides on the implementation of national health politics in Cameroon. Before experimenting with medicine on its population or using any modern medicine product, the authorization shall be granted

first by this WHO. If countries do not submit their medical ambitions to the WHO, they might face some sanctions that could worsen the health realities of the said country. Let us develop better these four notions.

***Reference to domination***

When Karl Marx was suggesting the end of every form or model of domination of the populations based on dictatorship even the soft one, he was among the authors of the new revolutionaries' circles known as Circle of Light raised in France wishing to see a new design of relations in the society based on the mutual benefit and the common interest of the participants in the said society. According to Marx, "*The thoughts of the dominant class are also, at all times, the dominant thoughts*". (Marx, 1847). This citation from this author indicates that a few groups of individuals are the ones controlling the entire society (Rivière, 1998) and are imposing on the large majority of participants their will even though it is not in line with the aspirations of the others. It is the dictatorship of a few numbers on the majority with a scene presenting the said few numbers taking some policies and enacting them without every time reassuring themselves if the common interest is being preserved. Going in the same sense as Marx Karl, Herbert Marcuse, (Herbert, 1941), another author of the theorization of the domination of people by other nations, suggests the reinvention of the relations in the society to take into consideration the aspirations of the majority, for the global sake and the improvement of their ability to control the actions and decision produced. According to Bourdieu, (Bourdieu, 1979) every domination process lies on the acceptability of dominated individuals bound with invisible ties because the domination is unconsciously accepted by the people under domination. Foucault (Michel, 1975) suggests that the rational people that are the one deciding for their own sake are difficult subjects or exposed to external influences and determinisms and every domination or power affirmation find its roots in the establishment of a well-drawn strategy. It goes with the theory of dependency. The theory of dependency or dependency theory stipulates that the domination worldwide is being fuelled by the peripheral positions of underdeveloped countries. A situation that can easily be qualified as the exploitation of an entity by others regardless of their perspectives. The related suggestion to curb the pictured reality can be the creation of a new model of cooperation replacing the capitalist system with the socialist one that will be the international system of changes that will integrate concrete and reals expectations of the majority of countries dominated by globalization. This Marxist theory stipulates the low level of development of third-world countries. The poverty that they are experiencing the political instability with permanent coup where one can assist on assaults to dismiss legal authorities regularly elected by populations are the consequences of a well-planned agenda of western countries to maintain in a dependant mode the poor countries Taking into consideration the WHO and the Cameroonian Health security, the domination appears in the obligation for the Cameroonian medical industry to refer itself

to the obligatory authorization of the WHO before producing and making available for Cameroonian nay medical treatment. The main consequence of this blockage is that local production cannot be boosted.

***Reference to unilateralism***

Presented briefly as a one-sided action or unique pole of decision, unilateralism is the practice that consists to do not take into consideration the observations or suggestions points of view of the other party before taking any decision even though the said decision is supposed to be implemented by the actors other than the ones that are taking and putting into force the said decision. Taking its foundation in 1926 around the concept of unilateral disarmament and being reinforced in 1964 and presented as the main opposition to multilateralism with the prescription of brainstorming among actors seeking the same objectives. Mentioning unilateralism with regards to post colonialism is underlining the ideology according to authors such as Said that taking into consideration the fact that the objectives of the superpower are to impose on less representative states their willingness, they rather proceed by the unilateral approach that is not taking into consideration the real expectations of the dominated countries. The simple reason is that if requested assistance is provided to third world countries, the said assistance will liberate them from any further assistance and will then impulse their development. Those requesting state will strengthen their independency and so doing will merge at their turn as free and untied countries with the ambition of challenging the former donators. Aminata Traore (Aminata, 2008) and Jean Ziegler in their respective researches (Jean, 1978), put a light on the aspect that under the post-colonial theory, poor countries states should not expect their former superpower countries to benefit from the conveyable politics that will free them from any sort of assistance. It is the reason why also according to Ziegler that international structures such as the World Bank or The International Monetary Fund will never develop poor countries. Through the politic of reinforcing the foreign debt of colonized territories, they will rather be maintained under the under development barrier and will not only not be able to use the international dotation that is oriented and controlled but will also be in the incapacity to refund the assistance received due to the inadequacy between the aid receive and the use of the said dotation on the field. For Aminata Traore, international assistance is rather an international measure to maintain the poor countries poorer and the rich countries richer. It is one-sided cooperation where there is a unique entry of decision and the other countries' members are mostly on the side of the receivers than being by the side of the stakeholder and policymakers. Concerning the World Health Organization and the health security of Cameroon, the reference to unilateralism suggests the reflection stating that the inadequacy and lack of concordance between the international politics of the WHO and the concrete need of the Cameroonian populations on the field, found its origin in the international system where persists the unilateralism of dominators. It is a system where the officially presented public politic is

at a time the opposite of the final observable and identifiable results. The unilateralism of the WHO is being explainable through the principles that according to the direct observation in the field and the verbal exchanges done with responsible health sectors in Cameroon, what is being offered to the country by the World Health Organization is not always in concordance with what the medical system is expecting. There is a gap between the projected needs for the health sectors and the realizations of the WHO in the field. Things are done as if the decision-making board of the World Health Organization is not taking into consideration the concrete wishes, the expressed requests, and the various demands of the Cameroonian health system. It rather seems that while implementing according to their perspective the politics adopted, it is being done by proceeding with a unilateral decision with respect only to their objectives and perspectives and not the ones of the Cameroon health system.

***Reference to imperialism and colonialism***

As same as domination and unilateralism, the post-colonial theory refers itself to the philosophy and scientific approaches of social sciences to imperialism. According to the online dictionary Oxford Language, imperialism is *the state policy, practice, or advocacy of extending power and dominion especially by direct territorial acquisitions or by gaining political and economic control of other territories and peoples.* More only, imperialism intends to widen its own rules and projections on other people or countries by the use of hard power methods such as military forces or by soft power technics such as culture and politics. This concept of imperialism has embodied the idea of superiority and influence of an actor or group of actors. Imperialism is the seed creating colonialism. All the above-mentioned references wouldn't have a sense without the origin of everything which is colonialism. Robert Young stipulates that colonialism implies the invasion of the territory by another one. The submission of its government and its populations to the regulations enacted by the invader. According to Edward Said, *imperialism involves the practice, the theory, and the attitudes of a dominating metropolitan center ruling a distant territory while colonialism refers to implanting settlements on a distant territory.* (Said, 1994). This citation refers to the control of an entity by another entity. The control of its decision, the ruling of its politics, and the subordination of its sovereignty. The colonizer under this approach is the builder of the realities observed, he is the one orienting the local life and presiding over the destiny of the surrounded population, he is the one creating everything aside. Bu the other side, subsists the dominated entity, the colonized territory, which is the one implementing the measure taken even if it doesn't match its concrete expectations. Taking into consideration the Cameroonian case, without the express authorization of the WHO, there is no local medical invention that can be freely developed and experimented on Cameroonians even though the said medical invention can be useful and provable, and efficient for populations. There is the obligation to refer to the WHO which is the only international body that can validate a

medicine and authorize its commercialization and consumption with the official justification of international health concerns and protection.

### 1.4. Data collection and analysis

The data collection that will be conducted in the field will focus on the interpretations of the experiments. It will try to capture a concrete experience taking into account the fact that the World Health Organization has been created more than fifty years ago. This fact gives us some necessary hindsight to be able to assess the impact, to assess the effectiveness on the well-being of Cameroonians. The said method is based on inductive and deductive codifications of what we believe is logic and common sense that will be well highlighted by documentary research in libraries, online, or with various documents. The choice of **the dual methodical qualitative and quantitative** approaches as research methods is based on our willingness to seek out several truths. These truths take into account the fact that we do not have a single approach to international organizations and that they do not deploy in the same way. To give a global account of the situation of efficiency or the advent of a post-multilateral world, we will adopt a dual position. First, there is a positivist position that consists in recognizing the relentless realities about the visible and palpable concrete achievements of the WHO as unique and these IGO globally. Secondly, at the same time, we will adopt subjective positions in a **comparative method** that takes into account our thoughts, our aspirations, our worldview, and what it should be compared to what it is now. The qualitative method as described by Richie and Spencer (Ritchie, 1994) proceeds with the compilation of verbal data and their concrete meaning. Through the **comparative method**, the approach will be to collect and evaluate the data recorded in the health sector in Cameroon and then compare what was supposed to be the predictions of the different statutes, organizational charts, and any other organic and statutory devices that are the key objectives of this global health institution and the concrete achievements on the ground. **Direct observation** will also be mobilized in the sense that we have had the privilege of being citizens of the said country case study and have a practical experience of expectations, gaps, and necessities for the health sector in the country. We will mobilize to turn well compiled for this research our analysis of a set of methods and techniques quite specific. These methods will be quantitative, expressing the number of concrete, tangible achievements of these international organizations, as qualitative, information on quality, on the added value of the actions and achievements of these international organizations. We will seek to show that quantity does not reflect quality, namely in the field of finance, for example, investing heavily to grant significant credit to a country in a specific sector is not a guarantee for the development of the country in question. The case of the representation of the WHO in Cameroon illustrates perfectly the controversy. The said agency which evaluates Cameroon in a health crisis, instead of offering respirators or ambulances to this country in short supply, prefers to offer vehicles to the tune of CFA 500 million.

Through the comparative method, the approach will be based on the process to collect and evaluate the data recorded in the Cameroonian health sector. This method will be useful to check the incidences of the implementation of the said health security measures, and then compare what was supposed to be done in the predictions of this Inter-Governmental organization and the concrete achievements on the ground. The direct observation of facts and realities will also be mobilized. We have had the privilege of being accepted in certain international organizations where we have been able to see and evaluate the march of these institutions. This is particularly the case of the African Development Bank central office, located in the Ivory Coast in West Africa where the global African perspective of health care is being planned, or our passage through the various diplomatic representations of Cameroon, notably those in the Kingdom of Spain. Also, it has been possible for us in our data collection process to arrive at the Cameroonian Embassy in Italy, the one in the High Commission in Nigeria where we have been in charge of evaluating the health condition of Cameroonians living in this jurisdiction. At the same, the one in Tunisia and the Cameroonian Embassy in the Kingdom of the Netherlands, where we have been able to access some capital information and so do have a deeper idea of the various grievances and solicitations that can be raised by multilateralism. Our dual-based approach model of research, which will focus on the interpretations of the experiments, will try to capture a concrete experience taking into account the fact that most of these international organizations were created more than fifty years ago, which gives us some necessary hindsight to be able to assess the impact, to assess the effectiveness in the well-being or cohesion of states. Based on the purpose to give a global account of the situation related to the efficiency of multilateralism and lately, to erect the possibility of the advent of a post-multilateral world, we will bear a positivist position which consists in recognizing the relentless realities about the visible and palpable concrete achievements of these Intergovernmental organizations. However, at the same time, we will adopt a subjective position that will intend to take into account our thoughts, our aspirations, our worldview of the orientation that should be given to international relations, and lately, what it should be done compared to what it is been done now through the ongoing form of multilateralism.

### 1.5 Outline of chapters

This thesis will be organized around six chapters. More precisely, the present developed chapter, chapter one entitled ***Research Questions and Hypotheses, multilateralism and Outline of Chapters*** is drawn to present the general context and environment of the study, the research question that underlines the principal problem identified by the chosen topic, the hypothesis that might be confirmed or rejected by the development of ideas and research on the field, state a clear understanding of the concept of multilateralism and finally, outline/# the various chapters that will constitute the analyses. Chapter two entitled ***The Multilateralism as the symbol of togetherness*** will

underline the fundaments of this model of international cooperation suggesting that the international society can be governed by institutions norms and principles that can bring together the global community. Having several aspects such as the military multilateralism materialized by NATO, the cultural side like the one creating the Francophonie or the Islamic Cooperation Organization, or the one that directly concerns us in this research, the health multilateralism symbolized worldwide by the World Health Organization. Chapter three entitled ***Research Design, Methodology, Data Collection and Analysis*** will as mentioned develop and explain the choice of our research design. This chapter will also present the selected methodology of research and outline the various technics mobilized to collect the data exploited to conduct this research. Chapter four related to ***The World Health Organization in Cameroon*** will draw on the history of the cooperation between the two partners. It will be a question to identify the trajectory of the relationship and the various concrete realizations of the said international organization in Cameroon. This chapter will identify the acts and deeds of the WHO in the country during the framework of the study. Chapter fifth named ***The alternative to multilateralism*** is the logical consequence of the previous chapter four which has identified the deeds of the WHO in Cameroon. Chapter five will set the path to the post-multilateral era by suggesting an alternative to the actual multilateral form of international cooperation. Chapter sixth ***Thesis Conclusion*** concludes the research and presents our findings by taking a definitive position on whether our hypothesis has been confirmed or retouched. It is the final part of our development that will state the final direction given to this thesis.

# CHAPTER TWO

## 2. MULTILATERALISM AS THE SYMBOL OF TOGETHERNESS

### 2.1. Introduction

Chapter two will give a wider comprehension of the notion of multilateralism in the sense of international relations to identify, explain and justify the hope and expectations of member countries concerning their need. So doing, the World Health Organization which is the study case illustrating the importance or not of the intergovernmental organizations in line with the health security in Cameroon will be presented and questioned in its concrete facts in the country presented as one of the African countries facing major health issues and that despite its membership and regular financial participations to the WHO annual budget. There will be an outline of the spirit of togetherness that has led to the institutionalization of multilateralism and the will of easing and facilitating the access to better health conditions ambitioned by the WHO by the various populations worldwide among them those of Cameroon. The constitutional texts of the WHO will be analyzed to discuss whether the final mission of the World Health Organization in Cameroon is to curb the rate of illnesses, in a context where the Covid19 pandemic has restrained all activities and caused important human losses such as the death of the late Minister Delegate to the Minister of External Relations in charge of the cooperation with the Muslim world His Excellency Adoun Gargoum, or the lamido of Garoua, Secretary of State in charge of Health sector Alim Hayatou or to keep the country in a permanent awaiting position.

### 2.2. Multilateralism in its foundation

Considered as the manifestation of the volunteer of state or IGO parties to put together their effort for a global and common sake, to joint their strength with the aim and purpose to consolidate international cooperation, the multilateralism that started to be implemented as a model of international cooperation after the Napoleonic's war can be in a simpler way been defined as an alliance between different states country targeting to achieve the same objective. Initiated with the Concert of Europe drawn during the Congress of Vienna of 1814-1815, multilateralism is opposed to notions such as bilateralism which consist of a relationship between only two states collaborating or States with an international organization in a face-to-face system, and to the unilateralism which is considered as the form of relationship where only one super country conducts the relations and indicates the way and rules that the other States must follow and implement, a multilateralism is a

form of international cooperation putting together the main principle of win-win principle. Concretely, through multilateralism, as opposed to the other mentioned forms of international cooperation, some major points must be pointed out in the case of the existence of an international treaty that creates the intergovernmental organization. It is also the case of the predominance of the win-win or togetherness principle.

- **There is the existence of an international treaty**

It means that Inter-Governmental Organisation is based and created through a Treaty that defines the missions, ambitions, functions, and the various conditions related to the evolution of the said IGO. It is the said Treaty that defines the conditions of membership, the conditions of withdrawal, and the duties and rights of all the members. Under bilateralism or unilateralism, there is no international treaty. The only elements to be taken into consideration are the interests of the State coopering.

- **The Win-Win or togetherness principle**

Through the win-win or togetherness principle, multilateralism is built on the idea to promote collective, common, and global wellbeing. It means that the principle outlined through these ideas is that all the members shall benefit with the same proportions as the opportunities promoted by the IGO. The objective is to reduce the gap between State members and give the possibility to members that do not have a comparable level of development to catch up by implementing in a good way the advantages received and granted by their memberships. The togetherness or international solidarity principle is the wish raised by State members to GET together as one. When a country member is facing a difficulty or is going through an appreciable condition, the other members shall stand by the said country to assist the country or to rejoice with their official. Such principles and recommendations are not stated in a bilateral or unilateral cooperation system. It is what drives Miles Kahler in ***Multilateralism with Small and Large Numbers*** to identify multilateralism as international governance or global governance of the many. Many here understood as the majority, the plural, as opposed to the single world governance (Miles, 1992). Taking into consideration Dimitris Bourantonis Kostas Ifantis Panayotis Tsakonas, with ***Multilateralism and Security Institutions in an Era of Globalization*****,** published **on the 1st Jan 2007** and the one of Katie Laatikainen and Karen Smith entitled ***Group Politics in UN Multilateralism*** (Katie Laatikainen and Karen Smith, 2020)***,*** we had through the above-mentioned books a clear idea of what is been understood as multilateralism in its essence and its functioning. More precisely, Karen Smith suggests that "Group Politics in UN Multilateralism provides a new perspective on diplomacy and negotiation. UN multilateralism is shaped by long-standing group dynamics as well as shifting, ad-hoc groupings. These intergroup dynamics are key to understanding diplomatic practice at the UN". Davut Ates, in ***Uluslararası***

***Örgütler: Devletlerin Örgütlenme Mantığı*** (Ates, 2019)**,** through a triple-sided vision of explanatory method, analyses the principle of international organization in their missions worldwide such as the World Bank, the International Monetary Funds, the UNCTAD, the European Union among others. The author gives his understanding of international cooperation and outlines some concrete facts that intend to present multilateralism as he observes it. However, and it is one of the limits related to the said publication, Davut Ates seems to not suggest a strong alternative to what he describes as realities and logic of the international context. In his production ***Multilateralism: An Agenda for Research*** (Keohane, 1997) **,** Robert Keohane sees multilateralism as the practice of coordinating national regulations in a group of three or more States. The author underlines the transnational characteristics of addressing problems that are localized in specific geographic points but that can be internationalized. Taking into consideration the fact there is no more through the globalization of the world, a question that can be raised nationally without finding a concern or some other parties that may feel interested in the issue.

Kathryn C. Lavelle while producing ***The Challenges of Multilateralism*** (Lavelle, 2020) gives an accessible history of multilateralism from its origins in the 1800s to the present Multilateralism system with the observation that it has long been a study of contrasts. She develops that "Nationalist impulses, diverging and shifting goals, and a lack of enforcement methods have plagued the international organizations that facilitate multilateralism. Yet the desire to seek peace, reduce poverty, and promote the global health of people and the planet pushes states to work together". These challenges, across time and the globe, have brought about striking, yet diverging, results. Lavelle focuses on the creation and evolution of major problem-solving organizations, examines the governmental challenges they have confronted and continue to face from both domestic and transnational constituencies, and considers how nongovernmental organizations facilitate their work. Going in the same line, John Ruggie sees in multilateralism the idea of "indivisibility". His publication ***Multilateralism, the Anatomy of an Institution*** (John, 1992) outlines the fact of bringing together international efforts by three or more States.

The said multilateralism can take all the sectors of cooperation and international interest such as military (NATO), trade (WTO), labor (WLO) justice (ICJ) peace and security (NU) cultural (Commonwealth, Francophonie, Islamic Cooperation Organization) politic and integration (EU, AU) monetary and Financial (WB, IMF, ABD) or sanitary (WHO). It will be important to set the basis of the analysis, to underline the main aspects of multilateralism in a wider mean. Multilateralism indicates the willingness to regroup under an alliance in many countries share as common the same objective and same targets in a specific area of competence. It is contrary to the unilateral form of international relations stating the superpower of only one state dominates the other and directs the other countries according to its interest. Multilateralism brings countries together and so doing gives

the floor and the opportunities to less representative States, according to their size, they are not well expressed international political influences, and their lack of economic weight, to also give their point of view, raising their voice on international concern and finally develop the impression to exist among the superpowers. Through the multilateralism principles, countries are no more important by their international size, historical and cultural background, or economic weight but have only one voice regardless of their superpowers or their weaknesses. Miles Kahler in multilateralism with small and large numbers underlined the fact that the said multilateralism can also be definite as global governance or international governance of the many. According to this author, the central principle that guides this approach to international cooperation is the fact that through this system, there is a willingness to oppose two practices. More precisely, the objective is to outline the bilateral discriminatory arrangements where some important points could have been of interest to a third party but that cannot benefit from it because the said country has not been included in the agreement. Bilateralism as concluded by Miles Kahler enhances the leverage of the powerful countries over the weak ones and so, does increase international conflicts (Kahler, 1992).

Robert Keohane in his 1991 production (Keohane, 1991), related the explanation of the new approach to power has *defined multilateralism as "the practice of coordinating national policies in groups of three or more states."* This assertion goes in a straight line with the position adopted a year before by John Ruggie (Ruggie, 1992) who e*laborated the concept based on the principles of "indivisibility" and "diffuse reciprocity" as "an institutional form which coordinates relations among three or more states based on 'generalized' principles of conduct ... which specify appropriate conduct for a class of actions, without regard to particularistic interests of the parties or the strategic exigencies that may exist in any occurrence."* Since the nineteenth century, the idea of multilateralism which consist of the determination of nations sharing common goals to move forward by mutualizing their willingness toward a specific target was a reality. In Europe, the Congress of Vienna, which took place just after the end of the war called the Napoleonic wars that have been at the origin of the reconstruction of the European continent from November 1814 till June 1815 with the foundation of the concert of Europe. According to authors theorizing another conception of this togetherness symbolized by multilateralism, Harris Mylonas and Emirhan Yorulmazlar, taking into consideration the fact some international situations can be solved by entities immediately surrounding the case in consideration, bringing closer the solution to the problems would be a better crisis resolving techniques. In other words, these authors precise that contemporary problems can be better solved at a regional level rather than at the bilateral or global levels (Yorulmazlar, 2012).

The conception of multilateralism suggested by Mylonas and Yorumazlar that can be identified by the regional multilateralism implies the fact that it will be more practice and coherent than that into consideration the possible similarities of culture (such as the Arab culture that goes

beyond a country's border), geographic proximities and other factor related, it is easier for neighbors to intervene in a situation involving another party that might be close to it with above-mentioned elements. At the same, it will be complex for an external entity living a thousand kilometers far from the country to take into consideration to come and start investigations. More concretely, to illustrate the said regional multilateralism, taking into consideration the case of the African continent, the Abuja Treaty of 1981, and the several major related agreements adopted in the continent, Africa has been divided into seven blocs geographically and politically organized. These blocs, also called REC or Regional Economic Community are regionally competent to address with competence all the requests raised and submitted by their State members. This is to mention that in the West Africa region is found the Economic Community of West African States in short ECOWAS with 15 States members. In the central Africa region, the Regional Economic Community founded is the Economic Community of Central African States (ECCAS) listing 11 countries as members. In the northern zone of Africa, the Community of Sahel-Saharian States presented as the CEN-SAD having 29 States members. On the east and sub-side of the continent, the Common Market for Eastern and Southern Africa with 21 country members. The Southern African Development Community has as acronyms SADC with its 16 States members, the AMU or Arab Maghreb Union with its 5 members, the East African Community EAC with 6 countries and the IGAD, also known as the Intergovernmental Authority on Development having 8 States members are these REC participating as same as the other above mentioned Regional Economy Community in the implementation of this principle of regional multilateralism as suggested by Mylonas and Yorulmazlar. However, the regional multilateralism described above differs from the minilateralism which even though it might also be regional, has the particularity to point out the reunion of a few states sharing some points of commonality and that have decided to put effort together in order by being more proactive to reach a highest potential result (Brummer, 2014). This consideration of the zonal multilateralism takes into consideration the realities stating that multilateralism can at the same time ring together many states cooperating among themselves such as the one through the World Health Organization, or request the intervention known as the subsidiary principle (principle of transfer) in the benefit of regions or specific entities. However, if the principle of multilateralism drags the necessity of transferring to the created international organization the subsidiary competence that requires its functioning, it remains one certainty called nationalism or spirit of self-sovereignty that prevents the states members of those IGO to accept the governance and international politics of these Institutions towards them. It is the reason why in his publications Hoffman presents the situation by describing nation states as sovereign states "unlikely to embrace abstract obligations that clash with concrete calculations of national interest." (Stanley Hoffmann, 1992).

In 1992, Cox R. (Cox, 1992) in his production entitled ***Multilateralism and world order*** tried in a post-cold war period to identify the place, role, and missions that multilateralism can play to consolidate the newly established world order. It has been questioned in this article published in the Review of international studies to give a practical understanding and a proactive implication of this model of international cooperation. According to the author, multilateralism is a tool in favor of the establishment of integrated cooperation around the world and a significant institution in the willingness to bring together the international community. Cox develops his thoughts on the observation of the growing consideration and interest granted to the multipoles system by academicians, politicians, and media. The post-cold war has been a period of uncertainty, presented by some authors such as Fukuyama as the end of history in his ***The end of History and the Last Man*** (Fukuyama, 1992), where there is only one country standing, the United States of America with the liberal ideology governing the world. The main limit identified in this article published by Cox is the over-esteem granted to multilateralism in the consolidation of the new world order. Besides a fully descriptive posture entirely dedicated to the promotion of this form of international cooperation, the absence of a critical approach that might seem neutral toward this American-oriented production remains questionable. It is almost the same position defended by Ruggie J (Ruggie, 1992) in ***multilateralism, the anatomy of an institution*** published in the scientific research review of *international relations. Ruggie presents the 1992 period as the era that has operated the "most fundamental geopolitical shift not only of the post-war era but also for the 20$^{th}$ century"* which is the end of the pact of Warsaw and the end of the URSS system. Being a fervent defender of international institutions, Ruggie, in his article presents multilateralism as the guarantor of world stability. The multilateral policies have been determinant in maintaining the peace and the sustainability of international cooperation after this post-cold war era. For this author, international organization, and so doing multilateralism, is the compulsory condition to maintain the balance between sovereign states worldwide.

Same, Katzenstein, Keohane, and Krasner, three specialists in the international system and global cooperation in their collective article *entitled* ***international organization and the studies of World politics*** (Katzenstein, 1998)**,** develop the link and coexistence between the establishment and implementation of the world politics and the enforcement of international organization. According to these writers, the international organization materializing multilateralism is the mechanism in favor of the diffusion and concretization of the world order and global politics. Keohane and Krasner defend in their collective publication the idea of the federation of destiny symbolized by multilateralism which remains according to them, the indicated mechanism that can significantly ensure the diffusion of the collective interest. One other important defender of the international system and multilateralism is Hurd. In 2020, Hurd has published ***International organizations,***

***Politics, law, Practices*** where he presents the international organizations as the major institutions around the world capable of designing international politics. By analyzing the implication of institutions such as the United Nations system, the World Trade Organization, the International Criminal Court, and some other organizations, Hurd invites the observers of the international system to understand the power, the limits, and the implications of these global institutions in the stabilization of the entire system. (Hurd, 2020). It is the question for the author to identify the impact of the international organizations on the politics, law, and the orientations that are being given to them on a practical approach around the world. By identifying this impact, the auto also underlines the limits and gaps in the realization of the intended politics concerning the evolution of the international system. He then suggested a remodeling of the international organization to give these organizations the possibility to achieve the missions and perspectives that are been granted to them.

Going in the same sense as the above-mentioned writer, Fen Olsen Hampson and Paul Heinbecker in their article published in the review Global Governance and entitled ***The new multilateralism of the twenty-first century*** (Hampson, 2011), presents the new perception that the observers of the international relations have on the evolution of the multilateralism worldwide. This article is a sort of logical deduction, which compares the classic method of action of an inter-governmental organization under the classic period of multilateralism and evaluates its incidences on the evolution of the global society and the modern approach to international relations. The logical incidence of this dichotomy remains in the fact that the twenty-first century has brought new realities, different from the ones prevailing in the nineteenth one. The most evident distinction is the end of the cold war and the dissolution of the United Soviet and Socialist Republics and the predominance of the capitalist system. Reading this book has given the present research a comparative perspective between was has been usually done before the year 2000 and what is being done actually. However, one of the limits found in this production of Heinbecker and Hampson is the fact that they are not taking a position on the usefulness of intergovernmental organizations. They are simply describing the new approaches of multilateralism without criticizing or underlining the aspects that might weaken or strengthen them. They are simply on a presentation approach at the opposite of our research topic which aims to demonstrate the need for the international society to establish a new era called the post-multilateral era. The same descriptive resources can be found in the article produced by Jervis entitled ***Realism in the study of World Politics*** published in the International Relations magazine (Jervis, 1998). The author in his production gives a theoretical and a practical incidence of the realist in the conduct of international relations. According to this author, we should understand the practice of relations in the international society through the lenses of the dashes of realism. The said realism is identified both in the academic approach and the factual approach. By academic approach, is understood the realism as presented by the discipline of international relations which is

the conduct of international policies according to the only interest of superpowers. On the other side, by practical approach, is understood the orientation given to international policies by stakeholders and decision-makers such as the main permanent members of the security council of the United Nations. They are the ones dominating the conduct of international politics and so doing they are the ones deciding on the finality of a specific program. The international organization and so doing the multilateralism finds itself painted in the color decided by these superpowers. This production of Jerk is interesting for this research in the sense that it lays the first path for the critics that we are formulating against multilateralism in its orientation in the disfavor of the majority. With the data collected in the Jervis article, it is evident for us to demonstrate the unbalanced system that is prevailing in the international system and multilateralism. Being specifically based on realism which is the doctrine guiding the positions and interventions of important countries worldwide, the conduct of international affairs cannot be different from their perspective. When Jerk introduce the notion of rationality in the conduct of international politics, Kahler in 1998 speaks rather of the rationality of the actors in the choice and the orientation of globalization (Kahler, 1998). According to him, two principles must be taken into consideration while developing international policies. The first one is the rational choice based on the rationality of individuals invited to take the decisions of global politics to be submitted to the other participants of the international system and the second one is the importance of the psychology of actors that will determine the level of the preoccupation they have for the wellbeing of the humanity. Randall Stone, Branislav, and Tamar London, in their article entitled ***Choosing how to cooperate***, ***A repeated public-good model of international relations*** (Randall W. Stone, 2008). Surdej in 2020 in ***Multilateralism and international governmental organizations, principles, and instruments,*** also indicates the fact that the international organizations are the symbols giving existence and concrete meaning to multilateralism. The evaluation that can be made on the effectiveness of the said multilateralism is the consequence of the orientations, ambitions, and reel incidences of these intergovernmental organizations on the field (Surdej, 2020).

The specificity of the above literature lies in the fact that it portrays multilateralism as an opportunity for humanity. It presents the intergovernmental organization as the guarantor of the good conduct of international relations among countries. The main identifiable weakness of this literature resides in the fact it does not identify the gaps or challenges that are confronting multilateralism. It is the reason why the upcoming series of literature has been compiled to ring a different alarm.

### 2.3. The challenges of the multilateralism

The multilateralism above presented is an opportunity given to countries worldwide to bring together the potential difficulties they might be facing with less cost of resolution for everyone. However, on the field, the implementation of this multilateralism is not always as painted on the official agreements and proclaimed ambitions. The said implementations can on the contrary portray a radically opposed situation. It is the essence of the literary production of these authors who, taking into consideration the challenges of multilateralism, are indicating the weaknesses that encounter this form of global cooperation in the field.

Among the said literature criticizing the politic, organization, and concrete road map of multilateralism (Inis, 1984), (Tirman, 2006), (Contessi, 2014) or (Kathryn, 2020) Routledge Advances, in the publication entitled ***Contested Multilateralism 2.0 and Asian Security Dynamics, in International Relations and Global Politics*** (Advances, 2020).In the years 1990, there has been recorded a value in interest in the reference to multilateralism in the Asia Pacific, led primarily by the ASEAN. Since the Global Financial Crisis of 2008, many non-ASEAN states have attempted to seize the initiative, including the United States of America, Japan, China, South Korea, and Australia. Kai He and his contributors debate the reasons for this contested multilateralism and the impacts it will have on the region's security and political challenges. Martin L. in ***Interests, power, and multilateralism*** (Martin, 1992)**,** goes in the same sense, states that multilateralism is a tool in the hands of superpowers. These one choose the international organization that will serve their interest and builds it in a sort that the international politics that will outcome from these IO will favor them in their ambition to maintain the global dominating countries.

Julie Gilson through the publication ***EU-Japan Relations and the Crisis of Multilateralism*** (Gilson, 2019)**,** while presenting the history of relations between the European Union and Japan, explains the origins and significance of the momentous 2018 Economic Partnership Agreement and its parallel Strategic Partnership Agreement. Set within the historical context of the 1991 Hague Declaration and Action Plan of 2001, this book analyses the impact of recent background changes to the liberal trading order, the proliferation of free trade agreements, and uncertainty about the role of the United States in the world on relations between Japan and the EU. In so doing, this book also raises important questions about the future of multilateral cooperation, exploring the potential for bilateral agreements to undermine the possibility of finding international solutions to increasingly international problems. Vincent Pouliot (Pouliot, 2011), in ***Multilateralism as an End in itself,*** suggests that the concept of multilateralism should not only be perceived as a means to an end but rather as an end in and of itself. More precisely, Pouliot goes against the perception that some analysts of the international organizations have on the finality of these institutions. According to him,

multilateralism should not be presented as a forum where some specific actors gain influence by orientating the international governance but rather as a space where it exists the possibility for every actor to produce itself and participate significantly in the implementation of the international enacted politics and by so doing, participates to its development. Multilateralism is therefore being designed as a provider of opportunities for all the participants. The author continues his statement by claiming that being a global governance forum, the inter-governmental organizations are characterized by an inclusive, institutionalized entity that produces a significant figure of processual and consensual interest and gains benefits for all the countries' members. The consensus that emerges in the decision procedure is the main guarantee of their implementation worldwide. That means that according to Pouliot, the togetherness principle of multilateralism which symbolizes the IGO and conveys to the actors of the international milieu to take collective decisions and measures is a major advantage to strengthen the political vision and promotion of global cooperation based on inclusive and non-discriminatory procedures. He stands clearly against the various calls criticizing the polarisation of multilateralism. This production is interesting for our research in the sense that it is a document that plans to discredit our ongoing research stating that all the oppositions raised against the practice of multilateralism are not productive. Standing as a defender of multilateralism, Pouliot presents the IGO and globalization as a chance to bring together nations worldwide.

Edward Newman, John Tirman in ***Multilateralism under Challenge? Power, International Order, and Structural Change*** **(Edward Newman, 2007),** demonstrate that the principles, values, and manifestations of multilateralism, including the United Nations, are under sustained scrutiny and assault. Their performance and effectiveness are questioned, as are their decision-making procedures and their representation, according to 21st-century standards of accountability and democracy. Multilateralism under Challenge? explores the performance and future of multilateral approaches and institutions concerning major global problems such as terrorism, weapons of mass destruction, HIV/AIDS, environmental sustainability, economic justice, human rights, and humanitarian assistance. "Multilateralism is an essential component of international life, as the contributions to this volume demonstrate, with the condition and conclusion that we need to make multilateralism more effective and more accountable. **Mario Telo**, *Globalisation, Multilateralism, and Europe: Towards a Better Global Governance?* **(Telo, 2014)** It provides its readers with a critical analysis of the key concepts of multilateral global and regional governance and Europe's role in the world. As such, this unique exercise in transnational multi-disciplinary cooperation provides extensive coverage of the main issues on multilateral cooperation - notably its history, troubles, legitimacy challenges, and efficiency questions - from a variety of national perspectives. Once more, Mario Telò, a specialist in the global system and international relations, with *Multilateralism and global governance* **(Telò, 2011)** gives historical and empiric outlines related to the multilateralism practices

in deeds. He evaluates the usefulness of the said cooperation mode and demonstrates the necessity to set out a new multilateralism due to the important gaps and dysfunction presented by the actual system. It is, in fact, a document that through a comparative method and a system approach goes in a straight line with our research and ambition to set a post-multilateral era.

James P. Muldoon Jr. through ***The New Dynamics of Multilateralism: Diplomacy, International Organizations, and Global Governance*** (Muldoon, 2010) give an overview of the practical applications of multilateralism and how global issues, governance, and institutions are changing the practice and character of diplomacy is also one of the references that will give the analyses driven by our perspective to demonstrate the failure of the actual multilateral cooperation. One of the pieces of literature criticizing the way is been conducted international cooperation through multilateralism is the book of Lena Partzsch entitled ***Alternatives to Multilateralism: New Forms of Social and Environmental Governance*** (Partzsch, 2020)**.** According to the author, multilateralism has proven unsuccessful in coordinating states' responses to global challenges. Lena Partzsch describes alternatives to multilateralism, offering analyses and case studies of emerging alternative forms of private, public, and hybrid social and environmental regulation. In doing so, she offers a unique overview of cutting-edge approaches to global governance. After laying the theoretical and empirical foundation of her argument, Partzsch presents three case studies from the countries most affected by these new forms of governance and so doing gives additional tools and data to the formulation and the defense of our hypothesis. Presenting the mechanism that leads to multilateralism, Randall Stone, Branislav, and Slantchev in ***Choosing how to cooperate, A repeated public Goods model of International Relations*** (Randall W. Stone B. L., 2008) indicate that cooperation in the international environment lies on a dual approach. it is either discriminatory or multilateral. By being discriminatory, the said cooperation is based on the unilateralism or unique center of a decision where a country is seeking its interests regardless of the consequences this process might occur on the others. On the contrary, the authors underline the multilateral option of international cooperation, through international organizations with more security, guarantee, and dedication to the global interest. This second form of relations among countries is qualified by the authors as the institutionalized form of cooperation.

Questioning the feasibility of a new multilateralism to amend and ameliorate the usefulness of this model of international cooperation, Edward Newman in ***Crisis of Global Institutions?: Multilateralism and International Security*** (Newman, 2007) put a light on the legitimacy of global institutions which address security challenges is in question. How they make decisions and the interests they reflect often fall short of twenty-first-century expectations and norms of good governance. Also, their performance has raised doubts about their ability to address contemporary challenges such as civil wars, weapons of mass destruction, terrorism, and the use of military force

in international politics. Addressing topical issues, such as the war against Iraq in 2003 and terrorism, and presenting defendable arguments, ***A Crisis of Global Institutions****?* explores the sources of the difficulties faced by multilateralism. The said crisis outlines the permanent changing nature of the international environment and more precisely, the permanent fluctuations in the sector of security and mark a stopover on the norms enacting the processes and the ways decisions are being taken within international organizations. This book gives some major points related to the necessity to consider how multilateralism might be more interesting and helpful for the needy populations of countries members and so doing, be more capable to face with more efficiency the contemporary and future international demands. Norman, in the first chapter of the above-mentioned document, develops the sources and various manifestations of what he has qualified as the multilateral malaise. According to him, multilateralism can be identified as the regular practice and the principle of bringing together three or more countries willing to work together on collective action and that are ready to bind their association with specifics and strategic norms and regulations that will determine the conduct of the cooperation among them. The purpose of the said multilateralism under the intergovernmental organization remains the expectation to face common and transnational difficulties and mutualize the opportunities that might outcome in their relationships. To consolidate the role that the inter-governmental organizations have to play according to Norman, the author insists on the guarantee and liability that the creation of international organizations inspire in governments around the world. The existence of either informal agreements or explicit arrangements among these countries worldwide under the lenses of multilateralism is the key point ensuring the consolidation of this togetherness around the world. The state, concludes Norman is no more the only and principal actor in the stabilization of the international relations but a participant in the IGO which remains despite the critics raised throughout this first chapter, the main organ conducting with more integration the evolution of the international society. The same reflection related to the adaptability of multilateralism to respond to the fluctuating demands and challenges of the international society is found in the publication of Rahman Sabeel entitled ***Another New World Order? Multilateralism in the aftermath of September 11*** (Sabeel, 2002)**.** Rahman in the above-mentioned article takes into consideration the post-2001 world trade center terrorist attack that took place in America and that has drastically changed the international perception of terrorism, threads, and international security. The author underlines the fact that the international institutions and more precisely, the ones in charge of the global peace and security at the United National Security Council, have reoriented the way the questions related to security and international cooperation were conducted. Not only does one assist in an informal revision of codes and procedures related to the consideration of the enemy and antagonism in international cooperation but the world has been divided into two camps. The one belonging to the modern civilization led by the United States of America and its ambitions to eradicate terrorism worldwide and the other one, the camp of the provider or supporter of the

terrorism that would be eliminated. This perception of a dualist division of the world which does not always fit with the perception that every country has to set on itself leads to disagreements and one of these disagreements is explained by Joachim Krause when he takes the case of the European countries. When in 2004, Krause published ***Multilateralism, Behind European views***, (Krause, 2004), he wanted to underline the fact that the targets, missions, and objectives pursued by multilateralism are a subject of disagreement not only across the Atlantic partners but also within the European countries themselves. The author underlines the fact that there are up to three different and non-reconcilable schools of thought about the international organizations in Europe. These schools, having each their perception of multilateralism are divided into the French school, the German one, and the British doctrine.

The challenges that are facing multilateralism are also part of the reflection conducted by Luc Van Langenhove in ***The transformation of Multilateralism. Mode 1.0 to Mode 2.0***. In this production published in 2010, Langenhove, by analyzing the multilateral system thinks that international cooperation is experiencing some major refreshments and up to three factors describe the said mutation. First of all, the author underlines the emergence of new transnational actors as one of the consequences of the evolution of the global society. Secondly, the author identifies the creation of new multilateral sectors with goes with the third point which is the emergence of new concepts, notions, and vocabularies related to multilateralism. The three above-mentioned evolution of the multilateral classic approach of international cooperation has shifted globalization into a "networked form of multipolarity". Going in the same option, Mike Smith 2018 publishes ***The EU, the US, and the crisis of contemporary multilateralism*** (Smith, 2018). This article paints the global situation and exposes the crisis that is undermining contemporary multilateralism. According to the author, the institutions, the norms, and the negotiations constitute the three main factors explaining the absence of coherence at the time observed in the ongoing form of multilateralism. This article is important for this research regarding the fact that it gives indications of the ambiguous positions occupied by the United States of America and by the European Union in their national policies and the implementation of their respective external relations under the lenses of the three above mentioned notions. It appears then that the inclination of an international organization may be explained according to the realities that the main actors or fund providers of these institutions are going by. To go beyond the only state-centered determinism that might jeopardize the real ambition of multilateralism, Marie Claude Smouts in ***Multilateralism from Below, A prerequisite for global governance*** (Smouts, 1999) suggest another approach to international relations and the orientation of multilateralism. Her suggestion is based on the analysis made by Ruggie earlier on the importance of coordination of actors regardless of their nature in the international domain to embody with more fruitful incidences the evolution and concerns of the international community. For Marie Smouts, world politics can only be beneficial for all the participants when the global policies will be based

on and influenced by the general principles of good conduct of every international actor. This article is important for our thesis in the sense that it is a production that not only criticizes multilateralism on the way it functions but also points out the fact that the international community is not only made by state and Government representatives. The international context is complex and should not be enclosed in a concert of super-powered states. The inclusion and federation worldwide should be done from below, which means from the less represented entity that can influence the evolution and the concretization of the international agenda to the States itself.

It is also the case of the production of Dore Gold entitled ***Babel Tower, How the United Nations has entertained the chaos*** (Gold, 2004), demonstrating the implications of this global organization in missions opposed to its ambitions. When the author will develop the moral failure of the organization and suggests the remedies, we will throughout this research, go beyond the initial goals and proposal formulated by Dore, by being more categorical with a simple claim which is the shutdown of this Institution. It will be the same approach with the ***Delusions of Grandeur the united nations and global intervention*** (Carpenter, 1997) of Carpenter and Ted Gallen or ***The United Nations, Multilateralism and International Order*** of Berdal (Berdal, 2008) developing the limits of the intervention of the United Nations worldwide. The thesis defended by these authors in the above-mentioned publications indicates the ambition of the United Nations to set a world order, and orient and organize the international system. However, and this is the point of interest for our research, these references state that despite the various prerogatives and visible strength of this UN, this international organization is rather weak in front of global concerns and more specifically when it is related to peace and war worldwide. There are some authors that although they defend in their publication the principle of multilateralism, are going beyond the simple criticism of this form of international cooperation. While exposing the advantages and positive implications drawn by the international organizations, they are standing in a neutral and objective position to suggest a remodeling of the inter-governmental organizations. The main aim of their research and publications is intending to redraw the framework, emergencies, and orientation which has to be integrated the multilateralism. While advocating for the maintenance of multilateralism, they are highlighting the limits and criticize the functioning of the actual stratification and structuration of the international society.

It is the case of Viktor Jakupec, Max Kelly, and Jonathan Makuwira in ***Rethinking Multilateralism in Foreign Aid: Beyond the Neoliberal Hegemony*** (Viktor Jakupec, 2020)**,** a book providing a contemporary, critical and thought-provoking analysis of the internal and external threats to Western multilateral development finance in the twenty-first century. This publication puts forward new ideas for addressing the current global social, political, and economic challenges concerning multilateral development aid.

Going in the same lens of suggesting an alternative to multilateralism as the better form of cooperation that brings together the nations around the world, the publication, ***Regionalism, and Multilateralism: Politics, Economics, Culture*** (Viktor, 2020) discusses the impact of cultural diversities and identities on regional and interregional cooperation, as well as on multilateralism. Employing a comparative approach to organizations such as ASEAN, MERCOSUR, SAARC, and the African and European Unions and also explores the diffusion of multidimensional interregional relations, including but not limited to the field of trade. The main strength identified in this book is its suggested alternative for the actual global governance, which is the "new multilateralism". Suggestion going in a straight line with our researches. Coralie Delaume and David Cayla (Coralie Delaume, 2017) at the ***End of the European Union*** argued that the European Union is already dead by is not yet aware since the European population is no more accepting the rules and principles raised by the Institution. The authors are presenting the failure of the economic policies of the Union and the questionable level of democracy existing, as the main causes of this death. Our differences with this author are the fact that four research not only embody all the sectors of human life and not only some as what have done by Cayla and Delaume, but also is not proceeding with the principle of bottom-up but by up to the bottom suggesting that the reject of Institutions is not the result of the general opinion of the population, but is inherent to the facts and deeds of the act of the institutions. For us, the death of Institutions is not the fact of populations' reactions, but from the controversies raised by the institutions themselves. Among the African literature presenting the way Africans are receiving the idea of multilateralism and the impact of the World Health Organization in the ameliorating of the social condition of the continent are listed the book of Ahmed Mohamed Gandhi, entitled ***The long walk of Africa towards the integration and the development and politic modernity*** (Ghandi, 2013). The author presents the sanitary situation of the African continent and the inability of the WHO to address with real incidences the needs and expectations of populations in curbing the situation. According to the author even though the World Health Organization has a regional agency there is no benefit for the populations confronted with various illnesses such as aid, cholera, malaria.

In the publication of Jessica Lynne Pearson, ***The colonial politics of global health, France and the United States in post-war Africa*** (Pearson, 2009), where she examines the link and continuity between the colonial health principles and the actual vision of global health policies in the former African French territories. To explain and demonstrate the inefficiency of the World Health Organisation, Fred Eboko and Marc Eric Gruenais in ***Un système de santé en mutation: le cas du Cameroun*** (Fred Eboko, 2002), are simply giving shreds of evidence that the World Health Organisation has failed in its initial ambition of promoting the equal access to health to every citizen in the country and the necessity to urgently draw up a new international health system. This failure conducts CN Fokunang to plead for the systematization of traditional medicine as a palliative to modern medicine that is presenting its insufficiencies in the country in 2011, he published the medical

production ***Traditional medicine, Past, Present, and future research and development prospects and integration in the national health system of Cameroon*** (Fokunang, 2011). Fokunang in his scientific document sets the basis of the weaknesses of the Cameroonian health system and suggests the introduction of the traditional approach of medical intervention that has been of great use in the past of the country in the national health architecture of the country. This suggestion is constituting a sort of supplement and additive approach to the ongoing medication in Cameroon, to strengthen the medical offer and facilities in the country. By presenting traditional medicine as the health practice and various compiled thoughts, practices, and beliefs using natural plants, some specific animals, referring to some local spirituality and ancestral invocations, manual techniques, and experimentations, the author underlines the fact that, when implemented singularly or in addition with the modern medical treatment, the effects of this traditional medicine participate to reinforce the treatment of patients. Fokunang in his publications insists on the fact that due to the general economic conditions of Cameroonians and taking into consideration the various expenses and costs of modern medicine that are not always affordable for the common citizens, replacing or adding another method of treatment that has been positively experienced by the population is the path to explore. For the above-mentioned writer, the high cost of medicine and the resistance to treatment observed in some patients suffering from malaria which is the main cause of death throughout the country, or that are undergoing some bacterial infections or are simply exposed to the impact of the sexually transmitted diseases, the traditional medicine seems to be a credible alternative. From this publication presenting the advantages of traditional medicine in Cameroon, one can understand that the WHO in partnership with Cameroon has initiated a strategic platform to promote the said traditional medicine in the country. This production is interesting for this research in the sense that it provides some capital information related to the consolidation of locally-based medicine. Developing the same arguments related to the importance of the systematization of traditional medicine in the health architecture of Cameroon, Ndenecho Emmanuel Neba 2011 pointed out in his publication entitled ***Traditional Health care system and challenges in developing ethnopharmacology in Africa Example of Oku in Cameroon*** (Neba, 2011), the importance of the ethnopharmacology in the strengthening process on the Cameroonian health security. For Neba Emmanuel, the African culture, in general, is set on the thought that the best approach to stabilizing health and maintaining in good conditions the population, is to combine both the natural aspect of reality and the supra-natural one also known as the spiritual world. the importance of this book for our analyze lays in the fact that same as data collected in the previous document produced by Fokunang on the traditional medicine in Cameroon, this document presents, promotes, and defends the importance of a local medicine system that might come if not as an alternative at least as a supplier to the modern medicine still practiced in the country with the relativity of results observed on the field. The advantage presented by this document is the fact it is a credible source of strengthening

our defense on the choice of an endogenous model of medical care. With the option of the author to produce a book that identifies the strengths, picture the weaknesses and describe with concrete facts the opportunities and the potential obstacle to this endogenous model of health care, Fokunang`s document is a source of credible comparative analysis on the suitable medical system to be implemented and widened in the country. For this author, the complexity of traditional medicine, which remains difficult to master and apply for non-experimented health personnel, is one of the explanations for the complicated coexistence between the modern one and this locally based method.

However, despite the deep interest raised by this literature criticizing the implementation and the polarization of multilateralism, none goes beyond the existence of these intergovernmental organizations. It is this red line, identified as the main gap in the actual international literature that this research intends to fill.

### 2.4. The World Health Organization

Identified as the Inter-Governmental Organisation originated from the international sanitary conference held in 1851 and officially found on the 7th of April 1948 in charge of public health, the WHO is a specialized agency of the United Nations having as its main objective to raise the international standard of global health. By advocating for universal healthcare, having an eye on sanitarian risks, and promoting human wellbeing. According to the official website of the said Inter-Governmental Organization, "the WHO has played a leading role in several health achievements such as the development of Ebola vaccine and is focusing itself on communicable diseases such as HIV/AIDS which represent a major cause of loss in life worldwide, malaria which is one of the worst diseases in Africa, Covid19 which since 2019 is the cause of the paralyzing of the entire planet. The World Health Organization is composed of 194 countries among them Cameroon.

However, despite the potential of this intergovernmental organization (it is the most important health organization worldwide) the result in the field are not always as expected. It is the reason why some publications are openly against the politics raised by the World Health Organization. It is the case of Yves Beigbeder (Beigbeder, 1998) with ***Organisation Mondiale De la Sante QSJ 3234*** or Jenny Lei Ravelo in ***Battered with criticism, what's next for WHO?*** Which are some articles published online journals, presenting the situation that led to the freeze of the financial support of the United States of America and the controversies of the World Health Organization regarding the management of the Covid19 crisis, Jenny Lei Ravelo, in a comparative method and a critic approach is suggesting in its article, a WHO post era which goes in a straight line with our researches. It is also the case of David Fidler (Fidler, 2020) with ***The World Health Organization and pandemic politics, the good, the bad, and the ugly future for global health*****,**

published on the 10th of April 2020 on the online medical-oriented magazine think global health.org present the gaps between the initial ambitions raised by the creation of the WHO in charge of the global health security and the concrete facts on the field. David Fidler concludes as same as Mayjon Wildman, Jeff Richardson, and Lain K Robertson (Mayjon Wildman, 2003) through their collective publication ***A critique of the World Health Organisation, evaluation of health system performance*****,** failure of the said international organization, and question the future of the global health, as same as that is been done in our researches. The World Health Organization enacts and suggests for implementation to countries members some health policies in the line with two principal objectives. The first objective is to address the underlying social and economic determinants of health. This process requires the implication of policies and programs that stimulate health equity and take into consideration pro-poor, gender-responsive, and human rights principles and approaches. The second objective pursued by the WHO in the implementation of their adopted heath policies for countries is the promotion of a healthier environment benefiting the majority. This promotion cannot be done without a stopover on the intensification of primary prevention and the intervention in the public policies in all the sectors of health concern. In so doing it will not only be possible for the World Health Organization (WHO, 2011) to implement its ambition in the targeted country but also permit the receiving country to benefit entirely from this external assistance with more impact on the health trajectories of the population.

On another hand and also going in the sense of taking a position in favor or against the world Health Organization, Adam Kamradt Scott in 2016 questions the analysts and readers of the scientific review third world quarterly if ***WHO is to blame? The World Health Organization and the 2014 Ebola outbreak in West Africa*** (Adam, 2016) **.** This interrogation takes place in a context where there is an epidemic of Ebola on the west side of the African continent causing important losses in human lives and impacting the social and economic evolution of this part of Africa. The author informs us that the various reactions and medical responses delivered by the World Health Organization have been the cause of several critics and disappointment in the populations affected by the said virus. It was the first time that openly, critics called for its dissolution and the creation of a new model of international health organization. The importance of this article for our research lies in the fact that this production, by examining the causes of the discussed responses from the WHO towards the health crisis, the reasons for the dysfunctions and disillusions of the WHO in this specific case, and the angles of corrections that can be exploited to reinforce the ability of the said WHO. The Lancet magazine, following this tendency of questioning the impact of the World Health Organisation concerning the international health demands in 2009 ***Who runs the global Health***? (Lancet, 2009). By producing the above-mentioned report, the objectives were to underline the existence since the years 2000 of a large disease-specific global health initiative that has reformulated

the way international donors participate in public health. This report also underlined the fact that according to some analysts of the global health evolution, the said initiatives rather weaken the health system of a few resource countries when they are not simply preventing the sustainability of the prevention in meeting disease-specific targets. According to The Lancet, if the preconized adjustments in the interaction between the GHI and countries' health systems are implemented, one will observe an efficient improvement and an outcome in global public health for countries. This report is specific to this research in the sense that it points out the importance to insert in the development of the health policies in a country the principles based on the Global Health Initiative which are more complex and structured that the official and unilateral position of the World Health Organization. Being a segment of the global diplomacy in charge of the promotion of health, the WHO international impact is also criticized by Herrington and Lee in their article in the Global Health when they published ***The limits of Global Health diplomacy, Taiwan observer status at the World Health Assembly*** (Herington, 2014). This article presents the complexity that governs the functioning of the World Health Assembly which is the governing body of the World Health Organization and indicates that it is not always the preservation and the promotion of collective health security that governs the decisions at the Assembly of the WHO. Some years before, BMJ, through the published document ***The World Health Organization, WHO in crisis***, develops the idea that the international attention has been more focused on the growing leadership of the WHO than on the identifiable factors that prevent the efficiency of the organization. By listing the elements such as the organization's structure, the methods of elaboration of global politics, and the internal management of the WHO, the author gives indications and keynotes to understand the causes and the consequences of what he has qualified as "growing dislocation between the regions and the headquarters". From this document, one can better understand why the slogan health for all by the year 2000 will remain only a slogan, lacking a methodology of application and strategy of implementation.

The identified gap in the above-reviewed literature lies in the fact that those scientific researchers are not going as far as our objective which intends to set a post-health multilateralism era. They are simply explaining why multilateralism is not the expected guarantor of global sanitary security.

**Table 1:** 2018-2019 WHO Top 10 contributors

| No. | Contributors | Assessed contributions | Voluntary contributions specified | Core voluntary contributions | Total (Biennium) | Share |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | United States of America | 237 | 656 | | 893 | 15.9% |
| 2 | Bill & Melinda Gates Foundation | | 531 | | 531 | 9.4% |
| 3 | United Kingdom of Great Britain and Northern Ireland | 43 | 335 | 57 | 435 | 7.7% |
| 4 | GAVI, the Vaccine Alliance | | 371 | | 371 | 6.6% |
| 5 | Germany | 61 | 231 | | 292 | 5.2% |
| 6 | Japan | 93 | 122 | | 214 | 3.8% |
| 7 | United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) | | 192 | | 192 | 3.4% |
| 8 | Rotary International | | 143 | | 143 | 2.5% |
| 9 | World Bank | | 133 | | 133 | 2.4% |
| 10 | European Commission | | 131 | | 131 | 2.3% |
| Others | | 524 | 1,484 | 103 | 2,289 | 40.7% |
| **Total** | | **957** | **4,328** | **161** | **5,624** | **100.0%** |

Related to the above-presented table, it is obvious to consider that the United States of America with its 237 assessed contributions and 656 voluntary contributions representing 15.9 percent shares specified is the main contributor to the global budget of the World Health Organization. Followed by the Bill and Melinda Gates Foundation with 9.4 percent of the total financial needs of the Organization. In the third position comes the United Kingdom of Great Britain and Northern Ireland with a 335 core of voluntary contributions and 435 biennia and 7.7 percent of the whole share. The GAVI also known as the Vaccine Alliance is the fourth contributor in order of importance in the consolidation of the annual budget of the World Health Organization representing 6.6 percent out of 100 percent of the global amount. Germany, with 61 assessed contributions and 321 voluntary contributions specified raising 291 of the total biennium has a share of 5.2 percent of donations. Japan ranked sixth out of the 10 most important donators to the budget of the WHO

records 93 assessed contributions and 122 specified voluntary contributions giving the figure of 214 of the total biennium and driving out 3.8 percent of the said budget. The United Nations Office for the Coordination of Humanitarian Affairs UNOCHA is also part of the main contributors to the financial needs of the WHO. More precisely, being the seventh most important participant, this organization, is part of the United Nations' global system galaxy, with 192 specified contributions and 192 of the total biennium representing 3.4 percent of the determined financial resource of the studied international health system.

**Table 2:** Regional offices of WHO

| Region | Headquarters | Notes | Sigle |
|---|---|---|---|
| Africa | Brazzaville, Republic of the Congo | AFRO includes most of Africa, except for Egypt, Sudan, Djibouti, Tunisia, Libya, Somalia, and Morocco (all fall under EMRO). The regional director is Matshidiso Moeti, a Botswana national. (Tenure: 2015 – present). | AFRO |
| Europe | Copenhagen, Denmark | EURO includes all of Europe (except Liechtenstein), Israel, and all of the former USSR. The regional director is Hans Kluge, a Belgian national (Tenure: 2020 – present). | EURO |
| South-East Asia | New Delhi, India | North Korea is served by SEARO. The regional director is Poonam Khetrapal Singh, an Indian national (Tenure: 2014 – present). | SEARO |
| Eastern Mediterranean | Cairo, Egypt | The Eastern Mediterranean Regional Office serves the countries of Africa that are not included in AFRO, as well as all countries in the Middle East except for Israel. Pakistan is served by EMRO. The regional director is Ahmed Al-Mandhari, an Omani national (Tenure: 2018 – present). | EMRO |
| Western Pacific | Manila, the Philippines | WPRO covers all the Asian countries not served by SEARO and EMRO, and all the countries in Oceania. South Korea is served by WPRO.[204] The regional director is Shin Young-soo, a South Korean national (Tenure: 2009 – present). | WPRO |
| The Americas | Washington, D.C., United States | Also known as the Pan American Health Organization (PAHO), and covers the Americas. The WHO Regional Director is Carissa F. Etienne, a Dominican national (Tenure: 2013 – present). | AMRO |

Source: WHO factsheets.

As one can observe in the above table related to the regional offices of the World Health Organization worldwide, the WHO is present in six regions around the world. Present in Africa, the global health organization lays its activities on the AFRO symbolizing the African Bureau. In Europe, Euro is the equivalent of the SEARO known as the South East Asian Representation of the WHO. EMRO in the eastern Mediterranean, WPRO in Western Pacific, and AMRO also known as PAHO meaning Pan American Health Organization are these 6 regionally based sub-organization that implement in their respective field the global health policies constructed by the governing body of the World Health Organization. The World Health Organization in its constitutional text stipulates that the main objective of the Organization is the attainment by all people regardless of their origins and geographical position of the highest level of health (WHO, WHO Constitutions, 2020). In another way, the WHO's main target is to raise the life expectancy and the sanitarian conditions of humanity by promoting and easing access to health facilities worldwide. To attain this objective, the health organization works with around 7000 people around the world. The said personnel located in 149 countries are in charge of the implementation of the annually based international programs (BBC, 2017) of the Organization. Established on 7th April 1948, the WHO reaffirms the ideology, philosophy, and principles that were in force under the previous League of Nations health organization and the French-based organization Office International de hygiene Publique short OIHP. So the WHO has also embodied the orientation given by the International Classification of Diseases known as ICD which is an international tool that helps to draw figures and statistics related to the health evolutions and realities of a community (WHO, "History", 2020).

As described on its official webpage, the ICD stands by countries' needs for technical assistance, and the enacting of internationally accepted healthcare standards while at the same time drawing a global picture of the international health system evolution. As same as all organized international organizations, the World Health Organization is constituted under a specific structure that determines its function. There is a decision-making board called the World Health Assembly. The WHA which elects an executive board constituted of 34 health specialists selected around the world according to their specialties, international reputations and credibility is the main organ that determines and decides the international politics and action that will be implemented by the WHO for a specific period and specific geographical zone. The assembly held regular meetings or international conferences where some major health issues are being debated under the denomination ISC or International Sanitary Conferences which has been initiated on the 23rd of June 1851 (Howard-Jones, 1974). It is the reunion of health experts that most of the time produces major recommendations that are being taken into consideration while elaborating the future action plan of the organization or that might polarize the intervention of the World Health Organization. One of the concrete outcomes of these international sanitary conferences as presented has been the suggestion

and the creation in 1902 of the PASB known as the Pan American Sanitary Bureau and just five years later in 1907 of the Office International of Hygiene Publique in short OIHP. The Health Organization of the League of Nations HOLN which has been created in 1920 under the logo of the League of Nations is also one of the successes recorded by the above-mentioned ISC which has later been replaced by the World Health Organization after the end of the second world war and the creation of the United Nations (McCarthy, 2002). It has been decided to name the organization with the notion Word instead of international to mark the willingness of the founder of the WHO to embrace the world in its globalist. International means simply among the nations while global represents the entire world. By sending a clear message about the ambition of the newly created organization, one can easily understand the position and the role the WHO intends to play worldwide (Journal., 1948). With regards to the ambition and hope raised by this renewed international organization, the World Health Organization became the first technical and specialized agency of the United Nations galaxy system to embrace the participation and membership of the major part of the countries worldwide (Shimkin, 1946). The adopted logo of the WHO symbolizing the healing process has been the Rod of Asclepius. The Rod of Asclepius also known as the Asklepios or Staff of Aspeculapius in Greek mythology is this symbol presenting a serpent entwined with the Greek God Asclepius called the god of health and medicine. (WHO, "World Health Organization Philippines", 2012).

On a constitutional basis, (ref. the constitution of the World Health Organization in annex 4) the World Health Organization set its ambitions according to its fundamental texts and clarifies its objectives and missions as follows. The first point stating the existence of the World Health Organization is the point related to its existence and function which mentions that the WHO functions as the main international reference for organizing, monitoring, and supervising global health. In other words, it is to evolve as the main board and the principal coordinating entity on international health issues. The second point outlines the fact that the WHO has to establish and maintain effective cooperation and collaboration with the United Nations which remain the main structure of international policy management. The same relations and cooperation must be maintained also with specialized agencies of the WHO and all the other agencies participating in the implementation of the WHO global policy. The Constitution of the WHO prescribes to the organization to nourish the relation with governmental health authorities, professional groups related to the health politic, and all the relevant participants that might intervene in the sanitarian process. The third mentioned mission of the WHO as prescribed by its constitution is to assist Governments upon request. It means that the WHO has to be by the side of States and Governments for the purpose to reinforce and so doing, strengthening their health service and facilities.

The fourth duty is to furnish concrete incidences, appropriate technical assistance and all the requested and available aid that can be helpful for the health issues of requesting parties such as

governments. One of the other duties recognized by the WHO by its founding texts is to provide as much as necessary upon the express request of the United Nations some health services and assistance to identified needy groups. The case of people from trust territories has been used to illustrate the case of the enlargement of possibilities of intervention of the WHO beyond the classic intervention in favor of States or Governments. The World Health Organization sets, establishes, and coordinates administrative and technical services with the requesting part and if necessary, conducts actions in epidemiological and statistical sectors. It is stated that the WHO stimulates and advances work to fight against epidemics worldwide, invent all the necessary actions and medicine to counter the spreading of all endemic and other diseases that might occur to protect and maintain the international health system. The World Health Organization promotes in accordance and cooperation with other specialized agencies intervening in the sector of health when the situation is requesting such action in order to stimulate the prevention when the entire eradication is not possible of accidental injuries. The willingness to eradicate as mentioned above all the possibilities of accidental injuries goes with the mission of improvement of nutrition with access to qualitative and quantitative food worldwide, rising the availability of housing opportunities for people living without homes called homeless people, sanitation, and recreation. By ensuring the fundamental needs of human being listed above, the WHO while cooperating with strategically recognized specialized agencies has also the duty to promote and guarantee the economic or working conditions of populations around the world and maintain other aspects of environmental hygiene. The WHO promotes cooperation among scientific and professional corporations which respectively according to their ambitions are also as same as the international health organization preoccupied with the questions related to the promotion of health and the improvement of access to health facilities worldwide. To achieve its goals and mission listed above, the WHO might be invited to propose conventions to its partners, to suggest and sign some agreements and regulations that can reinforce the level of health around the world. The WHO can also make some recommendations that the organization finds useful with observance of international health realities and concerns for implementation for the mutual benefit of the Organization and the populations around the world. According to the official information available on the website of the organization, it is stated that the World Health Organization resolves governmental health policies with two complementary objectives:

"*The mission to address the underlying social and economic determinants of health through policies and programs that enhance health equity and integrate pro-poor gender-responsive and human rights-based approaches*". The second clearly stated ambition is "*to promote a healthier environment, intensify primary prevention and influence public policies in all sectors to address the root causes of environmental threats to health*" (WHO, "Programme Budget, 2012–2013", 2012). On the previous lines have been presented the missions objectives and goals that the constitutional

background of the World Health Organization has determined for the functioning of the organization (WHO, "Programme Budget, 2012–2013", 2012). One can conclude that out of the thirteen distinguished zones of competence attributed to the WHO one must underline the role and the importance of providing leadership, reinforcing the governance, and deepening the partnership and cooperation with the countries members of the organization, the United Nations itself and all the other important partners which contribute to the implementation on the field of the WHO international policies. This imperium goes with the interest to be under the necessity to fulfill the mandate of the World Health Organization to boost the improvement of the global health agenda. In another segment, the various aspects of these thirteen points organizing the deployment of the WHO worldwide drag some identifiable aims. These objectives intend to develop and sustain the health organization as an adaptable institution, as a learning organization capable of applying with constant evolving competence the mentioned missions and ambitions. The World Health Organization is an international organization constituted of 194 countries members. The 194 countries are in the majority part of the United Nations galaxy except for Liechtenstein and the Cook Islands and Niue (Burci & Vignes, 2015). The constitution of the WHO mentions the required conditions to become a member of the organization. It is prescribed that a country becomes a full member of the WHO when it ratifies the treaty consolidating the /organization which is the constitution of the said Institution. The WHO functions with two associate members who do not have the same right and duties as the full members but can present in the general debate to have their perception of the mechanism that determines the machine of the WHO. The said associate members are Puerto Rico and Tokelau. (Hill, 2020).

Other countries and Governments such as Palestine have been granted the status of observer to the organization. Officially presented by the WHO as a national liberation movement, Palestine has been officially recognized by the League of Arab State which is the regional organization constituted of Arab countries. As observers to the World Health Organization general assembly also listed the Sovereign Military of Malta in its official denomination or order of Malta in its shortest form. As same, the Holy See has been officially accepted to participate in the WHO with the statute of observers. Its participation statute is mentioned, *nonmember state observer,* till the definitive validation of their candidature by an assembly which will take place in 2021, (Haltiwanger, 2020) (BBC, "US election: Joe Biden pushes forward with plans for office", 2020). In the same lens, the Government of Taiwan, taking into consideration the willingness of the ongoing Government of Taiwan to be independent and evolve without China, was authorized to participate in the sessions with the statute of an observer to the World Health organization under the appellation Chinese Taipei from 2009 till 2016. However, with regards to the diplomatic imbroglio and uncertainty raised by the ambition of China to reconquer this territory considered as a part of Great China, to be prudent

and conciliating, Taipei, after 2016, has not been invited anymore to the assembly and deliberations of the WHO (WHO, Japan PM Abe calls for Taiwan's participation in WHO as coronavirus spreads, 2020). The above-mentioned galaxy of members and observers constitutes the figure of 194 States participating in the United Nations health specialized agency which is the WHO is the one contributing to the annual global financial need of the organization (Timsit, 2020). Having its official meeting scheduled every year in May in the Switzerland city of Geneva, the WHO is in a practical way governed by the WHA known as the World Health Assembly which is, in reality, the legislative and highest body of the World Health Organization. It is in this instance that decide the norms and regulations will be submitted for implementation to the 194 members' states in their aspects taking into consideration the realities of every country.

### 2.5. The health situation in Cameroon

One of the objectives of this thesis is to reset the path for the reform of the Cameroonian health system to be more efficient and responsive to the needs and requests of the population. There is a large range of literature inspiring this reform. Among them, ***Rethinking health care systems, A focus on the chronicity*** of Allotey Reidpath Yasin, Chan, and De Graft (Allotey, 2011) which indicates that health care systems worldwide (thus the Cameroon case), face a crisis on an increasing burden of chronic disease complicated by the permanently rising rate of infectious diseases and the outbreak of international pandemics. The authors, by outlining the fact that the situation of the health care systems in low and middle-income countries are aggrieved by the ambient poverty causing chronic illnesses related to poor living conditions and the persistence of non-communicable disease, hell without clearly naming it, the Cameroonian health system. The described situation fits with our case study realities, this publication unveils a high interest in the development of our research.

There is rich literature related to the health situation in Cameroon. This health security is subject to various development and its presentation is subject to the sensibility of the authors analyzing the reality of the health security of the country. It is the case of the participation in this literature in 2014 of Emmanuel Ngwakongwi, Mary Bi Suh Atanga, and Hude Quan with their medical-based articles entitled ***Challenge to implement a national health information system in Cameroon, Perspectives, and stakeholders***. According to these writers, the Cameroonian ministry in charge of national health has developed a national health information system known in short as NHIS which presents itself as a revolutionary tool that will assist the medical personnel to collect data related to the health situation of the country (Ngwakongwi, 2014). The other contribution of this collective document in the analysis of the health security of Cameroon has made on three other points. It has been the case of the presentation of the situation describing an inefficient NHIS due to a lack of personnel a labor-intensive approach, a delay in the report of collected data, and a well

observable lack of incentives. The specific aspect that attracts our attention and that is important for this research on the evaluation of the Cameroon health system is the fact that these authors conclude their analysis by suggesting that the migration from an analogic method to an electronic health information system despite the potential positive incidences it may drag will be useless if the stakeholders and appropriate responsible elements. The other scientific production related to the health realities in Cameroon is the publication of Ssed Muhammas Israr, Oliver Razum Victor, and Ndifor Chu Patrick Martiny. These authors published in 2001 the book ***Coping strategies of health personnel during an economic crisis, a case study from Cameroon*** (Israr, 2001). By examining how the health personnel is coping in their daily duties with the economic crisis that took place in the years 1990 with the reduction of salaries and several advantages of the health personnel, these authors intended to determine the impact of an economic recession on the engagement, determination, and professionalism of the Cameroonian health agents. The results of the above-mentioned research have presented a situation where public health personnel had gone through an important cut in salaries without seeing their duties calibrated to their new remunerations. To this inadequacy of treatment, is been noted the end of allowances that impacts the motivation of this personnel. Muhamed Israr and Co mention the fact that to cope with the situation, some attitudes qualified as survival strategies have been developed by these agents. It is the case of the parallel selling of drugs or the request for payment for extra service to the patient admitted to the hospital. The statistic 2009-2020 of Annex 1 presents more figures and elements of the concrete health situation in Cameroon. Tandi, Cho, and Akam 2015 describe the inequalities in the Cameroonian health system by publishing ***Cameroon's health sector, Shortage, and inequalities in the geographic distribution of health personnel*** (Tandi, 2015). This collective article points out the fact that Cameroon one of the country members of the World Health Organization recorded a critical shortage of its health personnel. The said situation is being worsened by the geographical unequal repartition of the local health personnel. By using the end of the year 2011 general census of the population in the country, the authors indicate that some regions record a higher number of physicians than others principally located in the rural areas. The painted picture of the global situation of the health system of the country made by Tandi and Akam indicates that the poor working and establishment conditions that are facing these physicians explain the observed migration of this personnel from the public sector to private health facilities. Going in the same perspective, Ongolo Zogo Clemence (Clemence, 2020) in ***Improving national Health Research Systems Performance, The case of Research Production and use in Cameroon***, gives the precision that the Efficient National Health Research System known as NHRS is a source of knowledge capable of improving the health outcome in the country. However, to be efficient, a centralized database of health research should be created coupled with the effective applicability of this NHRS. The contribution of this article to our research is based on the fact that it gives information related to the various previous

suggestions that have been made to strengthen the Cameroonian health system but that to date have not still been implemented. It is therefore an occasion given to our production to rephrase the propositions done in this sector by actualizing the context of our study and adapting them to the ambitions of our research. Some years before, in 1993, Rene Owona Essomba, Malcolm Bryant, and Claude Bodart also table on the reorientation of health care in Cameroon. In the collective article ***The reorientation of primary health care in Cameroon, Rationale, Obstacles, and constraints*** (Rene Owona Essomba, 1993), the authors explain the inoperability of primary health care in the country around three factors. Besides an inadequate legal framework and an incompatibility between the political institutions and the health center's requirements, subsist an incompatibility between the ambitions of the refreshed health policy and the organizational chart of the Ministry of Health, and thirdly, a highly centralized system of management with a disputable centralized system of management with poor management of human resources. To solve the situation and impulse a new dynamic in operationalizing effective primary health care in the country, the inability of the system to ensure the availability and the easy accessibility of medicine and the inadequate health information system driving a poor promotion of adopted primary health care services are the weak points to address and kick off the practices of the modern health in Cameroon. We thereby appropriate the above-mentioned suggestions to reinforce the defense of this research to reinforce the health security of the country. These difficulties are also part of the work produced by Wanko Keutchafo, E. L. and Kerr J. in their 2019 article entitled ***Difficulties of unit managers in selected district hospitals in Cameroon*** (Wanko Keutchafo, 2019). The interesting part of this article is found in the observation made by the authors on the situation prevailing in some medical centers where at times, one can find a unit manager in a resource constraint district hospital that has no previous training in leadership and management. The obvious consequence of these facts is the mismanagement of the personnel and so a later dysfunction of the medical center for the disadvantage of the needy populations.

***Overview of the health realities in Cameroon***

With a life expectancy at birth of 60 for women and 57 for men (World Bank 2018) Cameroon is a country having as the top ten causes of death (CDCP, 2019): HIV/Aids, Malaria, Road Accident, thee Cirrhosis, the Ischemic, Coronavirus / Covid19.

***- HIV/ AIDS***

Officially identified in its long-form the Human Immunodeficiency Viruses, HIV which is from the family of retroviruses is the main cause of the Acquired Immunodeficiency Syndrome provoking a gradual weakening of the natural defense of organisms known as the immune system (Douek, 2009) and allowing some other illnesses to attack with less effort the said organism (Weiss, 1993). Transmitted through three main canals such as an unprotected sexual activity between an

infected person with a non-infected one by the semen the vaginal secretions, the transfer of unsafe blood that has not been verified and checked before its transmission to a needy patient, and from a mother to her child while breastfeeding it (Robert, 2019). Discovered in the United States of America in 1981, the notion of AIDS has been used first during a scientific meeting organized by the American CDCP known as the Centres for Diseases Control and Prevention in July 1982. HIV AIDS as a retrovirus has been officially adopted in September 1982 (Kher, 1982) and has been clinically examined by Robert Galo and Luc Montagnier, and Francois Barre Sinoussi in 1983 (Gallo, 2005). It is in 1985 that the first case of Aids has been detected in Cameroon. According to the official communication of the Cameroonian Ministry of Health, highlighted by the online health magazine S*ante Tropicale,* the rate of HIV/AIDS in Cameroon as of December 1st, 2020 is 2.7 percent of the population. Moving from 4.3 percent 9 years earlier in 2011 to 3.4 percent in 2018 and 2019, the said rate is decreasing. More precisely, from the first semester of 2020, 1250 000 individuals have been tested for the virus among them 329 218 pregnant women. 37 429 new positive cases have been detected and 30 061 have been immediately placed under medical treatment. Counting 10 regions in the country, the South region of Cameroon has been identified as the most exposed region with a percentage of 5.9 percent of positive cases. The center region comes second at 4.1 percent. The 3rd region is the East region with 4.6 percent of newly infected cases. Since 2007, the treatment of HIV in the country is free of charge and since January 2020, the HIV screening test is also free of charge and entirely sponsored by the Cameroonian Government.

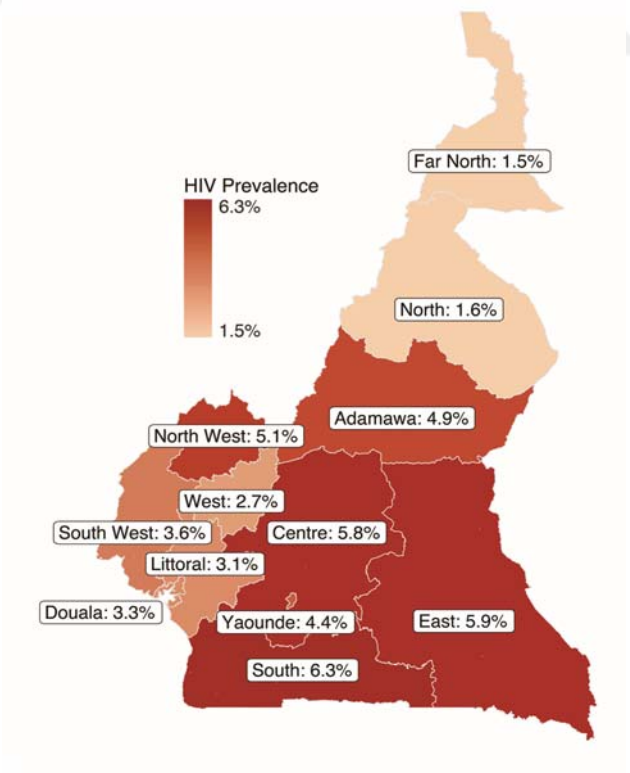
**Table 3:** HİV prevalence in the 10 regions of Cameroon

| Region | HIV Prevalence (%) | 95% CI |
|---|---|---|
| Adamawa | 4.9 | 3.1-6.7 |
| Centre | 5.8 | 4.8-6.8 |
| Douala | 3.3 | 2.5-4.0 |
| East | 5.9 | 4.5-7.3 |
| Far North | 1.5 | 1.0-2.1 |
| Littoral | 3.1 | 1.2-4.9 |

| | | |
|---|---|---|
| North | 1.6 | 1.0-2.1 |
| North West | 5.1 | 3.4-6.7 |
| South | 6.3 | 5.4-7.3 |
| South West | 3.6 | 2.4-4.9 |
| West | 2.7 | 1.8-3.6 |
| Yaounde | 4.4 | 3.2-5.6 |

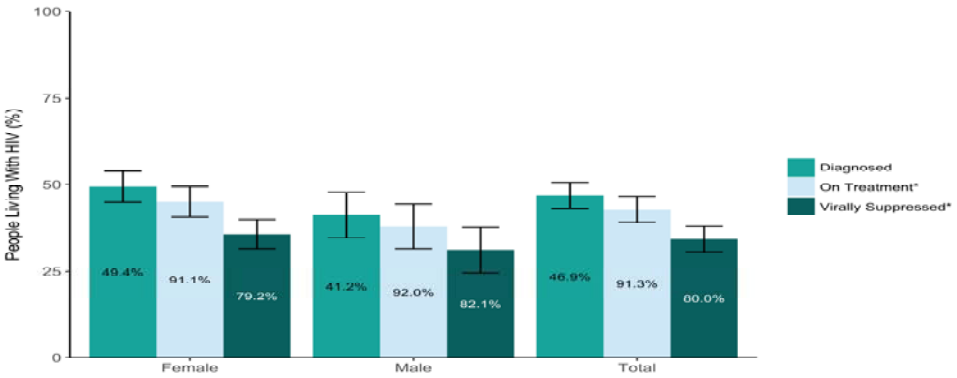
Source: Minsante 2018.

**Figure 3:** HIV prevalence in the 10 regions of Cameroon




Source: Minsante 2019.

**Figure 1:** People living with HIV in Cameroon by the year 2016




Source: Minsante 2018.

From the above-mentioned figure stating the percentage of people living with HIV in Cameroon by the year 2016, some points are interesting. Organized around gender and some key indications such as the diagnosed people in classic green, the people on treatment with the light green, and the virally suppressed people with the dark green. Among the female range of the population living with HIV in Cameroon, there is 49.4 percent of diagnosed patients, 91.1 percent of the said patients in treatment, and 79.2 percent of them recording viral suppression. Among the male range of the population living with HIV in Cameroon, there is 41.2 percent of diagnosed patients, 92.0 percent of the said patients in treatment, and 82.1 percent of them recording viral suppression. The total listed in this table state 46.9 percent of diagnosed patients both male and female, 91. 3 percent of the ongoing treatment and 80.0 percent of the identified patient that has witnessed their viral charges entirely suppressed.

**Table 4:** HIV indicator in Cameroon

| **HIV Indicator** | **Female** | **95% CI** | **Male** | **95% CI** | **Total** | **95% CI** | **N** |
|---|---|---|---|---|---|---|---|
| Annual incidence (%) 15–49 years | 0.44 | 0.18-0.69 | 0.08 | 0.00-0.18 | 0.26 | 0.12-0.40 | 770 |
| 15–64 years | 0.45 | 0.20-0.69 | 0.09 | 0.00-0.19 | 0.27 | 0.14-0.41 | 960 |
| Prevalence (%)<br>15–49 years<br>15–64 years | <br>4.8<br>5.0 | <br>4.2-5.3<br>4.5-5.5 | <br>2.0<br>2.3 | <br>1.7-2.4<br>2.0-2.7 | <br>3.4<br>3.7 | <br>3.1-3.8<br>3.3-4.0 | <br>22,444<br>26,031 |
| 0–14 years | 0.1 | 0.0-0.3 | 0.3 | 0.1-0.5 | 0.2 | 0.1-0.4 | 7,221 |
| Viral load suppression (%) 15–49 years | 42.1 | 37.6-46.5 | 38.0 | 29.1-47.0 | 40.9 | 36.5-45.3 | 792 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 15–64 years | 45.6<br>980 | 41.3-50.0 | 42.5 | 34.8-50.3 | 44.7 | 40.7-48.7 |

Source: Minsante 2018.

The interpretation of these tables below gives some information related to the HIV prevalence in the Country. This HIV indicator states that the HIV prevalence is up to 9.3 percent among identified females aged between 50 and 54 years old. This figure represents almost one and a half times more than the figure recorded for the males of the same age range. In other words, the figure related to male prevalence is 6 percent for men aged between 50 and 54 years old. The prevalence among the young Cameroonians aged between 15 to 24 years old is recorded at 1.2 percent. These 1.2 percent represent 2.0 percent of females and 0.4 percent of males making young girls more exposed to HIV in the country. The same statistics from the Ministry of Health f Cameroon present the situation where women aged from 15 to 19, the ones from 20 to 29 years old, and the ones from 25 to 29 years old are three times more contaminated by the virus of HIV than the male of the same age range.

**Table 5:** Sero-prevalence in the 10 regions of Cameroon

| **Region** | **VLS Prevalence (%)** | **95% CI** |
|---|---|---|
| Adamawa | 34.1 | 19.5-48.6 |
| Centre | 43.5 | 34.7-52.3 |
| Douala | 45.1 | 30.9-59.4 |
| East | 45.4 | 32.9-57.9 |
| Far North | 37.8 | 23.2-52.4 |
| Littoral | * | * |
| North | 27.6 | 14.3-41.0 |
| North West | 60.9 | 51.2-70.7 |

| | | |
|---|---|---|
| South | 34.4 | 18.4-50.5 |
| South West | 33.8 | 20.8-46.7 |
| West | 62.9 | 48.6-77.3 |
| Yaounde | 41.1 | 27.7-54.4 |

Source: Cameroon Ministry of Health 2015.

**Interpretation**

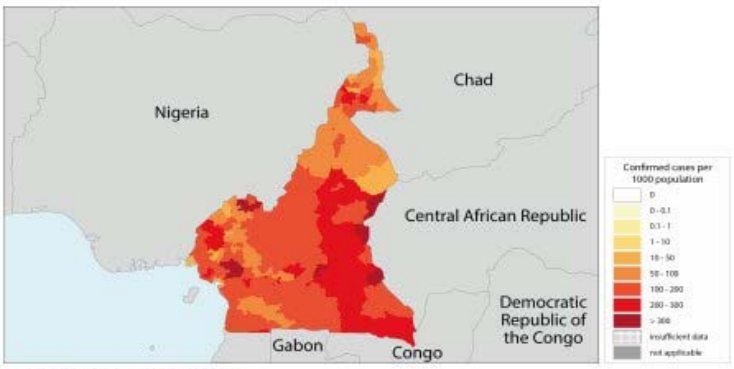
Among HIV-positive adults ages 15-64 years, Variation of LS varies by region, ranging from a high of 63% in the West Region to a low of 28% in the North Region. The estimation for the Littoral region is based on a very small number (less than 25) of unweighted cases and has been suppressed. The above-mentioned table indicates the figures related to the viral load suppression in the 10 regions of the country for a specific period in Cameroon. Annex 2 is giving a more precise view of the impact of HIV in Cameroon.

- ***Malaria***

Causing symptoms such as fever headaches vomiting or some unexplained tiredness through the apparition on infected bodies of signals like seizures, coma, yellow skin, and in some drastic cases the death of individuals, the malaria is a mosquito infectious disease-causing illness of human beings (Caraballo, 2014). Scientifically caused by a single-celled microorganism of the plasmodium group, Malaria wides itself through an infected female anopheles' mosquito which bites and introduces the infected element of illness with its saliva into individual blood. Present in the tropical and subtropical regions surrounding the equator, countries from Asia, Sub-Saharan Africa, and Latin America are the most exposed ones with a dramatic figure of 228 million cases worldwide in 2018 with a record of 405 000 deaths (WHO, World Malaria Report 2019, 2019) having among those one 93 percent of the global case and 94 percent of the total amount of dead are from Africa (WHO, World Malaria Report 2019, 2019). Presented as the illness of poor people, historically, malaria disease has been identified some 10 000 years ago with the development of agriculture and the development of human settlement (Harper, 2011). It was under the research of important scientific researchers such as Hippocrates, and Columela that the disease has been studied by medicine. It is presented as one of the main causes of the decline of the Roman Empire (Sallares, 2002) and identified later as the Roman Fever of its predominance and its impact on the former Empire. The

notion of malaria appeared first in the English medicinal literature around 1829 and benefited from an important evolution in scientific research in 1880 under the investigations of the Medicine Nobel Prize named Charles Louis Alphonse Laveran, a French army doctor serving in a foreign camp in Constantine in Algeria discovered parasites inside the red blood cells of infected individuals.

**Figure 4 :** Cameroon Malaria Distribution




**I. Epidemiological profile**

| Population (UN Population Division) | 2017 | % |
|---|---|---|
| High transmission (>1 case per 1000 population) | 17.1M | 71 |
| Low transmission (0-1 case per 1000 population) | 7M | 29 |
| Malaria free (0 cases) | 0 | - |
| Total | 24.1M | |

Source : Minsante 2018.

**Interpretation**

The above picture presenting the epidemiological profile of malaria distribution in Cameroon gives the possibility to identify 11 different types of the zone of impact of malaria in the country. the said zone is represented by 11 different colors being affected by the climate and the geography.

1- The white color representing 0 for a conferred case per 1000 inhabitants indicates that in the actual scheme in Cameroon no regions are recording zero expositions of the population to the malaria disease. The mention of zero cases confirmed, simply implies that Cameroon is a country where no potential zones are spared against malaria illness.
2- The mixed yellow color indicated from 0 till 0.3 out of 1000 inhabitants presents the Cameroonian geographical area where one can record 3 inhabitants out of 1000 that have been confirmed with the virus of malaria.
3- The yellow color presenting 0.3 till 1 out of 1000 inhabitants which are localized mainly in the northeast of the country suggests that out of 1000 populations there are up to 10 patients that were victims of the malaria virus in the sector. It also indicates the level where the confirmed case becomes more frequent.
4- The mixed pink color designates the regions where the scale of confirmed cases of malaria is between 1 to 10. It indicates that from a population of 1000 inhabitants

observed for a certain period, there are up to 10 confirmed cases of malaria among the population.

5- The pink color corresponding to the frame 10- 50 confirmed cases presents the situation stating that in a population of 1000 inhabitants residing in a precise medical area of analysis there have been up to 50 people who have been diagnosed positively with the malaria virus. This pink color corresponds to some regions in the center, the north, and the eastern regions of Cameroon.

6- The mixed red color with 50 to 100 confirmed cases out of 1000 as same as the above-mentioned diagrams stipulates that there are up to 100 patient bearers of malaria in a population of 1000 inhabitants. The regions of the North and North West of the country are the regions recording the majority of these cases.

7- The light red color recording the 100 to 200 confirmed positive cases of malaria identified in the littoral regions and some points in the Adamaoua mention the situation wherein those areas, there have been discovered for a thousand o population in density up to 200 confirmed cases representing 20 percent of the entire populations of the identified zone.

8- The red color with its 200 to 300 confirmed cases recorded in the East region is explainable by the fact that the East region is a region with a high density of forest and humidity. Taking into consideration the fact that mosquitoes that are responsible for malaria are an insect that develops themselves easily in humid and forestry zones it is obvious that this red color appears at this point in the country.

9- The solid red color indicating areas where there have been diagnosed more than 300 positive cases of malaria has as main signification that those zones are the most exposed to malaria and in a population of around 1000 inhabitants at least 30 percent of the said population have already been confirmed as the bearer of the malaria virus. Taking into consideration the figures related to the statistics related to the epidemiological situation of malaria in Cameroon, one can easily conclude that the areas such as the East and the Far North region of the country are the main basis of malaria in the country.

10- The white-grey color indicates in the above picture the spaces in Cameroon where it has been difficult to collect data and so doing to have a clear and precise idea of the malaria distribution in these zones. It was caused either by difficult access to these zone by medical campaigns or simply zone where people do not live in sedentary mode and are always absent.

11- The grey color indicates the other geographical zones out of Cameroon where the analyses do not occur. It shows on the map the countries out of Cameroon where the study does not apply.

In another segment, it is important to mention the fact that Cameroon has adopted a 4 years based strategy to counter the evolution of Malaria known as the Cameroon Strategy for case management for 2019-2023. The said strategy recommends other:

- To increase and boost the training for the professional of the health sector. It is a sort of a revaluation of the level of understanding and the capacity of reaction of the Cameroonian health personnel towards the treatment of malaria in the country. the objective is to have doctors and nurses more equipped with new national adopted solutions to counter the impact of this disease in the country.
- To bring closer the same time and on the same level of understanding the private and the public sector to form a tandem that will demonstrate the willingness of health authorities of the country to make the fight against malaria a national concern that is no more lying only on the hands of the public sector.
- Widen the integrated Community case management, in short ICCM to all the country and make it accessible to all the health institutions of Cameroon. It is the question to help the 22 000 CHWs in 109 Cameroonian districts that are not yet benefiting from this case management program. The objective is through this intention to ensure effective national coverage to build a sort of shield that will not permit the creation of some resistance in regions that were not been included in the program.
- The other objective targeted by this ambition to upgrade the ICCM at a national level is to implement the quality control of commodities.

The exploitation of available sources of information during the research in the field has permitted to collect the information stating that the research on the statute of case management practices has been made in 135 health centers in 13 health districts in the North region and the Far North region of the country in September 2019. According to the said data, 53 percent of medical personnel listed in these regions had not been evaluated and did not receive actualized and refreshed training in case of management with regards to malaria. They were still applying the former protocol with the same, not significant results recorded years before. As same, 81 percent of identified malaria-caused sick patients were treated with the injectable solution of artemether or injectable quinine which is the medicine prescribed in case of malaria. Injectable artesunate was also used and the cases recorded with pregnant women were all coming with the mention crucial and severe. Only 39 percent of the hospital in the North and Far North region of Cameroon were applying the free prescription and use of case management of uncomplicated and complicated malaria for children aged less than 5 years old. Another research on the methodology of free diagnosis and treatment of all types of malaria has been conducted from July to August 2018 by the NMCP with the remarks that only 39 percent of severe malaria cases were followed by a well-respected national treatment

guideline. The 61 other percent were treated with the former methods with the consequence of jeopardizing the national struggle against malaria. On another point, there have been recorded practices consisting of misuse of malaria medicine with inappropriate posology and counter-indications. More precisely, there have been recorded several cases where severe malaria medications were used in case of simple and uncomplicated malaria cases. The consequence is to drain the finishing of the said medications and so doing make them unavailable for needy people. The main and repeatedly medicine prescribed and consumed to fight severe malaria was intravenous quinine.

***Severe malaria case management in pregnancy***

There is a controversy raised by the willingness of the National Strategic Malaria Control plan to address with more efficiency the situation of pregnant women suffering from malaria and the prescriptions of the World Health Organization. More precisely, the 2014-2018 NSMCP prescribes that in a situation where a medical doctor has in front of him a pregnant woman who has been identified with the germ of malaria, she should be automatically treated as a patient suffering from severe malaria even if her case is not a source of worry. The point is that it is not the recommendations of the Who and the said prescription goes straight in opposition to the position of the WHO (Organisation, 2019).In another segment, the same study realized by the national program gives information that women in their first period of pregnancy were being administrated the intravenous quinine for the first 24 hours accompanied the day after by drinkable quinine for seven days of use. After the first trimester, in the case of recidivist malaria, the injectable artesunate was the medicinal protocol in force to face the illness reinforced by injectable quinine intramuscular artemether of injectable artesunate. However, the fact that the above-mentioned treatment was not free of charge, was not affordable for many poor rural women confronted with malaria. Recorded figures present the situation stating that up to 54 percent of pregnant women suffering from malaria or simply preventing the outbreak of this disease to protect their future baby received at least two administrations of intermittent preventative treatment of malaria in pregnancy. As same as the rate recorded in 2014, with 53 percent of women having received two doses of intermittent preventative treatment of malaria in pregnancy, in 2018, 54 percent of pregnant women have been injected with the double dose of vaccine. On a statistical basis, there is an increment in the rate of women who have received at least three doses of IPTp3 moving from 26 percent in 2014 to 32 percent in 2018.

However, concerning the above-mentioned figures, it seems obvious to identify a relativeness of the coverage of the IPT throughout the country. The said low coverage can be explained by the interpellation of some points such as,

- The low level or insufficiency of medicinal necessities,

- The critical management of antenatal care services at various health facilities
- The mismanagement of stock that is frequently lacking in health facilities points occasioned to transportation and furnishing delays.
- The inexperience of some health workers who at a time are not the bearer of the updated procedures related to the treatment of malaria cases,
- One of the most common difficulties related to the decision taken by women to make antenatal medical visits. There is still the predominance of culture and some others blockage such as some men mentalities that do not want men even if they are doctors or from the medical body to consult and so doing touch they wives. They prefer the traditional method where an older woman consults at home with their spouse. On the other hand, most frequently in rural areas where there are not many health services centers and where women are poorer than the ones living in cities because of inactivity, the habit of consulting a doctor during pregnancy is not the most shared practice, it is usual to find women starting their antennal visit at 8 or 9 months of pregnancy. At that stage, t is often late to take care of them if a malaria disease is diagnosed due to the delay driving all the consequences for the future baby if she succeeds in finally delivering.
- At last but not least, the cost of malaria treatment represents another difficulty impeaching pregnant women to afford malaria treatment. According to some of them, the supposed free-of-charge medicine is, in reality, payable and because most needy women are living with less than a dollar a day, it will not be then easy for them to benefit from malaria treatment.

Regarding the decisions and deeds of the Cameroonian government to tackle seasonal malaria out of the country, in 2016, the country adopted the SMC treatment using sulfadoxine-pyrimethamine and amodiaquine to reinforce the protocol related to the treatment of malaria in Cameroon. 1.1 million eligible children living in the north and the far north of the regions considered the poorest regions of the country have been taken as samples of administration of this new triple therapy corresponding to 86 percent of projected coverage. Statistics was available at the ministry of health of Cameroon state that about 3.5 million children have received the SMC in 2018. One of the outcomes of this new approach to the treatment of malaria by the first two SMC cycles in 2017 in the north and far north regions of Cameroon presents the results stating that the applied protocol has contributed to preventing the outbreak of malaria disease in more than 95 percent of children aged between 3 till 5 years. The main variance and the success of this new protocol reside in the fact that the ACT used in these parts of the country has been modified to Arthemeter Lumefantrine AL in place of artesunate-amodiaquine ASAQ which was previously used with uncertain results. The immediate consequence was the possibility raised by this new protocol to contour the potential resistance of patients towards amodiaquine. In the prevision of the WHO, the 8 other regions of

Cameroon will keep using the ASAQ, as usual, to be able to compare in 6 months the incidence and impact of the two distinct protocols (USAID, 2017).

- ***Lower respiratory infections***

Lower respiratory infection is present and counts among the most important causes of health insecurity in Cameroon. The table below indicates the evolution of this form of illness in the country from 2008 to 2017.

**Table 6:** Death due to acute lower respiratory infection among children aged less than 5 years old

**Deaths due to acute lower respiratory infections among children aged <5 years**

**0.15** (%) in 2017

Cameroon deaths due to respiratory infections was at level of 0.15 % in 2017, unchanged from the previous year.

The description is composed by our digital data assistant.

| DATE | VALUE | CHANGE, % |
|---|---|---|
| 2017 | 0.15 | 0.07 % |
| 2016 | 0.15 | 1.67 % |
| 2015 | 0.15 | 1.28 % |
| 2014 | 0.15 | 0.84 % |
| 2013 | 0.14 | -1.21 % |
| 2012 | 0.15 | -13.24 % |
| 2011 | 0.17 | -5.26 % |
| 2010 | 0.18 | 0.28 % |
| 2009 | 0.18 | 2.23 % |
| 2008 | 0.17 | 4.21 % |
| 2007 | 0.17 | 3.86 % |
| 2006 | 0.16 | |

Source: Minsante 2018.

**Interpretation**

The table below presents the rates and figures of death in Cameroon due to acute lower respiratory infections among children aged less than 5 years old. The said table begins in 2006. However, due to the time frame of this research starting from 2008, will only be taken into consideration information starting from this period. In 2008, with a value of 0.117 representing a change of 4.21 %, the 2009 recorded case of low respiratory infections in children aged less than 5 years old gained in value but dropped in change drawing the figure of 0.18 and a percentage of 2.23 % of the variation. In 2010, with a value of 0.18 representing a change of 0.28 %, the 2011 recorded

case of low respiratory infections in children aged less than 5 years old gained in value but dropped in change drawing the figure of 0.17 and a negative percentage of minus 5.26 % of variation indicating a decreasing value of human losses of life due to acute lower respiratory infections. In 2012, with a value of 0.15 representing a change of minus 13.24 %, the 2013 recorded case of low respiratory infections in children aged less than 5 years old lost in value and dropped in change drawing the figure of 0.14 and a percentage of minus 1.21 % of the variation. In 2014, with a value of 0.15 representing a change of 0.84 %, the 2015 recorded case of low respiratory infections in children aged less than 5 years old gained in value but dropped in change drawing the figure of 0.15 and a percentage of 1.28 % of variation about the 2012 and 2013 statistics. In 2016, with a value of 0.15 representing a change of 1.67 %, the 2017 recorded case of low respiratory infections in children aged less than 5 years old gained in value but dropped in change drawing the figure of 0.15 and a percentage of 0.07 % of the variation.

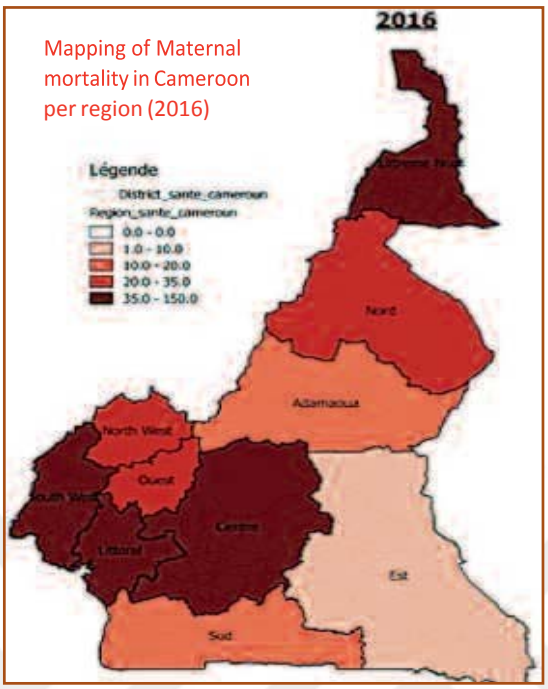
- ***Neonatal disorders***

In Cameroon, according to the production-related to the evolution of neonatal disorders in the country (Ndombo PK, 2017) by aside, to the official statistics available at the Ministry of Health and the Office of Statistics of Cameroon on a local basis, and one of the World Bank and the International Monetary Fund IMF at an international level, the Cameroonian neonatal mortality is 10 percent of the total average of the new-born. In Cameroon, out-born represent around 49.3 percent of the global figure of deceased newborn babies. In this figure, 11.3 percent of this 49.3 percent of babies have been delivered at home out of medical centers. Even though some years ago, precisely in 2004, 4 years before the beginning of the research, the death rate of new-born babies was turning around 12.4 percent and has drastically reduced to 7.2 percent in 2010, the rate remains highly elevated for a country planning its emergence by the year 2035. Among the main causes of the death of new-born babies in Cameroon, neonatal sepsis representing death at birth represents up to 37.85 percent of the general total of decease neo babies. Prematurity which indicates the babies that have been delivered before their term or before the expected time of their arrival which is 39 weeks is up to 31.26 percent. The birth asphyxia indicating the suffocation of the new-born baby at birth because of a long time waiting before being expelled out or because its ropes surrounded its neck for a certain time impeaching it to breath normally, represents 16 percent. The congenital malformation is 10.54 percent. The large majority of the disease cases advent at the first week of birth with 74.2 percent of total cases recorded embodying 35 percent of cases happening just after 24 hours of the life of the newly born baby. The same statistics present the situation clarifying that the rate of mortality is more important in the range of newly born babies weighing less than 2.5 kg and gestational age less than 37 weeks. Single parenthood is part of the cause of newly born decease due to the stress that has encountered by the mother and the lack of emotional concern she was supposed to receive from the

father of the future baby. The primiparous or first delivery women, indicating the women that the pregnancy has been conducted till its final stage for the first time, are also part of the most exposed categories of the sensible population with a potential source of neonatal disorders (Mah-Mungyeh E, 2014).

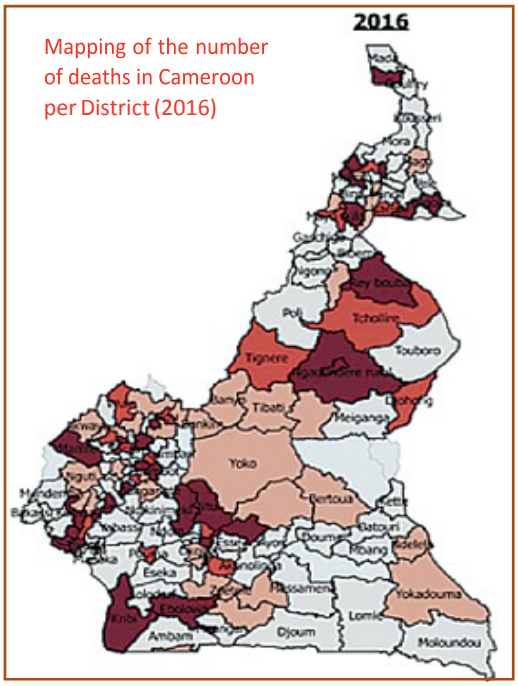
In Cameroon's rural areas, where the death of new-born babies is still a major cause of health inquiry, there are three causes of neonatal mortality. Besides the complications related to preterm birth consisting of delivery before the normal and expected time of the readiness of the pregnancy, is listed birth asphyxia which consists of many sources that prevent the new-born baby to breathe normally. It can be caused by the umbilici which during the delivery process might be blocked around the baby's neck and the more the mother tries to expel it and the more the said umbilici rope blocks the neck of the fetus. The other asphyxia causing neonatal death in Cameroon is the difficulty that encounters the baby after being delivered starts automatically breathing by itself without any assistance. The third cause of the new natal disorder in Cameroon is infections. Infections when the baby has been properly cleaned with all relevant toilet and hygienic procedures. Infections are caused by medical assistance which has been conducted according to the principle of medicine. Exposition of the baby to various sources of bacteria is also one of the causes of the infection of babies. To counter this phenomenon of neonatal disorder consisting of the death of newly born babies in Cameroon, there are some tips and suggestions that can significantly turn positively the life expectations of new-born babies in the country. The improvement of antenatal care as the exhortation and promotion of antenatal medical visits to the hospital is one of the points that can be taken into account. Women should start their antenatal visits earlier. The formation and professionalization of medical personnel in charge of taking care the pregnant women are also some important points that should not be neglected. This formation can include the technics related to handling neonatal resuscitation which is a cause of non-return of babies.

**Figure 5:** Mapping of Maternal mortality in Cameroon per region in November 2016




Source: Minsante 2018.

**Figure 6:** Mapping of the number of deaths in Cameroon per District in 2016




Source: Minsante 2018.

**Interpretation**

These two above reproduced images show the reality of neonatal disorders in Cameroon. The first image indicates the repartitions of maternal mortality. It is observable in this image that the regions of Centre, Littoral Far North, and North West are the regions where it is being recorded the highest level of maternal mortality. On the opposite, the regions of Adamaoua, South, and East are the ones, with the lesser percentage of maternal mortality. The second image related to the mapping of the death per district in 2016, also presents distinguished information. In this image, the districts of Rey Bouba in the north, the one of Ngaoundere in the Adamaoua, or the district of Kribi in the littoral region are in red. This color represents the district recording the highest rates and figures of recorded maternal mortality in the country.

***- Diarrheal diseases***

As same as the records published by the World Health Organization giving an overview of the neonatal disorder impact in Cameroon, the WHO 2018, announced that diarrheal diseases have caused Cameroon up to 15092 losses in human lives representing 7.17 percent of the total figures of deaths. This elevated and important rate of death classifies Cameroon at the 27$^{th}$ position in the world (Nchoji, 1994). The official data of the Ministry of Health states that up to 15 percent of deaths among children aged less than 60 months (5 years) of age are caused by diarrheal diseases (Evidence, 2016). To counter the prevalence and impact of these diarrheal diseases, the country has developed and implemented a program identified as the Integrated Disease Surveillance and Response IDSR strategy since 2005. The IDSR program has been integrated into the national strategy for the monitoring of diarrheal disease in the country.

However, despite the goodwill of this program, it remains some situations handicap the optimization of this IDSR in the field. One of the concrete examples is the case of refugees arriving in Cameroon. The Minawao camp in the Far North Region of Cameroon created after the terrorist attacks of the Islamic sect coming from Nigeria called Boko Haram has recorded a massive arrival of Nigerians in Cameroon. In addition to the internally displaced persons IDP, tracking the evolution of the diarrheal disease is not an easy matter. In 2014, the camp has recorded a cholera outbreak with up to 53 identified positive cases and 5 deaths with an almost 10 percent of lethality. This unpredicted situation has suggested the use of modern or more advanced technics for the detection of cholera to respond not only earlier but being capable of facing more possibilities in the declared cases. It is important to underline that diarrheal disease does not affect people the same way and it is highly related to the sanitation of the area. Populations living in poverty and the ones residing in developed countries with modern facilities are not exposed the same way. The scarcity of potable water access points in underdeveloped countries such as Cameroon is an additional factor rising the outbreak

possibility of this cholera and so doing diarrheal diseases. Although this illness has the advantage to be easily treatable, it remains with it's 15 percent an important source of human life losses throughout the country. More precisely, the existence of vaccines, oral rehydration tablets, and formation programs that already exist related to sanitation and global hygiene, if reloaded and relaunched, can constitute an important preventive measure against the widespread of this disease. In 2002, a multitask approach program called PERSAN or Population et Espace a Risque Sanitaire, supervised by the IRD or Development Research Institute specialized in the health system in less advanced areas such as rural zones have been created. The research conducted by this program has led to the establishment of data related to the prevalence of this diarrheal in the center region of Cameroon. Of the 3034 samples collected from children aged less than 5 years old, 60 percent were aged less than 2 years with 52 percent of male proportion. Out of 437 admitted patients, 260 cases were correlated to infectious etiology with a range of 59.9 percent. The same data present information that among the said 60 percent of positive cases of microorganism co-infection, 10 representing 03.8 percent were caused by pathogenic viruses, 96 representing 36.9 percent were caused by pathogenic bacteria and 154 representing 59.2 percent were caused by pathogenic parasites. To outline the importance of the impact of the living condition on the outbreak of diarrheal diseases, overcrowded and traditional ways of life represented in the same analysis up 78.4 percent compared to the 21.5 percent representing the positive case identified in a population living in modern and urban settlement houses.

***- Ischemic heart disease***

Presented as one of the main causes of health insecurity in Cameroon, ischemic heart disease can be defined as a dysfunction in the blood supply system by presenting an inadequacy in the normal scheme of blood circulation. This dysfunction is caused by a blockage by some liquids that are not part of the blood circulation system impeaching the blood to irrigate normally the located area. The notion of ischemic is used in the language of science and medicine as identification of an organ that is not receiving as expected or as is supposed to be enough blood and oxygen to function normally. Also identified as Coronary Heart disease in shirt CHD or CAD coronary heart disease, ischemic heart disease supposes the heart problem caused by the heart artery that brings to the heart the necessary blood. If the main cause is as underlined above the emergency of blood clot or the reduction and blockage of the blood vessel that conducts the blood to the heart, the building of plaque known as atherosclerosis is one of the main manifestations and symbol of the advent of ischemic heart disease. In absence of a regular circulation of blood from and to the muscle of the heart, one assist in the necrosis of the cells due to the blockage of the heart conducting to the heart attack scientifically identified as myocardial infarction MI. even though almost 50 percent of the heart attack is not presenting any symptoms, while atherosclerosis steps forward, observable and identifiable symptoms

might appear more precisely when the victim of IHD is exercising sports activities or going through emotional concerns. In a scientific approach, the IHD occurs in the majority when the future victim is exposed to an activity leading to the augmentation of the oxygen and blood by the heart under the acceleration of the cardiac rhythm. Also, there is a scientific appellation of the situation when the heart is lacking oxygen. It is known under the concept of angina pectoris. This angina is studied by Canadian medical experts under the Canadian Cardiovascular Society in short CCS. There have been identified 4 classes of IHD. The first class which at times may not alert the victim occurs with strenuous while exercising, being at work without necessarily requiring physical activity this first class of ischemic heart disease most of the time appears when the victim is practicing cycling, aerobic, a jogging square dancing, having tennis activities or squash discipline, rope skipping skiing aerobic ballet or climbing on a rope-skipping game. It also occurs when the future victim exercises walking activities with a speed evolving around 5 miles per hour. The second class of IHD presents itself as a sort of angina that paralyzed the future victim and prevent him despite his efforts and willingness to exercise some ordinary activities that he was used to doing before on ordinary days. It is the incapacity caused by sudden activities such as walking or climbing stairs with a faster speed than usual, walking on a long uphill without taking a minute to rest, walking or climbing stairs just immediately after eating. It is also caused when the subject is going under emotional stress that precipitated the cardiac rhythm and makes him feel different than ordinary days. The third class limitations are caused by walking one or two blocks on level ground, climbing one flight of stairs in regular conditions, playing a musical instrument, performing household chores, gardening, walking a dog, or taking out the trash. The last class or class 4 of ischemic heart disease is identified as the incapacity to carry on any physical activity regardless of its intensity and its length and the efforts required to produce them, without discomfort. It is simply the level of ischemic heart disease where the inability to move or exercise any activity does not come without a certain difficulty and a certain pain for the victim. At that level, even smiling might be difficult. Walking might seem impossible and going with daily activities unrealizable. It is stated that people having previously suffered from a heart attack or undergoing diabetes are highly exposed to ischemic heart disease and develop the silent version of this illness that gradually fragile the victim and weaken him before the occurrence of the hardest version of ischemic heart disease.

At the same time, ischemic heart disease stroke is a health system major cause of interest. The recurrence of this illness can be explained by some identifiable factors. Among them, is an elevated abdominal circumference, the level of sugar in the blood calculated by the blood glucose, cholesterol, and triglyceride levels. The same sources inform that the recurrence of stroke is linked to laterality, congestive heart failure, dysarthria, and facial palsy. The SBP measurement during the first 24 hours appears to be a prognostic factor of stroke recurrence and is commonly used to identify and point out high-risk patients. The program called PROGRESS or Perindopril Protection against

Recurrent Stroke Study identified that the fact of reducing the presence of SBP in the body after an exposition to stroke has an impact on the risk of recurrent stroke in the population of hypertensive and non-hypertensive patients. As same, diabetes is an additive situation that exposes to an occurrence of stroke. In another segment, there is an impact of the level of cholesterol and triglyceride in the body on the recurrence of stroke. Stroke is a disease that is declared to affect the same brain hemisphere and is located at the index stroke level. This excavation in the brain is due to an alteration of the anatomy and the physiology of the injured brain.

**Table 7:** Immunization coverage per antigen and region under routine EPI January to December 2016

| Regions | Complétude des données des DS | Complétude des données des FOSA qui vaccinent | Antigènes | | | | | | | | | | | | Taux d'abandon spécifique |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | BCG | DTC-HepB-Hib 1 | VPO1 | DTC-HepB-Hib 3 | VPO 3 | PNEUMO 3 | VAR | VAA | VAT 2+ | VIT A | Rota 2 | VPI | |
| Adamaoua | 100,0 | 98,4 | 90,8 | 103,5 | 117,2 | 93,8 | 90,5 | 91,7 | 78,7 | 77,9 | 63,8 | 56,5 | 79,0 | 80,4 | 5,2 |
| Centre | 99,7 | 92,6 | 68,1 | 84,5 | 83,6 | 78,0 | 76,7 | 77,7 | 71,0 | 70,7 | 53,0 | 38,1 | 76,9 | 68,4 | 8,2 |
| Est | 100,0 | 98,9 | 103,5 | 119,2 | 117,5 | 104,3 | 102,3 | 102,8 | 94,8 | 96,3 | 100,4 | 110,6 | 91,2 | 93,9 | 12,6 |
| Extreme Nord | 99,7 | 98,1 | 53,3 | 100,7 | 100,6 | 89,2 | 88,2 | 88,6 | 82,1 | 82,5 | 53,9 | 56,8 | 79,5 | 84,5 | 11,5 |
| Littoral | 100,0 | 98,7 | 57,6 | 67,6 | 68,1 | 66,4 | 66,0 | 66,2 | 62,7 | 62,6 | 47,4 | 42,3 | 63,7 | 65,1 | 3,4 |
| Nord | 100,0 | 85,9 | 71,1 | 101,7 | 100,6 | 92,4 | 89,7 | 91,2 | 84,2 | 86,1 | 77,8 | 64,3 | 85,7 | 86,3 | 9,2 |
| Nord Ouest | 91,7 | 92,8 | 55,5 | 66,5 | 66,5 | 65,3 | 65,2 | 65,3 | 62,3 | 62,1 | 40,0 | 44,0 | 63,4 | 64,6 | 2,7 |
| Ouest | 98,3 | 91,7 | 89,6 | 101,8 | 99,3 | 93,2 | 89,6 | 91,8 | 85,6 | 85,9 | 58,6 | 38,8 | 91,3 | 85,7 | 8,6 |
| Sud | 100,0 | 93,8 | 83,6 | 98,1 | 96,9 | 88,8 | 87,7 | 88,7 | 77,6 | 78,2 | 62,4 | 20,4 | 86,2 | 86,8 | 9,5 |
| Sud Ouest | 99,1 | 96,9 | 75,9 | 89,8 | 88,4 | 85,7 | 84,2 | 85,4 | 83,6 | 83,3 | 66,1 | 46,3 | 84,4 | 84,6 | 4,7 |
| **Cameroun (Janvier - Décembre 2016)** | 98,8 | 94,5 | 68,6 | 89,8 | 89,9 | 82,8 | 81,3 | 82,2 | 76,1 | 76,4 | 58,0 | 49,3 | 77,9 | 77,3 | 8,2 |

Source: Minsante 2018.

- ***Stroke***

**Figure 7:** The Health Education and Research Organization in Cameroun


Source: Hero Cameroon 2015.

In Cameroon, a country where up to 10 475 persons (4.98 percent of the total deaths) lost their lives because of stroke, there is one voluntary civil organization that has been created by young Cameroonians to assist the public services and all the actors intervening in the domain of the fight against diabetes. This association of voluntaries young citizens through the Health Educational and Health Organization in short HERO used to organize public consultations to identify the most common risks of a factor for stroke which are diabetes and high blood pressure in the local population. Risk factors of stroke in Cameroon include those elements.

**Table 8:** The Ischemic heart disease repartition in Cameroon

| Characteristic | Frequency (percentage) |
|---|---|
| | |
| Sex | |
| Female | 57 (57.0) |
| Male | 43 (43.0) |
| | |
| Marital status | |
| Married | 64 (64.0) |
| Widow | 31 (31.0) |
| Single | 2 (2.0) |
| Divorced | 2 (2.0) |
| | |
| Level of education | |
| Secondary education | 40 (40.0) |
| Primary education | 25 (25.0) |
| Tertiary education | 19 (19.0) |
| No formal education | 15 (15.0) |
| | |
| Residency location | |
| Urban | 64 (64.0) |

| | |
|---|---|
| Rural | 35 (35.0) |
| | |
| Profession | |
| Civil servant | 31 (31.0) |
| Unemployed | 29 (29.0) |
| Private formal sector | 19 (19.0) |
| Private informal sector | 16 (16.0) |
| | |
| Laterality | |
| Right-handed | 96 (96.0) |
| Left-handed | 4 (4.0) |
| | |
| Personal history | |
| Sedentary lifestyle | 51 (51.0) |
| Alcohol consumption | 49 (49.0) |
| Hypertension | 29 (29.0) |
| Diabetes | 21 (21.0) |
| Congestive heart failure | 17 (17.0) |
| Tobacco consumption | 17 (17.0) |
| Gout | 9 (9.0) |
| Chronic kidney disease | 5 (5.0) |
| Malignancy | 2 (2.0) |
| Family history of stroke | 27 (27.0) |

Source: Ministry of Health 2018.

**Interpretation**

This table indicated the incidence of ischemic heart disease in Cameroon. The said table is organized around some specific points such as gender, profession, personal history, laterality, gender

(male or female), profession, residency location (urban or rural) marital status, level of education, personal history, and the laterality (left or right-handed individuals). One can conclude from this table that the population living in rural areas is less exposed (35 percent) to ischemic heart disease than the ones living in urban cities with 64 percent. The right-handed 96 percent are more exposed than the left-handed 4 percent. Also can be understood from this table that married persons are more exposed to heart attacks at 64 percent than widows at 31 percent, singles at 2 percent, and divorced persons at 2 percent.

***Hypertension and the use of tobacco***

Hypertension is one of the main factors causing stroke in Cameroon. Even though no official figures are stating the rate and prevalence of hypertension in the country, the majority of cases studied by references mentioned above underline the fact that the patient admitted to a hospital in Cameroon for stroke has undergone a blood hypertension attack. It is no more need to mention the consequence of the use of tobacco worldwide. Despite the international campaign pointing out the danger that represents the use of tobacco for public health, the industry of tobacco keeps remaining florescent. In Cameroon, tobacco fabricant even should mention on the external side of tobacco bag the reality that consuming tobacco kills and represent a danger but despite that mention, the use of tobacco represents one of the main cause of stroke in the country and if drastic measures are not taken into consideration the stroke caused death rate will not benefit from a significant diminishing.

***The diabetes mellitus and the age of the population***

The diabetes is as same at an international level as one of the main causes of health concern for populations worldwide. Being a non-curable disease that can only be maintained to a lower level of influence. Being classified under two categories according to the level of evolution of the disease, we distinguish diabetes type 1 and diabetes type 2. The main symptom the hypo or hyperglycemia, diabetes which is a non-remediable illness obliging the victims of this disease to use insulin for the rest of their life. The non-availability of the said insulin that can no more be produced naturally by the human body must be replaced by the pharmaceutical one. And in the case of the absence of product in the local hospital, diabetes mellitus presents itself as a major source of stroke in Cameroon. Those aged 55 or older are the ones the most exposed to diabetes. It does not imply necessarily that the younger aged population are immunized but as a generality, it is often the 55 years and above people that are been recorded as a victim of the stroke due to the age. The African population in general and the Cameroonian, in particular, are indeed young with more than 70 percent that are aged less than 35 years according to the statistics and figures of the World Bank but in the 30 percent remaining a large fringe of the said population is listed in the red zone of a potential victim of this other source of health insecurity in Cameroon.

***A personal family history of stroke and a sedentary lifestyle***

This point put into reference the genetic approach to transmission and communication of disease. It is a sort of predisposition that suggest that because one or more of your parents are subject to or suffered from a stroke, the descendant of these have great chances and probability of also being a victim of the same stroke. It is a sort of fatality suggesting that despite all the willingness and living conditions that one can develop, if, in our historical genealogy, one of our ancestors has been sick of stroke, we also will be at our turn. In Cameroon, no official statistics and figures are pointing out the rate of victims of stroke due to a personal family history of stroke but are simply outlined as one of the potential causes that might explain the outbreak of the said illness in some patients.

By sedentary lifestyle, causes stroke is understood the fact that taking as a habit to live for a long time in the same place without any activities requesting the movement of the body or great movement can be at a longer period a disaster for one health trajectory. It is an example of the absence of the practice of physical activities such as sport or trekking and more particularly taking the Cameroonian context, without having farming or living stocks activities, which represents the first source of income for the country, represents a tread to the human health system. On the opposite nomadism consists of moving from one place to another, most of the time from one country to another crossing borders by foot with its animals to sell them on a more profitable market. In Cameroon, there is a group of nomad people called Mbororo who usually move from the northern part of Cameroon to the south of the country to sell their cows for profitable benefits. At times they are moving from Cameroon to neighbouring countries such as Chad, Gabon, Nigeria, the Central African Republic, or the Republic of Congo on their own feet. It represents a great source of physical activity and health system reinforcement and so doing, consists of a serious fight against stroke due to a sedentary mode of life.

***The heavy consumption of alcohol***

Cameroon is one of the countries with the highest level of alcohol consumption worldwide. In the central African sub-region, the country is second just after Gabon. According to the World Health Organization, 2019 statistics on heavy consumers of alcohol worldwide, around 9 liters of alcohol are drunk in Cameroon per habitant. Despite the fiscal measures taken by the government to dissuade Cameroonians to consume alcohol by upgrading the prices and cost of alcohol, the population still maintains the habit of consumption. There have been 2019 not less than three provisions in the 2019 law of finances which has created a new branch in the budget related to the consumption of alcohol. This measure goes in a straight line with the 2016 financial law preparing the budget where there has been an adjustment of the fiscal cost of raw materials imported to produce cigarettes in the country that was that measure conducted by the main Cameroonian alcohol

manufacturers are Society Anonym of Brasseries of Cameroun SABC, Guinness Cameroon, out of others.

- ***Measles***

**Table 9:** Distribution of measles cases and children vaccinated during the campaign against measles epidemics recorded in Cameroon in 2016 by regions

| Regions | Cibles | | SASNIM 1 (Avril 2016) | | | | SASNIM 2 (Decembre 2016) | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | VITA (6-59 mois) | | MBZ (12-59 mois) | | VITA (6-59 mois) | | MBZ (12-59 mois) | |
| | 0-11 mois | 0-59 mois | Enfants vaccinés | Couverture | Enfants vaccinés | Couverture | Enfants vaccinés | Couverture | Enfants vaccinés | Couverture |
| Adamaoua | 71 024 | 389 313 | 307 595 | 86,9% | 272 210 | 85,5% | 332 480 | 92,8% | 298 587 | 92,6% |
| Centre* | 227 367 | 1 128 246 | 813 462 | 80,2% | 721 826 | 80,1% | | | | |
| Est | 69 149 | 392 598 | 318 700 | 89,0% | 287 349 | 88,8% | 237 428 | 66,3% | 210 330 | 65,0% |
| Extreme Nord | 303 719 | 1 455 099 | 1 270 555 | 97,5% | 1 135 277 | 98,6% | 1 307 935 | 100,3% | 1 160 854 | 100,7% |
| Littoral* | 121 158 | 690 898 | 537 228 | 85,2% | 483 030 | 84,8% | | | | |
| Nord | 162 635 | 799 507 | 740 185 | 103,1% | 656 545 | 103,1% | 762 228 | 106,1% | 672 485 | 105,6% |
| Nord Ouest | 76 563 | 399 970 | 349 048 | 96,5% | 312 022 | 96,5% | 346 472 | 95,3% | 310 744 | 95,8% |
| Ouest | 95 813 | 522 064 | 458 701 | 96,7% | 415 030 | 97,4% | 461 893 | 98,1% | 419 485 | 99,2% |
| Sud* | 30 758 | 154 274 | 142 512 | 102,6% | 126 911 | 102,7% | | | | |
| Sud Ouest* | 58 096 | 289 167 | 273 792 | 105,3% | 244 270 | 105,7% | | | | |
| **Cameroun** | 1 216 283 | 6 221 136 | 5 211 778 | 92,9% | 4 654 470 | 93,0% | 3 448 436 | 96,6% | 3 072 485 | 96,6% |

Source: Minsante 2016.

This first table is related to the distribution of measles cases and the figures related to children vaccinated during the campaign against measles epidemics in Cameroon. Two types of vaccines have been administered. The VITA is for children under 12 months, and the MBZ is for the ones aged from 1 to 5 years. These figures, recorded by regions in 2016 present the general view of the prevalence of this other cause of health insecurity in the country. One can observe that children aged between 0 to 59 months are more exposed to measles than the ones of the proportion of 0 to 11 months.

As an illustration, in the Adamaoua region, it has been targeted 71 024 children aged from 0 to 11 months and 389 313 from 0 to 59 months. Having realized 307 595 vaccinations, the percentage of coverage for the first vaccine represented a coverage of 86.9 percent, and the percentage for the second vaccine was 85.5 percent. The second campaign of the same fight against measles in Cameroon which took place in December 2016 has recorded coverage of 92.8 percent from the first vaccine and 92.6 percent of coverage for the second vaccine. In the Centre's region, it has targeted 227 367 children aged from 0 to 11 months and 1128 246 from 0 to 59 months. Having realized 813 462 vaccinations, the percentage of coverage for the first vaccine represented a coverage of 80.2 percent, and the percentage for the second vaccine was 80.1 percent. However, due to the program

of national campaign complexities, the second campaign of the same fight against measles in Cameroon which took place in December 2016 has not been renewed in the center region. In the East region, it has targeted 69 149 children aged from 0 to 11 months and 392 598 from 0 to 59 months. Having realized 318 700 vaccinations, the percentage of coverage for the first vaccine represented a coverage of 89.0 percent, and the percentage for the second vaccine was 88.8 percent. The second campaign of the same fight against measles in Cameroon which took place in December 2016 has recorded a drop in the coverage of 66.3 percent from the first vaccine and 65.0 percent of coverage of the second vaccine. The reasons have not been made public in this situation. In the Far North's region, it has targeted 303 719 children aged from 0 to 11 months and 1455 099 from 0 to 59 months. Having realized 1 270 555 vaccinations, the percentage of coverage for the first vaccine represented a coverage of 97.5 percent, and the percentage for the second vaccine was 98.6 percent. The second campaign of the same fight against measles in Cameroon which took place in December 2016 has recorded a gain of interest from the population that has to participate massively in the good implementation of this second operation. The coverage of 100.3 percent from the first vaccine and 100.7 percent of coverage of the second vaccine has been recorded. In the Littoral region, it has targeted 121 158 children aged from 0 to 11 months and 690 898 from 0 to 59 months. Having realized 537 228 vaccinations, the percentage of coverage for the first vaccine represented a coverage of 85.2 percent, and the percentage for the second vaccine was 84.8 percent. As same as the second campaign of the same fight against measles in Cameroon realities for the center region, the littoral region has not recorded a second wave of vaccination which was initially scheduled in December 2016. In the north region, it has targeted 162 635 children aged from 0 to 11 months and 799 507 from 0 to 59 months. Having realized 740 185 vaccinations, the percentage of coverage for the first vaccine represented a coverage of 103.1 percent, and the percentage for the second vaccine was 103.1 percent. The second campaign of the same fight against measles in Cameroon, which took place in December 2016, has recorded coverage of 106.1 percent from the first vaccine and 105.6 percent of coverage of the second vaccine. In the northwest region, it has targeted 76 563 children aged from 0 to 11 months and 399 970 from 0 to 59 months. Having realized 349 048 vaccinations, the percentage of coverage for the first vaccine represented a coverage of 96.5 percent, and the percentage for the second vaccine was 96.5 percent. The second campaign of the same fight against measles in Cameroon, which took place in December 2016, has recorded coverage of 95.3 percent from the first vaccine and 95.8 percent of coverage of the second vaccine.

In the West region, it has targeted 95 813 children aged from 0 to 11 months and 522 064 from 0 to 59 months. Having realized 458 701 vaccinations, the percentage of coverage for the first vaccine represented a coverage of 96.7 percent, and the percentage for the second vaccine was 97.7 percent. The second campaign of the same fight against measles in Cameroon, which took place in

December 2016, has recorded coverage of 98.1 percent from the first vaccine and 99.2percent of coverage of the second vaccine. In the South's region, it has targeted 30 758 children aged from 0 to 11 months and 154 274 from 0 to 59 months. Having realized 142 512 vaccinations, the percentage of coverage for the first vaccine represented a coverage of 102.6 percent, and the percentage for the second vaccine was 102.7 percent. There has not been realized a second campaign of the same fight against measles in this region. In the South West's region, it has targeted 58 096 children aged from 0 to 11 months and 289 167 from 0 to 59 months. Having realized 273 792 vaccinations, the percentage of coverage for the first vaccine represented a coverage of 105.3 percent, and the percentage for the second vaccine was 105.7 percent. As same as the case of the Centre, Littoral, and South Regions, the second campaign of the same fight against measles in Cameroon, has not been done in the South West Region. In total, Cameroon has targeted 1 216 283 children aged from 0 to 11 months and 6 221 136 from 0 to 59 months. Having realized 5 211 778 vaccinations, the percentage of coverage for the first vaccine represented a coverage of 92.9 percent, and the percentage for the second vaccine was 93.0 percent. The second campaign of the same fight against measles in Cameroon, which took place in December 2016, has recorded coverage of 96.6 percent from the first vaccine and 96.6 percent of coverage for the second vaccine.

**Table 10:** Measles cases and children vaccinated during response campaign to measles epidemics in Cameroon in 2016

| Régions | District de santé en épidémie | Date (epid Week) onset index case | Nombre de cas enregistrés | | | | | Caractéristiques des suspects de rougeole | | | Information sur la riposte | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Confirmé au laboratoire | Confirmé par lien épidémiologique | Total cas | Décès | Total dans les MAPE | % cas agés < 5 ans | % de cas vaccinés | % de cas non vaccinés ou inconnus | Age cible | Population cible | Nombre vacciné | Couverture administrative |
| Nord | Lagdo | 10/07/2015 (W40-2015) | 16 | 83 | 99 | 0 | 28 | 67,0% | 7,0% | 73,0% | 9 mois - 19 ans | 34 380 | 42 671 | 124,0% |
| Adamaoua | Ngaoundéré rural | 25/02/2016 (W08) | 4 | 2 | 6 | 0 | 18 | 37.5% | 0,0% | 100,0% | 9 mois - 14 ans | 1 605 | 2 005 | 125,0% |
| Adamaoua | Tignère | 16/04/2016 (W15) | 5 | 8 | 13 | 0 | 12 | 25,0% | 6,0% | 94,0% | 09 mois - 14 ans | 2 098 | 1 978 | 94,00% |
| Sud Ouest | Mbonge | 22/04/2016 (W16) | 5 | 20 | 25 | 0 | 42 | 41,0% | 7,0% | 93,0% | 09 mois - 14 ans | 7 260 | 6 913 | 95,00% |
| Extrême nord | Kolofata | 23/03/2016 (W12) | 3 | 66 | 69 | 0 | 142 | 67,0% | 0,0% | 100,0% | 09 mois - 14 ans | 56 647 | 56 204 | 92,00% |
| Extrême nord | Mora | 19/08/2016 (W33) | 20 | 56 | 76 | 0 | 83 | 86,0% | 6,0% | 94,0% | | | | |
| Nord | Poli | 06/11/2016 (W44) | 5 | 0 | 5 | 0 | 8 | 87,5% | 12,5% | 87,5% | | | | |
| Cameroun | | | 58 | 235 | 293 | 0 | 333 | | | | | 101 990 | 109 771 | 107,63% |

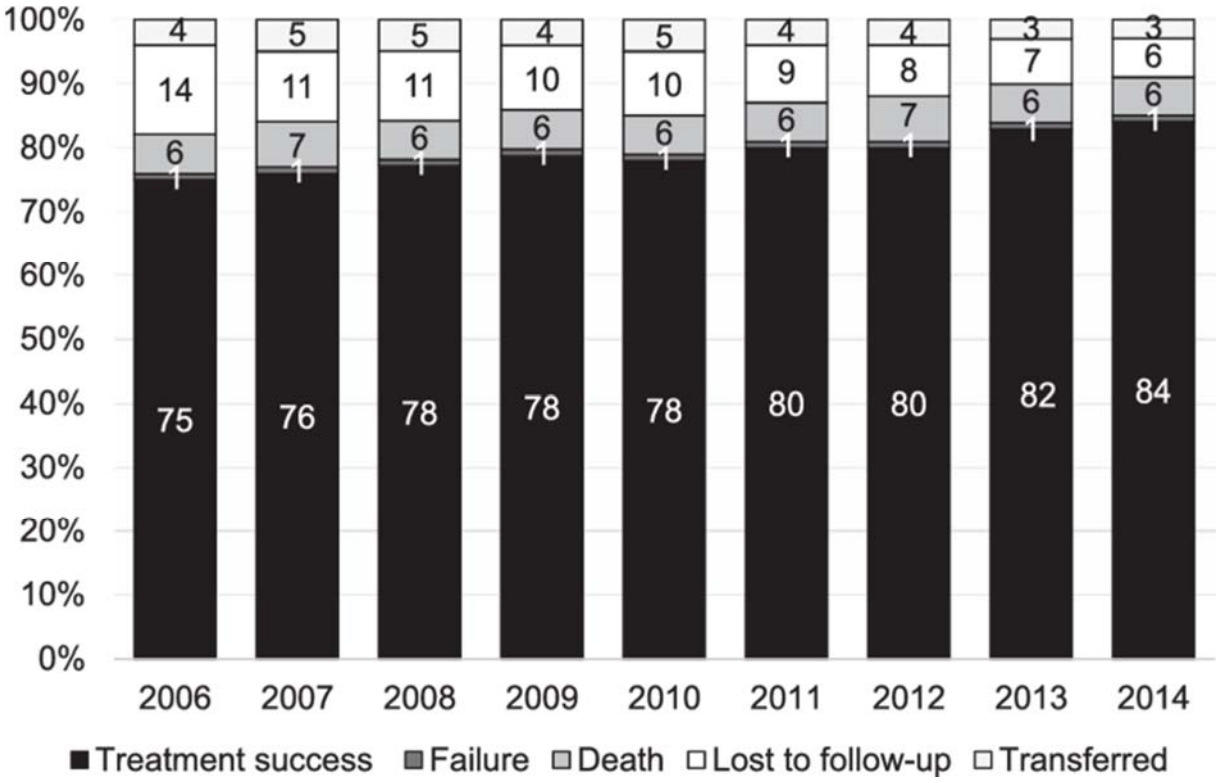
Source: Cameroon Ministry of Health (2016).

In line with the first table related to the coverage of vaccination against measles in the country in April and in December 2016, this table presents the results and incidences of the campaign conducted by the Ministry of Health in Cameroon.

***- Tuberculosis***

Also dangerous and causing several deaths every year throughout the country, tuberculosis is one of the most important sources of health insecurity in Cameroon. In the table below, the entitled proportion of new smear pulmonary tuberculosis cases by treatment outcome and year in Cameroon from 2006 till 2014 is giving some precise indication of the BCG impact has on the country.

**Table 11:** Proportion of new smear-positive pulmonary tuberculosis cases by treatment outcome and year in Cameroon, 2006–2014




Source: Minsante 2018.

**Explanation**

Five colors are indicating some data such as the treatment success for the black color, the grey-black color is used for the failure records. The light grey indicates the number of deaths the white one the patients diagnosed positively but that have been lost to follow up and the last one, the clear white represents the transferred patients.

- In 2008, there have been up to 78 percent of patients who have been treated positively. This figure indicates that more than ¾ of patients suffering from tuberculosis in Cameroon have recovered from their illness. In the same year, there has been 1 percent of treatment failures. The Cameroonian local medical facilities were unable to secure 1 percent of the total number of patients admitted to the hospital in 2008. 6 percent of

declared patients have loosed their lives while 11 percent have disappeared from observance and have been unable to be followed up by hospitals. 5 percent have been transferred to other hospitals or medical centers to benefit from a better health care system.

- In 2009, there have been up to 78 percent of patients who have been treated positively. This figure indicates that more than ¾ of patients suffering from tuberculosis in Cameroon have recovered from their illness. In the same year, there has been 1 percent of treatment failure. The Cameroonian local medical facilities were unable to secure 1 percent of the total number of patients admitted to a hospital in 2009. 6 percent of declared patients have loosed their lives while 10 percent have disappeared from observance and have been unable to be followed up by hospitals. 4 percent have been transferred to other hospitals or medical centers to benefit from a better health care system.
- In 2010, there have been up to 78 percent of patients who have been treated positively. This figure indicates that more than ¾ of patients suffering from tuberculosis in Cameroon have recovered from their illness. In the same year, there has been 1 percent of treatment failure. The Cameroonian local medical facilities were unable to secure 1 percent of the total number of patients admitted to the hospital in 2010. 6 percent of declared patients have loosed their lives while 10 percent have disappeared from observance and have been unable to be followed up by hospitals. 5 percent have been transferred to other hospitals or medical centers to benefit from a better health care system.
- In 2011, there have been up to 80 percent of patients have been treated positively. This figure indicates that more than 4/5 of patients suffering from tuberculosis in Cameroon have recovered from their illness. In the same year, there has been 1 percent of treatment failure. The Cameroonian local medical facilities were unable to secure 1 percent of the total number of patients admitted to the hospital in 2011. 6 percent of declared patients have loosed their lives while 9 percent have disappeared from observance and have been unable to be followed up by hospitals. 4 percent have been transferred to other hospitals or medical centers to benefit from a better health care system.
- In 2012, there have been up to 80 percent of patients have been treated positively. This figure indicates that more than 4/5 of patients suffering from tuberculosis in Cameroon have recovered from their illness. In the same year, there has been 1 percent of treatment failure. The Cameroonian local medical facilities were unable to secure 1 percent of the total number of patients admitted to the hospital in 2012. 7 percent of declared patients have loosed their lives while 8 percent have disappeared from observance and have been

unable to be followed up by hospitals. 4 percent have been transferred to other hospitals or medical centers to benefit from a better health care system.

- In 2013, there have been up to 82 percent of patients have been treated positively. This figure indicates that more than 4/5 of patients suffering from tuberculosis in Cameroon have recovered from their illness. In the same year, there has been 1 percent of treatment failures. The Cameroonian local medical facilities were unable to secure 1 percent of the total number of patients admitted to the hospital in 2013. 6 percent of declared patients have loosed their lives while 7 percent have disappeared from observance and have been unable to be followed up by hospitals. 3 percent have been transferred to other hospitals or medical centers to benefit from a better health care system.
- In 2014, there have been up to 84 percent of patients have been treated positively. This figure indicates that more than 4/5 of patients suffering from tuberculosis in Cameroon have recovered from their illness. In the same year, there has been 1 percent of treatment failure. The Cameroonian local medical facilities were unable to secure 1 percent of the total number of patients admitted to the hospital in 2010. 6 percent of declared patients have loosed their lives while 6 percent have disappeared from observance and have been unable to be followed up by hospitals. 3 percent have been transferred to other hospitals or medical centers to benefit from a better health care system.

Besides this table, there was for 9 years in Cameroon a program established to counter tuberculosis called the Cameroonian National Tuberculosis Program CNTP. The goals and mission of this program I to assess case surveillance data for the period starting from January 2006 to December 2014. Through the case finding method using routine surveillance data, the program intends to focus on sociodemographic characteristics, the retrospective descriptive analysis of tuberculosis, the data on sociodemographic characteristics, the disease category, the clinical and laboratory tools, and the analysis of geographic regions. In Cameroon, the co-infection of HIV, the Human Immune Deficiency Virus, is one of the main preoccupations of medical caretakers. The reason is that from 2009 to 2014, up to 39 percent of Tuberculosis cases in Cameroon are HIV-positive patients. Described as an airborne bacterial infection due to the mycobacterium tuberculosis, TB is a disease that is easily contaminable. It can be acquired simply by being exposed to contaminated air when breathing when being close to an ill person when he produces air droplets while coughing or sneezing. According to the World Health organization data related to tropical diseases, tuberculosis can also be contracted by ingesting non well pasteurized contaminated milk by bovine tuberculosis scientifically known as mycobacterium bovis. In its manifestation, tuberculosis which attacks principally the pulmonary area, affects the lungs, the lymphatic system, the urogenital zone, the joints, the central nervous system, and the bones. In most cases, the patients diagnosed with the TB infection, in short LTBI, which is an asymptomatic stage, develop latent TB infection and are

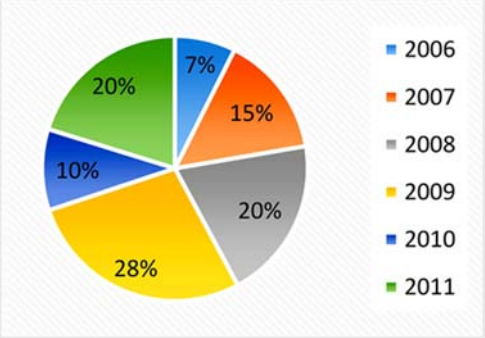
representing between 90 to 95 percent of the identified cases. Detected cases of patients suffering from Tuberculosis disease also scientifically known as active TB are developing signs and symptoms that can easily help to identify and so doing isolate them. These signs are excessive coughing. This coughing not only are repetitive and extraordinary and can even produce blood. Another manifestation of Active TB is the lack of appetite. One who was a normal food consumer start losing weight and reduce with no apparent reason his appetite. The general weakness of the body. One feels tired without even having tried to produce an effort. Chest pain. Most of the time just after coughing, the suffering patient feels like a sort of fire in the chest that at the time prevent or impeach him from breathing normally. Having in front one person with swollen lymph gland and or suffering from fever or abnormally high body temperature can be demonstrative of the effectiveness of the TB bacteria in the body. Some other physical manifestations such as chills or night sweats where the future patient finds himself completely wet on his bed while sleeping at night might call attention to the possibility that one is in front of a tuberculosis case. Even though the above-mentioned symptoms can be confused and compared to pneumonia or bronchitis that are having almost the same manifestations, the neglect of the TB infection can lately be fatal for the patient. According to specialists and medical personnel, the treatment of Tuberculosis implies the use of antibiotics for a certain period. Most of the time 6 months are required. However, as a living organ submitted to evolution, the bacteria causing the tuberculosis illness evaluate to and so doing complicate the treatment of the patient. It is the reason why in Cameroonian hospitals it is easy to find drug-resistant sick people with a permanently growing number of recorded cases. They are no more responding to the previous system of treatment which, confronted with the evolved bacteria, does not have an impact on the illness as expected and as reacting to the previous medicine used. In another range, the overuse or misuse of drugs prescribed or not related to the Tuberculosis treatment, people suffering from identified Tuberculosis might result in MDR TB meaning multidrug-resistant Tuberculosis which is a medicinal term defining people that are no more responding to the classic treatment prescribed in their case. There can be a severe case where an MDR TB who normally after adopting a new treatment to his case can respond in favor of the new treatment become non-sensitive to any form of medical prescription and become insensitive to all the various input of cure by related identifiable drugs. In that case, the multi-drug resistant infection is classified under extensively drug-resistant Tuberculosis short XDR TB.

- ***Road injuries***

The National Institute of Statistics in Cameroon as same as the publication of the World Health organization presents the figures related to road injuries in the country and it is stating that in 2018, Road traffic accident deaths through the country attained the rate of 6.873 representing 3.26 percent of the total deaths recorded in the country in the same year (Tsala S Onomo C Mvogo G and

Ohandja, 2020), (WHO, World Road Safety Situation Report, 2018). That situation of excessive road danger has ranked Cameroon as the 29th country worldwide recording the most important cases of losses in human life due to road accidents.

**Table 12:** Accidents in Cameroon from 2006 to 2011




Source: Minsante 2018.

**Interpretation**

The above-represented graphic will only take into consideration the figures presenting the situation and percentage starting from 2008.

In 2008 represented by the grey color and rating 20 percent of accidents, the Ministry of Transports in collaboration with road safety authorities of Cameroon outlined the fact that in 2008, there has been a net progression in the numbers of victims of road accidents. It can be partially explained by the fact in this year, the Cameroonian football team was playing the African cup of nations which is a pan-African football tournament. Cameroonians have been passionate about football, they certainly enjoyed the play of their national team and so doing, due to a high level of joy and happiness consumed some alcohol with the logical consequence of non-observance of road driving rules and regulations. In 2009 represented by the yellow color and pointing a 28 percent is the year recording the highest level of accidents in the country. It is almost 1/3 of the whole recorded cases during the period of observation and analysis. In 2010 in blue with 10 percent, it recorded more than half of the 2009 rate of accidents on the road. This reduction of the cases and the lethality of the said accident is the result of the various campaign conducted by the Cameroonian ministry of transport and the various actors in road accident prevention. In 2011 in green with 20 percent, as same as the percentage of road accidents recorded in 2008, the year 2011 has been in Cameroon a year of regaining road unsafe mode of use by drivers. According to one article published in the Cameroon accidental review by Tambekou (Sobngwi-Tambekou J Bhatti J Kounga G, 2009), the major causes of road accidents in Cameroon are organized around excessive speed and it represents up to 20 percent of the listed accident recorded throughout the country, mechanic dysfunctions with

28 percent and a third range pointed at 23 percent due to tire problems and hazardous overtaking. The said 28, 23, and 20 percent of general causes of road accidents mentioned above can be reorganized for a better understanding of some detailed topical points. The general sources or causes of road accidents in Cameroon are not easy to list in their entirety. However, we will try to identify the main ones according to the figures and statistics presented to us by some medical institutions in the country.

- **The lack of control**

The lack of control of the vehicle is one of the main causes of road accidents in the country. The said lack of control can be originated from the driver himself, from the vehicle, or the quality of weather or road. The lack of control from the driver may be caused by the inexperience of the driver. In face of certain unexpected situations, the said driver might lose control of the vehicle because he is not mentally prepared for the situation. The quality of the weather may also influence the concentration of the driver and reduce his concentration. It is the case of rain that when heavy can diminish the driver's sight, blocking him to have a wider angle of view to drive safely the vehicle. It will therefore be difficult for him to drive securely risking causing an accident. The quality of the road is also part of the potential causes of the lack of control of a driver. It is the case of wholes on the road. A driver might wish to avoid or contour them and so might lose control of the vehicle.

- **The driver's carelessness and the bad parking**

The attitude of some drivers may be the cause of road accidents. It is the case of drivers who do not observe the code of driving such as how and when one can park, double another car or turn left or right. It is at a time easy to find one driver who does take into consideration the fact that a road is a commonplace not only belonging to him and see him using the road regardless of the other road users. That situations result most of the time an accident that at time paralyzes circulation. This driver inattention is one of the main ways to explain the regain of road accidents in Cameroon has a range evaluated at up to 23.424 percent of the general total of recorded cases by the Ministry in charge of Transport. Bad parking is understood as the fact that some drivers park their cars in a way that is not normally designed for it. When it is not the road that is being blocked or reduced due to the car's bad parking it is a risky way of parking the car that can result in an accident. It is the case when another vehicle comes on speed on Cameroonian highways such as the ones of Yaoundé Douala, Douala-Bamenda, or Yaoundé-Bertoua. Not only the roads are not wide but some drivers simply park their vehicle at junctions or just at a turning point where another driver coming with speed will not have enough time and necessary reflex to avoid the said badly parked car and is, unfortunately, oblige to hit it with the consequences of human lives lost that are regularly recorded on these highways.

- **The brake failure and dangerous manoeuvring**

By brake failure is presented and understood as a default related to a dysfunction of the brake system. This failure might be caused by the negligence of the brake fluid control. It is required to control the level of the different liquids that help the vehicle to move such as the gear liquid or the brake fluid. The deficiency of this liquid may cause an error in the system and prevent the said brake to function. There might also be a default of the ABS model for the safety of the car. The ABS technology assists the vehicle in its security procedure and may engage the brake system in case the vehicle start moving without control. But to work properly, there must be a permanent check-up of the engine and maintenance of the system. Some drivers use to conduct their vehicle imprudently. More precisely, most of the time not only there are manoeuvring their vehicle regardless of the code of the road and principles of road safety but so doing expose and endanger their own life. It is the case of young drivers that to demonstrate their driving skills and abilities to the observers, use to practice some risky figures with the cars such as drifting or other uncertain moves that most of the time end with critical accidents. Besides these teenagers' risky practices of drifting to impress the observers, some drivers do not take into consideration the general status of the road. There are some corners where the drivers are supposed to break or reduce the speed of the car because it is not possible for them to distinguish whether some other cars are coming in front of them. But the non-observance of this basic rule of road safety most of the time leads to misfortune and damageable road accidents.

- **Mechanical failure and the driver's inattention**

Mechanical failure concerns generally the dysfunction of the vehicle itself. This failure might be caused by the age of the vehicle or a deficit of technical visits and general maintenance. By the age of the vehicle, there is a lot of vehicles called second or third-handed vehicle circulating in Cameroon. There are even some vehicles where it is impossible to find pieces of change when occurs a problem in the car. Some other vehicles must have been parked because normally they are no more authorized to circulate and are one the main causes of the pollution of air. Driver inattention cause road accident is being explainable by the fact that at the time, some drivers, rather than staying concentrated on the road traffic are rather been captivated by passenger moving along the road. It is the case of those drivers that are been seduced by a beautiful woman passing on her way. The driver rather than monitoring the road and where he takes his car concentrate on the lady till he causes an accident. The said inattention can also be caused by the use of a cell phone or all the other gadgets that one can find in the car such as Bluetooth devices to connect or a screen that the driver can set while driving. While driving, the driver might be tempted to take selfies, discuss with someone else on the phone and show the city to his correspondent, or simply be searching the said telephone while the car is on move. It results in a disastrous road accident that no one wishes to experiment.

- **Wheel bursting and excessive speed**

Several factors might cause the wheel to burst. The quality of the road, the level of air in the wheel, and the loads on the vehicle. When attending a driving school there is required to usually pay attention to the level of air in the wheel before taking a long road. The quality of roads with big holes requires that the drivers should use the brake of the car permanently. As the title of this section indicates excessive speed, it is the part pointing to the impact of excess speed on the level of road accidents in Cameroon. Excessive speed is understood as a dangerous way of driving consisting of going beyond the speed limits indicated on the various plaques on the borders of roads. As it has been learned in driving schools, there are two types of limitations of speed. The one in town which shall not exceed 50 km/h and at some points 30 km/h when it is overcrowded of besides most frequented areas. The one when it is out of cities and goes to 130 km/h for tourism cars. The excess speed starts to be pointed when according to the geographical position of the driver, he moves the car more at a speed above the ones indicated and authorized. The excess of this speed limit represents not less than 15.30 percent of the accidents on the Cameroonian road recorded by the various authorities in charge of road prevention and accident prevention in the country.

- **Lack of control**

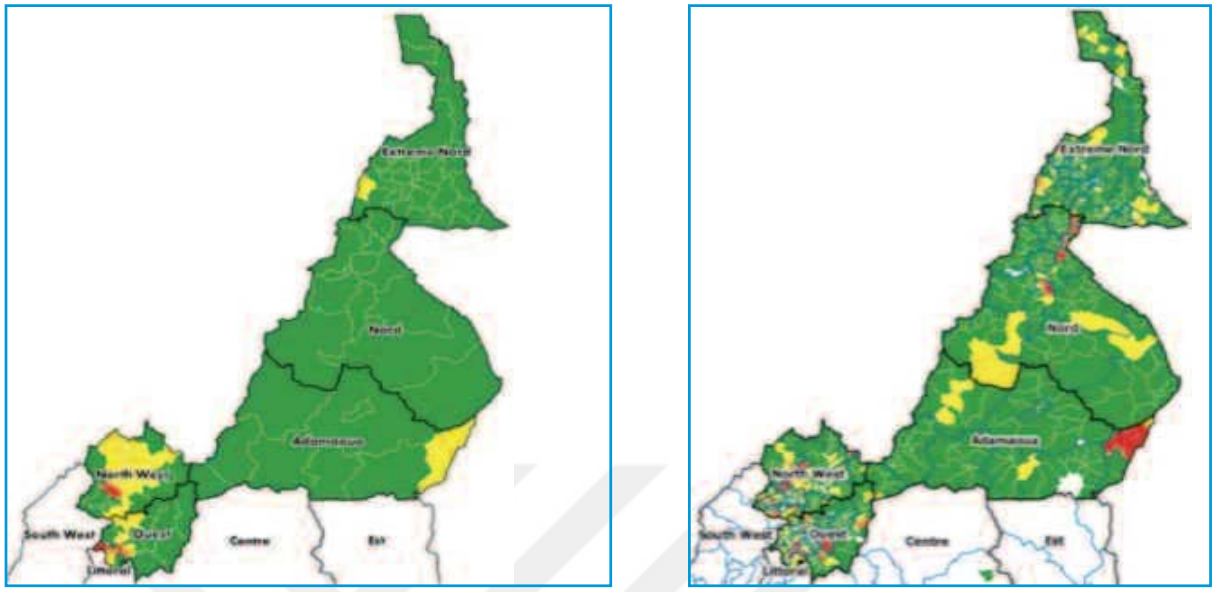
The lack or poor control of the vehicle indicates the fact that some owners of vehicles do not take into serious consideration the prescriptions related to the control of the vehicle such as the renewal of engine oil, the air in the tires, the level of speed oil or the availability of the brake fluids. With an average of 1200 deaths, every year causing a material loss evaluated at about 100 billion francs CFA, road accident is out of the main cause of human life lost in the country. Besides this statistic, the above-mentioned accidents are also causing between 4000 to 5000 injuries listing among them hundreds of people who will remain disabled for the rest of their life. For the Cameroonian nongovernmental organization Secouroute evolving in the sector of car safety, road security and passenger protection, the hazardous overtaking, the general vehicle condition such as age and maintenance added to the condition of the driver such as fatigue or distraction while conducting the vehicle are the most important cause of road accidents in the country. With around 70 percent of national accidents recorded in the country, the axes tiding Douala the economic capital to the political capital Yaoundé, and the one connecting Douala to Bafoussam, the third most important city of Cameroon are the most accident-prone roads. According to the official figures available on the official website of the Cameroonian Ministry of transports which is the ministry in charge of road safety in the country between the years 2007 and 2011, there have been recorded increasing road traffic accidents with a 15 % average and 20 percent of injured as a difference in 2008 compared to the 2007 statistics. This difference includes also a 13-17 percent drop in 2009. If the 2011 records present a reduction of road accidents of a general rate of 47 percent, the figures of the lethality o the

said accidents are in reverse worse than the previous records. More precisely, the fatality rate has increased by 40 percent of difference-making the 2011 road accidents in Cameroon one of the most critical and dangerous for road users in the country. The year before, in 2010, there were almost more than half of road accidents were conducted to the death of road users. Taking into consideration the fact that from the period of observations of the data mobilized by the Ministry of Transport the majority of road accident in Cameroon involves a vehicle and a pedestrian, the said data presents that for 100 accidents case recorded, up to 58 were fatal for the victims. Out of the above-mentioned victims are recorded 27 percent of pedestrians and 35 percent of 2-wheel users globally identified as VRU or Vulnerable Road Users.

***- Cirrhosis, Covid19, and Polio***

According to the discussion developed with the personnel of the Ministry of Health of Cameroon, it is very difficult to find traceable and regularly updated data on the prevalence and mortality rates related to cirrhosis in Cameroon. Databases of the YUTH Yaoundé University Teaching Hospital indicate that liver cirrhosis drives a prevalence of 11.2 percent and 6.5 percent for patients bearing hepatitis B and C and represents 10 percent of the burden of the disease. The most frequently identified causes of cirrhosis are viral hepatitis B with up to 40.2 percent of incidence, the viral hepatitis C represents up to 36.8 percent of the causes of this illness. The consumption of alcohol raises the rate of incidences to 25.6 percent and the mixture made by the hepatitis B/D co-infection represents 8.5 percent. The fact that liver cirrhosis remains undetectable and asymptomatic for a long period and is most of the time identified at an advanced stage where the chance of getting better is strictly reduced. If the curb of the lethality of cirrhosis is dropping in Europe and some developed countries worldwide, remains prevalent in sub-African countries due to the fact the rates of prevalence of hepatitis B and hepatitis C remain high and elevated. (Andoulo, 2004). In another segment, due to the ongoing situation of Covid19 Worldwide and due to the necessary distance a researcher should adopt while producing a scientific document, the Covid19 case despite the major impact on the country will not be developed. These figures related to the administrative immunization coverage of Polio in the northern part of Cameroon indicate the proportion of the prevalence of this illness in the country. Three colors are being used to point out the polio situation in the country. The green color presents the geographical areas free from polio in the country. The yellow one presents the regions where polio is present but has not yet constituted a major source of worry for health services. The red color presents the cities in the country where polio records the most important figure of victims and where the impact of this illness is a matter of national interest.

**Figure 2:** Administrative immunization coverage of the Polio VD from 19th to 21st of November 2016 in the northern part of Cameroon




Source: Cameroon Ministry of Health of Cameroon 2016.

**Table 13 :** Results of Polio response campaigns conducted between August and December 2016 in Cameroon

| Tour de campagne | Cibles | Enfants vaccinés | Couverture VPOb (%) | | | Taux de perte (%) | Nombre de cas de MEV détectés | | | | Résultat monitorage | | | LQAS (Nbre moyen enfants marqués par DS) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 0 - 59 mois | 0 - 59 mois | 0 - 11 mois | 0 - 59 mois | Zero dose | | PFA | Rougeole | FJ | TNN | Ménage | Hors ménage | Ensemble | |
| Tour 1 (27 - 29 août 2016) | 2 643 919 | 2 630 546 | 94,6 | 99,5 | 1,1 | 3 | 6 | 6 | 19 | 0 | 2,3% | 3,9% | 2,6% | 3 |
| Tour 2 (17 - 19 septembre 2016) | 3 565 953 | 3 537 625 | 95,2 | 99,2 | 0,6 | 5 | 14 | 12 | 33 | 5 | 2,6% | 3,9% | 2,8% | 3 |
| Tour 3 (08 - 10 octobre 2016) | 3 565 953 | 3 603 867 | 97,4 | 101,1 | 0,5 | 3 | 22 | 24 | 32 | 2 | 2,5% | 3,4% | 2,7% | 3 |
| Tour 4 (12 - 14 novembre 2016) | 3 565 953 | 3 610 566 | 98,1 | 101,3 | 0,6 | 3 | 20 | 29 | 30 | 0 | 2,7% | 3,0% | 2,6% | 3 |
| Tour 5 (03 - 05 Decembre 2016) | 3 565 953 | 3 610 566 | 98,1 | 101,3 | 0,6 | 3 | 20 | 29 | 30 | 0 | 2,3% | 3,1% | 2,5% | 3 |

Source: Cameroon Ministry of Health 2016.

According to this table indicating the results of the Polio free strategy in Cameroon conducted in 2016, up to five tours of the campaign have been successfully realized in the country in 2016.

The first tour which took place from the 27th to the 29th of August 2016 targeted 2 630 546 children aged from 0 to 59 months. 2630 546 children have been effectively vaccinated. This represents 96.6 percent of coverage for children aged between 0 to 11 months and 99.5 percent of children aged from 0 to 59 months. The second tour which took place from the 17th to the 19th of September 2016, targeted 3565 953 children aged from 0 to 59 months. 3537 625 children have been effectively vaccinated. This represents 95.2 percent of coverage for children aged between 0 to 11 months and 99.2 percent of children aged from 0 to 59 months. The third tour which took place from the 8th to the 10th of September 2016, targeted 3565 953 children aged from 0 to 59 months. 3537 625 children have been effectively vaccinated. This represents 95.2 percent of coverage for children aged between 0 to 11 months and 99.2 percent of children aged from 0 to 59 months. The fourth tour which took place from the 12th to the 14th of November 2016, targeted 3565 953 children aged from 0 to 59 months. 3 610 566 children have been effectively vaccinated. This represents 98.1 percent of coverage for children aged between 0 to 11 months and 101.3percent of children aged from 0 to 59 months. The fifth and last tour of vaccination which took place from the 3rd to the 5th of December 2016, targeted as same as the previous objectives, 3565 953 children aged from 0 to 59 months. 3 610 566 children have been effectively vaccinated. This represents 98.1 percent of coverage for children aged between 0 to 11 months and 101.3 percent of children aged from 0 to 59 months.

### 2.6. Concluding remarks

The objective of this chapter was triple.

- Give an overview of the notion of Multilateralism
- Present more concretely the WHO
- Give a picture of the Health Security of Cameroon

With this triple objective, it has been for us, through a specific literature review, to outline the main facts participating to give keys of analysis to understand gradually what multilateralism is and what the principles this form of international cooperation includes are. On another side, it wouldn't have been understandable to identify the usefulness of the World Health Organisation without stating what it is. The other step of this chapter has given a general view of the mission goals and objectives of the said intergovernmental Organization. Finally, it would not have been feasible to discuss the importance of multilateralism in Cameroon without presenting the factsheet on the health security in the country. The last point has given all the required elements to analyze the health situation of the country and so doing evaluate the impact of the WHO in a strict and direct sense as suggested by the first hypothesis and to question in a wider perspective the usefulness of multilateralism in the country.

# CHAPTER THREE

## 3. RESEARCH DESIGN, METHODOLOGY, DATA COLLECTION, AND ANALYSIS

### 3.1. Introduction

This third chapter, entitled research design methodology data collection, and analysis, will present the framework, angle, and orientation of our research. It will also be a question of explaining our methods and technics mobilized to reach our goal which is to understand the importance of multilateralism in the strengthening process of the health security system in Cameroon. The above-mentioned research cannot be done without concrete defendable and valid data. This chapter, will therefore also be a question of exhibiting and demonstrating the tools tips, and strategies that will be taken into consideration to mobilize data that will justify the orientating given to this thesis.

### 3.2. Qualitative research

The qualitative research that is being mobilized as a method of scientific research for this production is a method built on some principles that determine its importance. Qualitative research takes into consideration the collection and analysis of non-numerical data such as videos, audio, or text messages. This collecting of data has as its main objective to understand the others' points of view, the notions and concepts encountered during the research, and to give a sense to the acquired experience. This option of qualitative research can also be mobilized to gather deep insights from a distinguished phenomenon and so doing, participate in the creation of new concepts, new phenomena, and new paradigms that can be used later in research by the science. Presented as the opposition to quantitative research which at first sight indicates this research is based on figures and countable realities, qualitative research doesn’t focus on the collection and analysis of numerical or statistical data but only on the evaluation of the nature of the importance or the opinion that a specifically studied reality inspires. Qualitative research is taken into consideration when the researcher intends to understand the angle of view of observed individuals and to understand the way they accept and explain their life. In the light of the present research based on the usefulness of intergovernmental organizations in the lenses of the case study of the health system security of Cameroon, the qualitative case study methodology employed will provide us necessary tools to enlighten the reality of the impact of the World Health Organization in Cameroon concerning the ambition raised by this international organization and the expectations and concrete needs of the local population. To conduct a scientific-based production, the said research, will be taken into

consideration some recommendations guiding every qualitative approach. It is the case of the observation of the Cameroonian health system realities. It will be a question to take note of all relevant information collected in the field while discussing with health personnel in the countries and exploring libraries and archives of the Cameroonian Health Ministry. It is also the case of the interviews conducted with responsible individuals encountered in the country.

### 3.2.1 Methods of case study

The method of case study is a method that refers to the implication of the observation of reality and draws principles from them. As mentioned by Creswell, the case study data analysis integrates an iterative, spiraling, or cyclical process. This integration proceeds from the most general approach to the more specific observation (Creswell, 1998). The specification of the case study method lies in the fact that this method set its analyses on multiple source data. It requires the imbrication of diverse and complementary information to develop an analysis. According to the method of scientific research published by Marie Claude Smooth, the case study has the advantage to be multimodal and mixed. The case selection method combines the exploitation of one specific form of data to draw out research or integrate more than one form of data from different paradigms and outline the convergence they are resorting. The case section selection pursues a dual objective. The first one target the willingness to provide descriptive information such as portraying a reality the way it is without analysis and critics. The second objective of this method plans to suggest theoretical options relying on scientific principles with demonstrable determinants. It is in this sense that Robert Yin, one of the main references in the case study analysis suggests the difference between convergent notions such as descriptive, exploratory, and explanatory case studies dividing by so doing the method of a case study into three distinctive segments. According to Yin, the descriptive case study is this method of case selection having as main intention to describe, to portray as above mentioned reality. It is this method with identifies a subject of study and list its characteristic the way it looks without introducing any sort of analysis. It is a simple and neutral picture of the observed reality. Besides the descriptive case study model, Yin presents the explanatory case study specificity. This second form of the case study has as its target thee explanation of the reason for the nature of observed realities. It answers the question to know how and why some social facts are the way seen by the analyst and the observer. It also explains why some realities happen or simply why they do not happen. It explains the causality of things. Why observed phenomenon has the nature it has. At last, is listed the exploratory case study method. This segment of the case study method is being used to identify the research question that will drag the analysis. It is being adopted with the target point of bringing out the guidelines of the research, the neck points of the investigations which are problematic, and the various interrogations that the theme might inspire. The exploratory method of

case selection is also being mobilized when the researchers try to find out the procedures to be used to develop under the lenses of the scientific approach the thematic to explore and the new principles to publish. Being in the range of the qualitative analysis, the case study method requires from the analyst a high sense of methodical observation of the target to be analyzed regardless of its nature since the said method digs deeper to have a wider angle of view and understanding of the phenomenon to expose. It takes into consideration the process and the correlations between those processes. H Odum presents the case study method as a technique allowing the analyst to analyze individual actors, institutions, or simply an event that occurs in daily life basis at the level of an individual or a group of persons in their relations with other entities in the said observed unit. It was Frederic Le who is considered the reference to this method of research in social sciences since he has been the one who developed this approach to understanding the process of a family budget. Herbert Spencer is known as the first theoretician to use the case study method in his analysis and comparisons of different observed cultures worldwide. Dr. William Healy (Healy, 1936) while exanimating juvenile delinquency presented the case study technique as the best technique to highlight the collected statistic related to the collected data on a social phenomenon.

As every method is recognized by the sciences and more precisely the methodology of research in social sciences, the case study method is built on some principles that determine its originality and its specificities. The mains one is the principle of uniformity. This principle stipulates that the basic nature of human beings is the same. Only differ the reactions and attitudes with regards to situations occurring to everyone. The second main principle raised by this case study relies on the idea that this method gives the necessary facilities to study the natural history of the observed realities to analyze. To be useful and interesting for analysis, some steps must be taken into consideration. The first step is the recognition and determination of the status of the phenomenon to be investigated r the social fact rising the attention and the interest of the researcher. The second one is related to the collection of useful information or data, the examination, and the comprehension of the nature and essence of the realities to be analyzed. The third step when a case study method is being mobilized is the diagnosis that should be done and the outline of causal factors. This step is important because it allows the analyst to set the basis of the treatment of data and production of a scientific document. After this diagnosis and the causal factors identified, the application of remedial measures such as the various propositions or casework is being modeled. It is the various proposals that the researchers suggest with regards to the identified problems raised by the thematic. The last point is the follow-up program which tries to evaluate the efficiency in the field of the suggestions presented in the analysis. Referring to the case study method presents the advantage of being a complete study of a social phenomenon. With the case study method, the researcher can have a global view of the observed social fact he intends to analyze. Horton Cooley indicates that the case study method deepens the perception of the analyst and gives him a better view of life. The case study method

permits the researcher to get the first source of data related to personal experiences and variables that help him to understand others' attitudes and behavior. By easing the formulation of the hypothesis by providing the researcher with all necessary information that facilitates the conduct of the research, the case study method permits the researcher to draw the correlation between the studied realities and the projected ambition of the research. Even though the method of case selection has as identified limits the fact that it is used on a specific domain and limited point, this method of the case study will be used in this thesis research with the purpose to use the case of the Health system security of Cameroon to evaluate the usefulness of intergovernmental organization and more precisely the importance or not of the World Health Organization.

### 3.2.2. Data collection and analysis

This section entitled data collection and analysis intends to point out two different methods. The first one presents the data collecting process mobilized and the second identifies the approach that will be helpful to analyze the collected data.

- ***Data collection***

Data collection is understood as the method mobilized to collect all the necessary data to produce the actual research. It includes the techniques and system of finding data that refer themselves to the theme, to the research questions, to one or all the parts of the sub-questions, to the hypothesis or simply that can serve as additional information to strengthen the analysis. The said data collection has consisted of a trip to Cameroon for 6 months during which the main responsible persons have been met. Among them, a part of the official at the Ministry of external relations of Cameroon, the ministry in charge of the external affairs of Cameron and which is in charge of maintaining and strengthening the cooperation between Cameroon and the World Health organization, the responsibility of the Ministry of health which us the technical ministry in charge of the implementation on the field of the various agreement signed under the patronage of the MINREX of health services have been met. Also responsible for hospital centers in the region f North and the Far North have been met at same as the health personnel from confirmed doctors to simple assistants. From another side, documents have been consulted at the Ministry of Health and in the regional hospital. In addition, the libraries have been consulted and several books exploited to have a wider angle of view and questions related to multilateralism, the opportunity this form of cooperation represents, and the potential critics that are been raised. The internet with a computer has also been consulted more precisely online encyclopedia, the official website of the World Health Organization, and other official institutions mobilized throughout this research such as the US presidency website, the United Nations website among others because of the inaccessibility of some documents in a library or at the office in Cameroon.

- ***Data analysis***

Data analysis in its turn indicates the way the collected data are been integrated into the analyses. The modulation on which they are been selected, filtered, and highlighted to produce a convenient, understanding, and enriching research production with qualitative information. Taking into consideration the fact that some data are easily integrated with the general corpus and of the research and that the researcher already knows where the said collected data will be mobilized, the said analysis might start immediately at the same time of data collection while filtering the first important one and classifying the collected guidelines.

### 3.2.3. Semi-structured interviews with selected individuals

It was a question to get information on the impact of the WHO on the health security of Cameroon and to get it was intended by us to interview two groups of individuals.

The first one is health service officials of some hospitals far from the main cities and where the concrete needs are being expressed such as Guider in the North Region of Cameroon and Kaele in the Far North Region of the country. The second group is made of the population met on the street in the same cities to compare the declarations of officials and the impact on the field felt by the population to outline the gap between the health politic and the tangible need of the population. These sites and individuals were being selected since in the said region some basic illnesses are still prevalent such as malaria, cholera, and many other diseases called tropical illnesses, the first group is the one in touch with the multilateralism cooperation under the WHO and the second ones is the one who can evaluate the importance of the international assistance. Being a sort of elite of the said regions, it was easy for us to contact the health official without an appointment and be welcomed by them to give us all the requested information. Having some officials throughout the country encouraging young researchers to pursue and deepen their research for the good sake of the country is one of the keys that eased the data collection process. Being aware of the fact that the research can lead to better health security in Cameroon was a decisive argument to conduct our interview with the expectation to get the wider opinion as possible. The interviews consisted of three sets of questions.

***Question 1. What are the main threats to health in your region?***

This first question had the ambition to collect the first based and raw opinion of heath personnel met in the regions visited in Cameroon. The output of this question is designed to draw a general map of the health reality in the country. This question was also submitted to officials at the Ministry of Health of the country and regional health representatives.

***Question 2. What is the health reality of your health center?***

This second question tried to round out the health facilities' availabilities throughout the country. It was a question for us with this question to understand whether the medical center was capable of handling the cases submitted and the patients' requests. This question was intended also to determine if the medical personnel were aware of the refreshed and updated protocols related to health care [promoted by the government to fight against some health situations. The question was asked to heath personnel, doctors, and nurses at some strategic medical centers throughout the country.

***Question 3. Do you know the WHO? Is this IGO supporting your activities?***

This third question asked to some officials at the Ministry of External Relations at the Ministry of Health and some hospital managers have a triple objective. The first objective was to know if it exists, above official texts and concretely in the field of the WHO ties with the Cameroonian Government. This first objective planned to denounce the inexistence of the theatre of operation of the WHO if the answer was negative. The second objective of this question was to identify the trace of the cooperation between the World Health Organization and Cameroon in the sense of the amelioration of the health system security of the country. We wanted to know if the WHO is participating in the national health infrastructural development of the country. The third objective of this question was to get the opinion of the specialists in the field on the usefulness of this World Health Organization with regards to their expectations in the field. In general, the interviews took from 40 to 70 minutes. Most of the interviews, especially those with members of the medical corps were recorded.

### 3.3. Ensuring the reliability and validity of the study

Ensuring the reliability and validity of the study has its important for all conducted and produced scientific research. It is in this case question to consider the common criticism revealed by the qualitative research by pointing out the fact that qualitative productions are anecdotal and qualitative analysis is an interpretative process. According to Lacey and Luff, this process of ensuring the reliability of the research, the preconceptions, and assumptions of the analyst are determinants to influence the way he produces emerging theories. Four main points can be developed to ensure the validity of this research. These points intend to determine whether the project is credible or not, whether the research is transferable or not, whether the process is dependable, and whether the findings can be confirmed.

***The project is credible***

This first step in the validation of our research responds to the question of how congruent are the findings with the realities? Are the outcomes of the research in line with the observed and analyzed realities? Is the described and evaluated situation of the health security system of Cameroon linked to the collected data on the field and the exchanges made with health responsible in hospital centers of the country? According to the doctrine of methodical research, credible research is one made under the preoccupation of the doctrinal established research method. The said method requests the neutrality of the analyst and objectivity while collecting data and developing the correspondent analysis. In our opinion, this step has been validated and the information made available in this document has been produced according to the prescription o the research in social sciences and has been conducted with total neutrality and objectivity without taking part in any subjectivity.

***The research is transferable***

By the prescription to have a transferable research outcome is recommended the obligation for the researcher to develop an analysis that that easily be applied to other realities and domains of study. Research becomes transferable when the process in which it has been commended and conducted can inspire some other research. Transferable research is research that can inspire some other research. Taking into consideration the first quality information mentioned in this research, the organization of ideas, and the defense of our hypothesis related to our research question, we can affirm that this research is obeying the rules and principles of the transferability of research.

***The process is dependable***

As same with the transferability and the credibility of the research developed above, the process dependability is another point retained to ensure the validity of the research. By a dependable process is understood the obligation of which the processes should be reported in detail, can be repeated by other researchers. The research realized the usefulness of intergovernmental organization with the case study of the Cameroonian health system security towards the intervention of the World Health Organization has been done with detailed elements. It is the case of the different parts of this research presenting gradually the various health situation in the country with related figures demonstrating the seriousness that has guided the development of the research.

***The findings can be confirmed***

The last point that set the validity and the reliability of scientific research is the prescription stating that the findings can be confirmed. This confirmation that can be done on the field or by consulting the listed annexes and references mentioned is one important step in sealing the credibility of an analysis. It simply indicates that the information mentioned in the research is not invented. The

said information has not been created just for the research but is existing and can be retraced and reproduced. The drawn conclusions are the result of evidence that can be verified. The interviewed people in Cameroon can confirm their declaration and the data consulted can be available to furnish the same information. This point of confirmation also tries to identify if the researcher has as mentioned in the text been in the field and o the collected data are from a first and reliable source.

# CHAPTER FOUR

## 4. THE WORLD HEALTH ORGANIZATION IN CAMEROON

### 4.1. Introduction

There is the World Health Organization but the world suffers from various diseases and access to care for all is not guaranteed. There is the IMF and the World Bank, but poverty is rampant. There is the International Labour Organization but unemployment is real around the world. There is the African Union but it remains the problem of borders and access to states in the continent. This raises the problem of effective African integration. There is the Arable League, the Organization of the Islamic Conference but we are witnessing the auction of human beings in Libya in 2017.

Moreover, despite the existence of the International Monetary Fund, despite the existence of the World Bank, several countries remain poor and highly indebted. Despite the existence of the World Trade Organization, the practice of trade is not always done fairly. Despite the existence of the International Labour Organization, practice, access to work, and more specifically, decent work, are not always done appropriately, and countries apply legislation in this area according to their aspirations. Despite the existence of the United Nations Security Council, which is supposed to be the executive in charge of world peace, we are seeing on both sides of the globe the desire for secession from armed groups that are undermining the established order as is the case in Cameroon with the revolution of the Ambaboys (Kamé, 2018) for the creation of the Ambazonie (Mokondo, 2019). This is also the case of maritime piracy in Africa in the Gulf of Guinea and the cases of guerrilla warfare in South Sudan or the war in Syria. Despite the existence of institutions such as the International Organization of the Francophonie or the organization of the Commonwealth, the realization of the domination or even the predominance of the culture of the main country that is either France or the United Kingdom, in other cultures we find that despite all the pious wishes of these different international organizations, there is still poverty, there is still malnutrition, there are still problems of access to safe drinking water, which remain crucial problems for the future of humanity. According to data from the 2017 WHO and Unicef report, 11 percent of the world's population figures have more than 850 million people still lack access to a source of drinking water.

Because of these above observations, what is still being done in these organizations when the history of international relations tells us that in the time of ancient Egypt the great scientists and all scientists did not need the authorization of any supranational body to give credit to their discovery, especially in medicine, other diverse sciences. How can we understand today that for any discovery to be approved, a committee of external experts would have to be found to either validate or invalidate

the results of the research, for a drug against Covid19 to be accepted because it was discovered by Madagascar, the world's poorest country as if to speak as the President of Madagascar himself, faces a challenge from World Health Organization?

### 4.2. Basis of the relations between Cameroon and WHO

As a newly independent country, Cameroon that has joined the United Nations system galaxy in 1960 and has so doing automatically joined the other agencies constituting the global UN nations, among them the World Health Organization (WHO, Cooperation Strategy of WHO, and the Republic of Cameroon, 2017-2020, 2017). However, it is important to present some facts that stimulate the said relations. With 23 million inhabitants according to the 2015 population census raised by the ministry of interior and the national institute of statistics, the country records a human development index of 0.504 which might require enhancing the development process that has been promoted since 2011 under the label of emerging the country by the year 2035. The said relations lay on a philosophy of cooperation called the Strategy of Cooperation between Cameroon and the World Health Organization and described in the WSCC document also known as the guideline of the intervention of the WHO in Cameroon. The said WSCC identifies, describes, and plans the action that the World Health organization intends to realize in Cameroon during a specific frame time with specific sectors and specific results expected. In short, it is the WSCC that represents the main document and instrument that states, establishes, underlines, and suggests for a specific time the ambition, program, and expected realizations of the World Health Organization in Cameroon. It is the said document that presents the sectors of intervention, the priorities of actions, and the calendar of deployment of the health organization for benefit of the Cameroonian population. Being in 2020, the document in force is the third generation which start from 2017 to 2020 scale and which has succeeded the first generation starting in 2003 till 2009 and the second generation of the WSCC initiated in 2010 till 2015 (WHO, Cooperation Strategy of WHO, and the Republic of Cameroon, 2017-2020, 2017).

Even though one of the main weaknesses of this document is the fact it has been adopted in a period when no one was expecting the outbreak of Covid19, the fact that it doesn't imply the actions and measures that would have been taken to counter the said Covid19, the ongoing document called the third generation of SCC or Strategy of Cooperation with Countries outlines is set on a philosophy that conveys the consensus of the majority of country members. More precisely, the SCC put in force the main reforms projections that have been adopted by the World Health Assembly targeting the willingness of stakeholders to witness a correlation between the concrete sanitarian needs of populations worldwide and the policies that are being considered for implementation. It is imperative to address with more effectiveness and results from the expectations of States Members. Succeeding as mentioned in the second and the first generation of SCC, the actual version of the general orientation of the intervention of the WHO in Cameroon has been adapted to the experiences

harvested from the experience of the previous versions. The contribution of a UN specialized agency, the United Nations Development Assistance Framework known as UNDAF has its importance in the sense that it is one of the main agency of the United Nations Galaxy System which finger out the information on the field and expect to match the outcome policies with the information obtained from the field.

It is therefore expected from the SCC to be the link, the connector between Cameroon and the World Health Organization. It has to play entirely its function of general information and sensibilization of the populations. This prescription of assuming the role and function expected from this international organization goes with the inherent obligation to remain this police maker that will determine whether the person in charge of the implementations of context mentioned in the said document in Cameroon is keeping an eye on their missions and duties. The SCC engaged the credibility of the WHO in Cameroon, mobilize necessary finances and coordinate the intervention of other health partners in the country that might help the SCC to attain its objectives in Cameroon such as UNDAF, local or international private or public partners. It is stated that the third generation of this document guiding the activities and framing of the deployment of the WHO in Cameroon takes into account the recommendations made by the HHA or Harmonisation for Health in Africa by one side and the International Partnerships for Health and Similar from another angle. From the point of view of cooperation and partnership for development, the document gives a short description of the help environment in the country and analyses the action of WHO as perceived by partners in the past, of collaboration with the United Nations system in the framework of UNDAF and the United-in-action strategy, as well as the description of proposals made by partners in the leadership role that WHO should play during the next four (4) years in matters of health. This WCSC can thus be used to draw the plan of action of the WHO office in Cameroon for the next two years, as well as guidelines on the way WHO's representation office in Cameroon, shall operate and collaborate with the other levels of the Organisation. WHO's cooperation strategy with Cameroon (WCSC) has been on since 2003 and is materialized by the first generation document which spells out the mid-term strategic cooperation framework between the government and WHO. It takes into account the evolution of the political, economic, and institutional contexts in the country.

### 4.3. The ambitions of the WHO in Cameroon

To identify the ambitions of the World Health Organization in Cameroon, one needs to focus on the various interventions and positions taken by the legal representation of the said WHO in the country. It will be a question to take into consideration what the main responsible of this intergovernmental organization is presenting to the Cameroonian government and what is been published on their official website and various documents produced in direction of Cameroonians. More specifically, these will be presented the official positions of Mr. Roungou Jean Baptiste. He is

the Representative of the WHO in Cameroon and develops the position of the World Health Organization for the development of health facilities in the country. Above all the first mission of the international health organization in Cameroon is to clarify the role importance and objectives that are supposed to achieve a health service toward the expectations of the population. The WHO intends by so doing through this first ambition to center back on the position that every health personnel is supposed to play for the sake of national health security. To do so one of the main axes that will be outlined I the incidence that has the health level of a country on its development. Health is at the service of the development of a country and without good health conditions and facilities, the ideal of development remains just a utopia, a non-realizable dream. Another ambition of the WHO in Cameroon is to bring closer the population to the modern health center by rebuilding the confidence of the population and reinforcing the reliability of hospitals to regain the participation of the said population. It is obvious to conclude that without the population there is no need for hospitals. They are made for their comfort and their wellbeing. This comfort and wellbeing will remain unreachable if these populations do not adhere to the idea of visiting the said hospital. Reaching this struggle of trust and confidence of the population requires the participation both of public and private actors that must invest in the development of the said health facilities to build hospitals capable of responding to the majority of the patients' requests.

One cannot plan to reopen the destination hospital with low service quality. A non-satisfied patient is non-neglected damage to the image of the hospital and being unable to face the situation presented by a patient is a bad advertisement for the institution. It is precisely this point that intends to correct the WHO by reinforcing the capacities of the hospital of the country regardless of the regions identified. Participating in the effectiveness of the too-long announced and awaited Universal Health Care Coverage UHC, by enhancing the various strategies tools, and tips that can contribute to the achievement of this project by investing in the health system which does not remain static but is rather affected and impacted by variants that most of the time are unpredicted and unexpected. Marking special attention, and so doing, multiplying actions in favor of the fight against non-communicable diseases is also part of the ambition of the WHO in Cameroon. The World Health Organization intends to emphasize actions and general mobilization on the health of teenagers and adolescents who are the ones representing a priority target in the global struggle against HIV Aids. Also will be taken into consideration in the national intervention of the WHO in Cameroon the challenges related to maternal and neonatal mortality in the country. As same as systematic vaccination to fight against the neonatal disorder presented in this research as one of the main causes of human lives lost in the country, the WHO has the ambition to keep Cameroon a polio-free area where no polio will be maintained at 0 levels as it is the case actually, but also, the WHO will develop all the necessary measure on order to impeach the outbreak of this illness.

The World Health Organization factsheet 2010 presents Cameroon as one of the African nations going through an important crisis in human resources to promote sustainable health conditions throughout the country. More precisely, in Cameroon, there are about 1.1 physicians and 7.8 nurses and midwives per 10 000 population (WHO, AHWO Cameroon Fact Sheet, 2010., 2010). The difficulties that are facing the health system facilities in the country embodied the reality stating that there is an unbalanced geographic distribution of health workers and personnel intervening in health facilities throughout the country. This inadequacy of repartition of personnel is more observable in the regions of North, Adamaoua, and the South of the country where are listed the fewest doctors, nurses, and health assistants. One of the other points that jeopardize the efficiency of the Cameroonian health system that the World Health Organization ambition to ameliorate is the average age of the health workers in the country. With more than 66 percent of the total Human Resource in the Hospital census in 2011, up to 53 percent of health personnel aged between 40 and 51, and 31 percent of the workers in the health public sector are aged more than 51 years. Statistics indicate that up to 15 percent of medical agents between 2010 and 2012 were normally supposed to be retired but are still been maintained in function. The fact that the personnel is getting older affects the efficacy of this personnel because with age there are some situations that old medical doctors will not be capable to handle or there will be some physical necessity that they will not be in measure to handle and support. The limited human resource dedicated objectives and recruitment of new personnel according to the demand of the population is also part of the lack that influence negatively the production of the Cameroonian health system. When pointing out the recruitment of young personnel is also understood the fact that the recruitment procedure is still centralized in Cameroon. It means that till 2020, it is the Ministry of Health in Cameroon that launches the recruitment process, elaborates the examination, and decides the selection of the personnel and lately, affects them in regions. The result and incidence of this method of action are that the most of time there is an inadequacy between the expectation of the various health system in the region and the national politics of the Ministry of health. It would have been more optimal if it was every region that could organize its recruitment. Reforming this system of recruitment and management of personnel will have as a main result the adaptation of the local health facilities' requests to the regional health politic (MINSANTE, 2010). The National Health Development Program for the period going from 2016 to 2020 also known as NHDP 2016-2020, which is the national strategy to develop the health system in the country for the specific time of implementation mentioned is taking into consideration the global decennial ambition 2016-2027 of the Ministry of Health of Cameroon and the 12th World Health Organization general plan of work and strategic priorities.

Five strategic priorities are being taken into consideration in this ambition of health system improvement. It is the case of the support granted to the fight against communicable and non-communicable diseases in the country. The ambition is to develop a system in the country capable

of preventing, diagnosing, and treating these communicable illnesses. It embodied the question related to the environmental impact on health such as water quality, hygiene promotion, and sanitation minimum required caretaking plans. Also are being taken into consider the sources of non-communicable diseases such as unsafe food consumption habits. It is stated that food is one of the main causes of the health trajectory of an individual. The quality of eaten food will determine the ease and comfort one will feel in his body. The correlation between food and health is hereby highlighted and a vulgarisation program on the importance of the quality of nutrition is emphasized. The practice of regular physical activities is one of the segments founding the strategy of this global strategy. It is no more necessary to underline the importance of the sport for the metabolism of an individual. The other identified causes of the low level of the health system in the country will also be taken into account. It is the case of the reinforcement of the capacities of the health personnel throughout the country and no more only in main urban areas as has always been the case. The disparity of information and the non-equal access to information related to the protocol to be applied in front of a specific case of illness will be dismissed by the harmonization of the health information system of the country. by so doing, it will therefore be possible for medical personnel serving in the south as same as their colleagues in the far north region of the country to access the same information related to a specific case anytime that will be confronted to. The availability of drugs and medicine is another point that the World Health Organization in its new agenda plans to resorb. The shortage of stock in essential drugs and medical consumables is one reality that paralyzed the good functioning of the Cameroonian health system. It is often the case of patients that are being diagnosed with a specific illness and are being directed to pharmacies to get medicine to start their treatment but are facing unavailability of these products dragging a risk for their recovery and so doing risk for their own lives. The third generation of the national strategy of cooperation between Cameroon and the World Health Organization, which is the document reference indicating the missions, objectives, and deployment calendar of the WHO in Cameroon for a specific time of action, with qualitative and quantitative expected results, has underlined some specifics categories of the strategic program of the WHO in the country. The first one intends to ameliorate the epidemiological monitoring around the country. A sort of shield that will detect the earlier as possible the advent of a new epidemic in the country. This amelioration will be done through the utilization of modern information and data, communication, and location technologies at all the stages of the pyramid level of the health system in the country. The adoption and the enforcement of new protocols of the WHO related to the handling of ARD and the support granted to the improvement of the quality of the DOTS services mobilized to fight against tuberculosis and more specifically the resistant version of tuberculosis.

The said strategy intends also to organize fundraising for the World Fund with the purpose to achieve and support the universal coverage of international intervention to fight against the persistence of malaria in Cameroon. It is projected to set a plan of NTD and enact a better-referenced

politic related to the availability of medicine for mass distribution and specific treatments. The WHO will participate in the survey on tobacco consumption in the country by adults and younger people. This monitoring will conduct a better hand on this addiction in the country. The WHO will also contribute to the qualitative measure of ameliorating the health of the mother and her newly born baby, the health of adolescents, and neonatal disorders reduction. This last point has as the main target to support the application on the field of the national road map consisting to accelerate the reduction of maternal and neonatal morbidity by turning into reality the wish of local government to tackle this phenomenon of the dead while giving the life. It will require the increment of maternal death surveillance notably via the use of telephone interconnections. The human resource capacity building that will be conducted to develop the response abilities of the health personnel will permit to conduct of good investigations of maternal death concerning the integrated treatment of infant diseases. The road map of such action requires the improvement of coordination among various actors intervening in the domain to set and establish and implement the H6 and RMNCAH/ TRUST FUND project.

This third project will have an asset in the contribution to the inclusion of new vaccines in the national program of vaccination called EPI. It will be organized several vaccination campaigns to fight against poliomyelitis, measles, yellow fever, and meningitis. Also will be created centers dedicated to captivating issues related to youth problems in health facilities. Those centers will be well equipped and capable of immediately handling the exposed requirements and problems of youth. Out of other missions that intend to pursue the WHO in Cameroon according to this third-generation document, the organization plans to mobilize financing from various donors to conduct humanitarian assistance in the country. The World Health Organization also plans to develop hospital infrastructures such as the offices in Bertoua, the one in Maroua, and the other one in Douala the economic city. There will be functional operating hubs in Garoua Boulai and Batouri in the East region of the country, and health units at the Minawao camp of refugees recently opened in the far north region of Cameroon. These operations will be difficult to implement if there is no means of transport to carry the personnel in charge of the said new policies. It is the reason why it is envisaged to acquire new vehicles and equipment odd transport for the sake of regional health services. To have a better result on the field, the field experienced personnel will be the ones handling emergencies and the various intervention for the benefit of the populations such as refugees, internal or external displaced persons, and wounded ones as a result of war, fight, or natural crisis. The WHO finds it urgent to advocate for the adoption by the Cameroonian parliament the law setting the anti-tobacco rules aside and to lobby for the creation of the association of journalists for the Promotion of vaccination and the strengthening of the national health system. Senior consultants will have their capacity of reaction reinforced by refreshed and adapted programs more precisely on health management procedures. There will be an elaboration of the manual of administrative, accounting,

and financial procedures or EVP and the creation of a national diagnosis and therapeutic guide to be exploited for primary and secondary health care services. The NHRDP or National Human Resource Development Plan will be created as same as a human resource monitoring tool. To make its actions and intervention in the country easily identifiable, clearer, and less discountable, the World Health Organization tables on the creation and the publication of an annual health report stating statistics on the most frequent diseases identified in the country as same as the one which shall be declared. The creation of a computerized system introducing the use of computers and new information and technology systems to identify health zones on the map for a better overview of the national health map of the country is also one of the priorities raising the concern of the WHO. This computerized system will be determinant in the updating process of the national list of essential drugs and so doing, presents an estimated figure of the country's needs for medicine, reagents, and other medical necessities used in the first level of medicinal concern such as HIV/Aids, Malaria, NTD an all than others. One of the last points of intervention of the WHO in Cameroon is the elaboration and enforcement of a national blood transfusion strategic plan. This strategic plan will give the opportunities for the national blood bank to be able to respond to the demands of the population.

### 4.4. The WHO in deeds in Cameroon

In this section, it will be of interest to the research to identify the concrete realizations of the World health organization in Cameroon it will be a sort of portrayal of the factual deeds of this international organization for the sake of the health security of Cameroonians.

**Table 14:** The distribution of the Human Resource for Health strategic plan in Cameroon


Source: WHO factsheet 2015.

The above-reproduced table related to the distribution of the human resource strategic plan as planned by the World Health Organisation in Cameroon is organized around five steps.

The first step is the Human Resource for Heath coordination stipulates that there should be an integrated overview of all the various actors intervening in the field of the health sector in Cameroon to ease the management of this one. By coordinating the Human resource for health it will be easier to reorganize the dispatching of the personnel, the certainly related to their formation and reinforcement of capacities with actualized information and protocols in responding to populations' health necessities.

The second one is the HRH situation analysis. This second step has the ambition to understand the fluidity of the personnel and so doing understand where there are gaps or inadequacies

of the medical body. It is at this step that evaluated whether the needs expressed by patients in specific health areas can be compiled and resolved by the transfer of an adequate doctor or simply the substitution of one personnel where his presence is not required. The third is HRH planning. In this step is being planned the carrier of this personnel. The elements such as the retirement of some nurses and doctors or the recruitment of new health actors are being taken into consideration as same as their transfer to regions or hospitals where they will be more useful. This is the step that is being taken into consideration the various regional demands and the human resource availability. The fourth is the Resource mobilization for HRH. To have a competitive and well-trained human resource, it is important to invest in the formation and recycling of this personnel. That recycling process requires resources. This step has its importance lies in the fact that modern information has a cost and is getting more expensive with specializations. Without a good financial surface, it will not be easy to conduct a national reform with just a sample of medical personnel that has been updated by the entire body. The fifth and last step is the implementation of the HRH plan. By implementation of the human resource for health, the approach is understood the use of this newly competent person who has received a recycling course and that has been declared optimum to respond to all the requests of the population. It is at this last point, the question to dispatch on the field the qualified personnel with the certainty to have a better medical corps for better service to the population and so doing better stimulation of the health security of the country. According to data collected at the Ministry of Health of Cameroon, the country has completed phases 1 and 2 of the CCF. Cameroon has successfully established an HRH coordination mechanism and an HRH situation analysis. As same, the country is currently developing a costed HRH national strategic plan which in short term will reinforce the already done stepping forward of the country. It will be the case of the HRH baseline case study profile developed some years ago by the health authority of the country. This Human Resource for Hospital baseline has provided analytics and a well-exploitable overview of the coordination and the governance system of the HRH in the country. In the range of evolutions made by Cameroon that the WHO intends to consolidate in its mandate in the country, the new HRH committees established are part of the program. On the same front, Cameroon has achieved an in-depth HRH situation analysis through the CCF process in line with the national strategic plan to elaborate. The World Health Organization has mobilized additional support from partners for the development of African countries to reinforce the investment realized in the development of the HRH in the country. in addition, the WHO in collaboration with the Ministry of Health of Cameroon has reported the presence of a multispectral coordination mechanism with a wide broad implication of partners to the development and enforce the existence of other mechanisms and processes that will permit keep updated the policymakers and decisions takers related to the HRH lacks, gaps and various request for its optimization. As concerns potentially epidemiological diseases (PED), catastrophes, and other public health emergencies, the epidemiological landscape has been greatly

characterized by cholera, bacterial meningitis, measles, yellow fever, and poliomyelitis outbreaks. The table below presents the evolution in the number of cases and deaths due to these epidemics between 2011 and 2015.

**Table 15:** Evolution of PED in Cameroon from 2001 to 2015

| PED | 2011 | | | 2012 | | | 2013 | | | 2014 | | | 2015 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Death percentage (%) | | | Death percentage (%) | | | Death percentage (%) | | | Death percentage (%) | Cases | Deaths | Death percentage % |
| Cholera | 23 152 | 843 | 3,6 | 125 | 4 | 3,2 | 29 | 0 | 0 | 3 409 | 191 | 5,6 | 123 | 6 | 4,9 |
| Meningitis | 2733 | 191 | 7 | 1128 | 103 | 9,1 | 1010 | 68 | 6,7 | 944 | 51 | 5,2 | 1221 | 61 | 5 |
| Measles | 4 574 | 27 | 0,6 | 14 806 | 73 | 0,5 | 1 681 | 10 | 0,6 | 4 152 | 16 | 0,4 | 9874 | 34 | 0,4 |
| Gastro-enteritis | 1 366 | 2 | 0,1 | 21 877 | 60 | 0,3 | 46 017 | 63 | 0,1 | 53 477 | 80 | 0,1 | 55793 | 70 | 0,1 |
| Bloody diarrhoea | 2 114 | 4 | 0,2 | 7 376 | 13 | 0,2 | 10 966 | 7 | 0,1 | 13 066 | 11 | 0,1 | 12656 | 9 | 0,1 |
| Typhoid fever | - | - | - | 55 100 | 21 | 0 | 138 758 | 31 | 0 | 176 899 | 28 | 0 | 226342 | 28 | 0,0 |

Source: PED Data 2011-2015.

The table above presents the evolution of PED in Cameroon from 2011 to 2015. It is organized in a sort that it is outlined the main PED taken into consideration by the program, and the marge they are related to.

It is the case the **Cholera** recording in 2011 23153 declared cases with 843 dead representing a percentage of 3.6 percent of the total number of malaria officially diagnosed cases throughout the country. In 2012, there is a significant drop in the censed cases with 125 recorded patients and 4 losses in life corresponding to 3.2 percent. In 2013, with the progress of medicine, there have been 23 cases with 0 human loss representing logically 0 percent of the dead. However, in 2014, 5.6 percent of the dead has been listed among the 3409 new patients and the 191 dead. In 2015, the 4.9 percent recorded were corresponding to 123 patients positively diagnosed with cholera with 6 deaths. The **meningitis** recording in 2011 a 2733 declared cases with 191 dead representing 7 percent of the total number of meningitis officially diagnosed cases throughout the country. In 2012, there is a significant drop in the censed cases with 1128 recorded patients and 103 losses in life corresponding to 9.1 percent. In 2013, with the progress of medicine, there have been 1010 cases with 68 human losses representing logically 6.7 percent of the deaths. However, in 2014, 5.2 percent of the dead has been listed among the 944 new patients and the 51 dead. In 2015, the 5 percent recorded were corresponding to 1221 patients positively diagnosed with meningitis with 61 deaths.

The **measles** recording in 2011 a 4574 declared cases with 27 dead representing a percentage of 0.6 percent of the total number of measles officially diagnosed cases throughout the country. In 2012, there is a significant raising in the censed cases with 14806 recorded patients and 73 losses in life corresponding to 0.5 percent. In 2013, with the progress of medicine, there have been 1681 cases

with 10 human losses representing logically 0.6 percent of deaths. However, in 2014, 0.4 percent of the dead has been listed among the 4152 new patients and the 16 dead. In 2015, the 0.4 percent recorded were corresponding to 9874 patients positively diagnosed with cholera with 34 deaths. The **gastroenteritis** recording in 2011 1366 declared cases with 02 dead representing 0.1 percent of the total number of gastroenteritis officially diagnosed cases throughout the country. In 2012, there is a significant rising in the censed cases with 21877 recorded patients and 60 losses in life corresponding to 0.3 percent. In 2013, despite the progress of the medicine, there have been 46017 cases with 63 human losses representing logically 0.1 percent of deaths. However, in 2014, 0.1 percent of the dead has been listed among the 53477 new patients and the 80 dead. In 2015, the 0.1 percent recorded were corresponding to 55793 patients positively diagnosed with cholera with 70 deaths.

The **bloody diarrhoea** recording in 2011 a 2114 declared cases with 4 dead representing a percentage of 0.2 percent of the total number of bloody diarrhoea officially diagnosed cases throughout the country. In 2012, there is a significant regain of the censed cases with 7376 recorded patients and 13 losses in life corresponding to 0.2 percent. In 2013, despite the progress of the medicine, there have been 10966 cases with 7 human losses representing logically 0.1 percent of deaths. However, in 2014, 0.1 percent of the dead has been listed among the 13066 new patients and the 11 dead. In 2015, the 0.1 percent recorded were corresponding to 12656 patients positively diagnosed with cholera with 9 deaths. T**yphoid fever** has not been recorded in Cameroon since 2011. In 2012, there have been up to55100 recorded patients and 21 losses in life corresponding to almost 0 percent. In 2013, despite the progress of the medicine, there have been 138758 cases with 31 human losses representing logically around 0 percent of the dead. However, in 2014, 0 percent of deaths have been listed among the 176899 new patients and the 25 deaths. In 2015, the 0 percent was recorded as corresponding to 226342 patients positively diagnosed with cholera with 28 deaths.

**Table 16:** The main health delivery indicators in Cameroon

| Indicators | Coverage Rate | Source |
|---|---|---|
| | 3rd dose of the combined five-effect vaccine: 79,6 % | |
| | 3rd dose of the anti-polio vaccine: 84,5 % | |
| | BCG : 91,2 % | |
| | Anti-Measles vaccine: 79,9 % | |
| Percentage of fully immunised children | 64, 4 %<br>(ranges from 50,8 % (North Region) to 89,9 (Centre Region, excluding Yaoundé) | EDS-MICS 2014 |
| Contraceptive use | 34,30 % | EDS-MICS 2014 |
| Antenatal care (percentage of women aged 15 to 49 who have received antenatal care from trained health personnel | 64 % | EDS-MICS 2014 |
| Assisted childbirth | Varies between 34,6 % (the North Region) and 95,2 % (Douala) | EDS-MICS 2014 |
| Percentage of facilities which can carry out diagnosis tests | ND | |
| Availability of WHO's standard tracer molecules in health facilities | 86 % | Ministry of public health: "state of affairs and diagnosis of the Health Sector" |

Source: Minsante 2016.

The country is gradually acquiring what is needed to enforce the international health regulation (IHR) (2005), which includes the coordination mechanism in case of emergency (the existence of an Emergency Operation Centre (EOC) at the central level, and at the Provincial centers to prevent and combat epidemics which have at their disposal rapid intervention units; the supervision system which relies on some 2500 connected telephones and an alert system via mobile phones. Besides the mentioned achievement or impulse of the World Health Organization on the field, there is also the fact that it is easier to identify the more competent staff in the hospital centers throughout the country. The existence of a certified national laboratory producing qualitative documents such as clearer scanners, more readable IRM, and all the image-made medical outcomes. The said technical plateau has been raided at the international level standard to ensure the convergence between international diagnostics and the one a patient can realize in the country. the level 3 biological security that is benefiting the Cameroonian health system is one of the achievements that should be added to the credit of the WHO general politic in Cameroon as additional measures are promoting the networking among the laboratories in the country to share experience and set a mutual assistance platform for the sake of the population. Despite the absence of a national road map of activities that normally should be the guideline that will suggest the national intervention of the WHO and the specifically zoned intervention as observed actually, the Cameroonian government has identified the priority risks for the country and so doing drive the attention of the health system partners on the necessity to augment the interest put on this sector. The visits made in far located hospital in Cameroon during the data collection phases realized in the country has permitted the researcher to confirm the fact that the stock of medicine and medical needs have been already shared and transmitted to the medical centers around the country to prepare them and give them necessary tools to face any epidemic that could outbreak such as cholera and meningitis that usually and repeatedly point out in the country despite the vigorous intervention of the government and the health sector specialists. As same as meningitis or cholera, with the support of the WHO local Bureau in Cameroon, the country can face any catastrophe with more confidence such as terrorist attacks or road accidents identified as one of the main causes of human lives lost in the country.

### 4.5. The gaps and the inadequacy between the ambitions and the realizations

According to the data collected in the field and the various documentation exploited in medical centers throughout the country during the research aside and the recognition of the institute in charge of monitoring the concrete implementation of the WHO calendar of activity in Cameroon, there are some important gaps and inadequacies between the announced objectives and the result observable or the ponderable impact of the sanitarian multilateralism in Cameroon.

Those gaps and inadequacies among others are:

- The World Health Organization is not providing sufficient assistance to the Cameroonian health department to influence and consequently curb the health crisis in the country. One of the reasons suggested is the non-availability in the country of recognized experts and well-qualified professionals to run with more competence and vision the national representation of the WHO in the country. To this non-availability is been added the lack of resources to support the political ambitioned by the national bureau.
- It subsists a sort of relative cooperation between the WHO Bureau in Cameroon and the correspondent departmental ministry in the country related to the availability and the share of documentation. According to the report made by the Representation of the WHO in the country, it is difficult for them to get documentary evidence to drive with more confidence their duty on the field. The said blockage is identified more precisely on the financial side when there is a need raised by the local bureau and the necessity from the office to get as planned in the agreement between the WHO and Cameroon the financial support from the government.
- The above-mentioned difficulty related to the financial assistance from the government that affects and impacts the implementation of the annual politic of the Bureau throughout the country, the insufficient donations of some technical programs such as the NCD, and the various campaign to promote health in the Country with a stopover on some point of interest such as malaria, HIV aids among others.
- The health system is itself a global galaxy that embodied politics, economics, and strategies. That means that if the sector is well exploited, there are opportunities to create strategies that can autonomies the local system. But on the field, one of the points that demonstrate the gaps and potential limits to the achievement of the ambitions of the WHO in the country is the absence or scarcity of health economists who would have been the experts in charge of drawing sanitary cartography by insisting on the economical side of the intervention. The said economic side would have been a crucial element in favor to finance the health system and so doing, participating in the project raised by the Cameroonian government to promote the Universal Heal care coverage promised to the populations some years ago that is not still applied.
- A politic that wants to present itself as an ambitious one is a politic that presents the willingness to expand itself to embrace more territories. But in the case of the World Health Organization management approach, the case of emergency seems to not have been taken into consideration. A rapid observation of the practice of the organization shows that there is no systematization of an aggressive politic when it comes to purchasing goods on the international market. Rather than being aggressive to

maximalist the gains for the sake of the future beneficiaries of the dotation, the WHO's passiveness on the international market reveals itself as an important gap that jeopardizes the representation of the WHO worldwide.

- The observation and analyses of the trajectory of the budget of an institution give sufficient elements to the observer to understand the type of institution one is dealing with. When the budget is being reduced, the logical deduction is the act that the said institution is dropping some ambitions and prefers according to the realities of the field to concentrate on only crucial points that will limit the financial losses. On the contrary, when an institution upgrades its budget, the immediate deduction that comes to the mind of the analyst is the fact that the institution has decided to expand itself and conquer some new territories. The said territories can be economic, political, or strategic. However, and this is the main point of inquiry, the budget of the World Health Organization remains the same ear after years. It simply indicates that there is not a deep intention to take into consideration the dysfunctions observed some years before to correct them by adopting a budget more realistic and ambitious.

This section intends to analyze the implication of the WHO in Cameroon concerning the described health situation in the country in the 2.5 section. That implicates the medium of the comparative analysis method to outline the impact of the global health security insurer and the 10 most predominant illnesses in our case study. This is to answer the question to understand what has the WHO done to curb the rates of Malaria, HIV, Lower respiratory infections, neonatal disorders, diarrheal diseases, ischemic heart disease, stroke, tuberculosis, road injuries, cirrhosis- Covid19. It seems obvious that the WHO is not competent to solve the situation. The WHO doesn't permit Cameroon to curb the rate of the main causes of health insecurities which are Malaria and HIV in Cameroon, lower respiratory infections and neonatal disorders, diarrheal diseases, Ischemic heart disease, Stroke, Cirrhosis, Road injuries, Tuberculosis, polio, and the Covid19. The who has rather offered 14 cars to fight against the Covid19 in the center region. In the west region of the country, the WHO offered 3 cars to hospital responsible officials to ease their movement in the region rather than investing in the quality of the equipment of hospitals in the same regions.

### 4.6. The implications of the post colonialism on the health reality of Cameroon

The implications of the post-colonialism theory on the research itself and the health reality of the country are identifiable on a double approach. The implication on the theoretical fundament and the implication on the practical basis.

- ***The implication of the post-colonial theory on a theoretical basis.***

Will be highlighted under this paragraph, the incidence of the hypothesis and the incidences on the principles of international cooperation.

Two hypotheses have been suggested in the framework of this analysis and the theoretical background gravitating around post-colonialism and the similar identified notions are indicating the linkage and inferences of this theory on those conceptual notions.

*"The World Health Organization has been created to enhance, promote and strengthen the global and so doing, Cameroonians Health Security System. Based on a well-shaped agenda and planning of activities, the WHO has identifiable actions and realizations in Cameroon (1). However, the deep and concrete observations of the Health situation of the country drag out, not only the World Health Organization limits in Cameroon but also raises the question of the finality of the philosophy and the conduct of worldwide multilateralism. These, command a reflection on another model of international cooperation based on a post-multilateral era (2)."* These two formulations have been presented as the main two hypotheses guiding the research. Let us dissociate them.

The world health organization under chapter 2 and chapter 3 has been presented as an institution that is organized under some principles and regulations. So, the first one of this principle is the predominance of the permanent member of the security council of the united nations in the range of the main contributor to the budget of the organization. Post colonialism indicates that one of the techniques to maintain the international domination of previous dominating superpowers on the colonized entities is to have the main and largest shares in international organizations. This is to mention the predominance of countries such as the United States of America which by adding the shares of its nationals such as Melinda and Bill Gates to the USA's contribution, it is up to half of the global budget of the World Health Organization. One can easily understand now why Bill gate has been one of the main deciders of the solution given by the WHO to the Coronavirus outbreak.

To come closer to the first hypothesis stating the organization of the WHO around some well-identified and adopted international health policies, the post-colonial theory indicates that the international policies taken by international entities cannot be done in favor of formerly underdeveloped countries. The deeper observation and analysis of the realities goes in line with the above-stated mention. The World Health Assembly which is the governing assembly of the World Health organization is represented by 193 states represented by one member per state member. This is to indicate the principle of objectivity that is supposed to govern the decision adopted by the WHA. However, the reality indicates that the implementation of the said policies, the choice of the calendar of activities, or simply the choice of priorities of intervention belongs to the general secretariat of the

organization. The Secretariat of the organization which is the one in contact with the national representations of the world health organization in the various countries is the one indicating to the local national health authorities the axes of intervention that the WHO intends to develop with them. It is what an author such as Spivak indicates under the notion of the *subaltern*. Here the concept of the subaltern is understood as the entity placed under the domination of a superpower deciding on the orientation of a policy and expecting this subaltern to simply apply or implement the politic dictated to him regardless of the concrete implications and benefits it might bring to the said subaltern. It is a sort of soft oppression where one is executing the instructions received from an entity that does not always work for the global interest. In this sense, the concept of epistemic violence can also be integrated to indicate discomfort or the difficult togetherness between the WHO international policies and the concrete expectations of the Cameroonian health system. This aspect will be better developed in the concrete aspect of the incidence of post-colonialism on the health security of Cameroon in the following sections. Under this first theoretical explanation of the incidence of the post colonialism on the Cameroonian health system, one can outline as main outcomes:

- The philosophical approach that governs the decision and the choice of international health policies of the World Health organization is biased due to the polarization and the domination of superpowers on the secretariat of the said health IGO. By having the predominance of deciding countries such as the United States and its nationals as main contributors to the budget of the organization, it is obvious that the outcome of international politics in the health sector by the WHO can only be favorable to the orientation decided by these main donators.
- The idea of post-colonialism is to maintain under the statute of permanent expectation the former colonized territory and undermine the possibility given to them to freely decide on the choice of the health policies they wish to implement. By placing the decision of the WHO at the center position guiding the orientation that every country member should adopt, the aspiration to self-determination, targeted by post-colonialism is jeopardized. So doing, the implication of post-colonialism on a theoretical background is clear. The WHO in its principle is not in favor of the emergence of the health sovereignty of states worldwide.
- ***The implication of the post-colonial theory on a practical side***

Will be underlined in this segment the implication of post-colonialism on the concrete realities of the health security of Cameroon. By concrete health, realities are understood the observable picture portraying the general sanitarian situation of the country concerning various health facilities such as hospitals or medicine availabilities by a side or permanent of basic diseases

or rate of new illnesses by another one. The said picture goes in a straight line with the approaches described by Vivek Chibber when he presented the European context and the African context as two different realities having no chance to go together. According to this author, it is a utopia to imagine a universalization of destiny. It is quite impossible for a human being and so did for an international organization to promote the development of global policies or to project itself at the same time on the global needs with the same values interests and abilities. It is another formulation to point out the fact that it is quite impossible for an organization such as the World Health Organization, despite the existence of national representations in its state members, to address with competence at the same time the health issues of up to 193 countries.

This incapacity leads the organization to select its priorities, to choose the politics it wishes to implement, and is not always the one in charge of the verification of the good implementation of the presented health policies. It is the reason why in Cameroon, there are some regions where, despite the importance of the density of the population, it is at times difficult to find a conveyable health center well equipped and capable of facing the majority of health requests submitted by patients. Besides the low representation of the sanitarian card indicating the distribution in a specific locality of the various health centers reside the quality of the material used. Another approach of post-colonialism indicates that it is consciously and well planned by the former colonizing superpowers to maintain the former colonized territory in a middle level of development to expect from them a permanent request of assistance. It can be the reason to explain the fact that in Cameroon, even though the country is planning its emergence by the year 2035, there are still a considerable number of foreign sanitary evacuations of patients every year. According to the figure collected by the Ministry of Health of the country, it is almost 1000 cases of foreign health evacuated patients are recorded every year. This figure represents an important financial loss for the country and does doing, contributes to enriching the foreign countries. The other point of the domination underlined by the post-colonial theory lies in the fact that the former dominating countries are looking forwards to maintaining all forms of supremacy on former possessed countries and one of the angles of implementing this intention is to organize themselves as destinations of specialization where the doctors and medical personnel of Cameroon will go to perfect themselves. They represented their destinations as the place to be to get the necessary knowledge to be competent in the medical domain. It is also one of the reasons why the medicine language universally known is English. Concerning the three above-mentioned elements such as the quality of equipment, the number of good hospitals and the level of knowledge of health specialists such as doctors and other health personnel, the implication of post-colonialism in the Cameroonian health system has been pictured as a reality. Nevertheless, for the future of Cameroonian health policies. What should be expected? In is the point

that will be developed in the next paragraph stating the implication of the post-colonial theory on the post-WHO relation with Cameroon.

- ***The implication of the post-colonial theory on the post-WHO relation with Cameroon***

The main struggle of post-colonialism is to erase any trace or sign of colonialism in the daily life of every former colonized territory. The post-colonialism expects all the former possessed territories to freely administrate themselves and freely decide on the politics they intend to implement on the national and international side. In line with the above-mentioned implications of post-colonialism on the practical face of the health realities of the country, this segment intends to simply give the floor to the post-colonial principles which are by definition opposed to the maintenance of ties with the World Health Organization. Presented as an organization under the domination of superpowers which are the ones governing the international health system, keeping the relations with the World Health Organization under the lenses of the post-colonialism approach, for a country like Cameroon, experiencing the virulence of major health issues, is almost a paradox. A country cannot be a permanent member of a sectorial organization and even though the issues going in line with the ambition of the said organization are not well fulfilled in its territory, the said country still maintains the ties with the organization. The implication of the post-colonial in this domain consists of the advent of a post WHO relations in the Cameroon era. It is an invitation made to the country to withdraw itself from this intergovernmental organization which is not reaching its objectives to counter major diseases around the world and so doing in Cameroon.

The post-colonialism indicates that the only questions that matters are the questions touching directly on the interest of the superpower country managing the world health organization. A practical case demonstrates how deep might be true the principle outlined by this theory. It is the case of the outbreak of the Coronavirus in 2019, which internationalized itself in 2020. Being an illness having touched the superpowers, one has witnessed how fast and proactive has been the World Health Organization which was fast and competent to find the mechanism to counter the said virus. International measures have been put into force and practical policies have been implemented to counter the spread of this Covid19 in a faster period while at the same time, for more than 20 years, malaria is one of the most important causes of dead in Cameroon. Malaria has been presented as one of the main causes of human live losses in the country without assisting with an emergency intervention from the World Health Organization. Considered the illness of poor men, malaria continues to destroy life in Cameroon while a sudden illness such as Covid19, touching rich countries, has almost been kicked out.

The post-World Health Organization relation with Cameroon implies the center back of Cameroon to local medicine and concerted African practitioners of indigenous health care having demonstrated its strength before the introduction of modern medicine and so doing, the predominance of the World Health Organization.

## CHAPTER FIVE

## 5. THE ALTERNATIVE TO MULTILATERALISM

### 5.1. Introduction

This chapter analyses the concrete impact of the WHO and so doing of multilateralism in the country to discuss with more shreds of evidence its usefulness for the country from a first side and the global cooperation from a general perspective. This chapter will take into account the fact that the observation and study of international organizations provide information on significant losses for some of the member countries. Losses on the economic, diplomatic, and cultural levels. Politically and diplomatically, participating in an international organization is a major financial burden on States members. Failing to honor certain statutory dues can have diplomatic consequences for the image of the country in question. For example, Mali was deprived of a vote at the United Nations in 2016 solely for non-payment of dues. Imagining what a loss of a right to vote can cause against the image, credibility, or even the honourability of a country, regardless of what the country in question might be going through an economic phase that is difficult for its internal well-being.

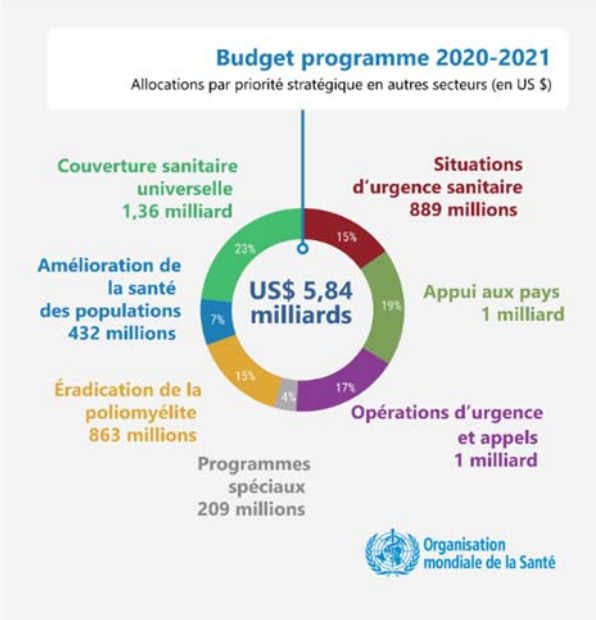
Thus, according to Article 19 of the Charter of the United Nations, any member state of the right to vote is foreseen if the amount of its arrears of contribution is equal to or greater than the contribution of the previous two years. As same as Mali, it was also the case in Somalia, Comoros, Sao Tomé and Principe, Gambia, Central Africa, Lesotho, Venezuela, Lebanon, and Yemen, which were suspended at the 74th United Nations General Assembly. This is a strong act to discredit one of the crucial aspects of the life of a state which is its image both internally and internationally. On the economic front, the loss is identified through the substantial shares of royalties to be paid to these international organizations while there are whole sectors of the economy and national social life of these contributing member countries that remain unfunded. As a result, participating in these proceedings through the payment of statutory contributions proves to be a burden against the financial base of certain states. On the diplomatic front, the trademark image of countries ostracized by world society for failing to honor their dues as mentioned above is a blow to their honourability, prestige, and international influence. At the institutional level, the losses for these Member States are assessed in the sense that there are international organizations that give the impression that they exist only to take into account "crimes" committed by certain leaders and not others. To better understand this state of affairs, it is easy to refer to the recriminations made against the International Criminal Court judged as a court against Africa and its leaders and whose desire for mass withdrawal was born

on the part of the African authorities in 2015 taking into account the reality stating that when the crimes committed by certain forces including those of the United States of America, cannot be dragged into these jurisdictions. Some African leaders and personalities, such as Omar al-Bashir, Laurent Gbagbo, Jean Pierre Bemba, and Charles Blé Goudé, find themselves either dragged or judged there, thus taking up the principle of double standards.

### 5.2. The budget program of the WHO for the 2020-2021 years

This is to show that the WHO has not planned to address some crucial points of the Cameroonian diseases in its programs for the year 2020-2021.

**Figure 1:** The budget Programme of the WHO for the year 2020-2021




Source: World Health Organization, 2020.

Apart from the projected budget for the 2021 year presenting the simple fact that the African problems in general and the ones of Cameroon more particularly will not be taken into consideration, the above-pictured document indicates that the WHO routinely spends about $200 million a year on travel expenses, more than it spends to tackle major health. It is important to outline the fact that the 2020-2021 budget program of the WHO is in its globosity at 5.84 billion US dollars and is divided into 7 domain f expenses identified. Those domains of intervention are corresponding to seven colors. The said colors are represented in this picture to point out the basis of expenses intended by the Budget program of the World Health Organization for the period 2020-2021.

- The violet color corresponds to the allocated budget for emergency interventions and operations. It is also dedicated to all the expenses related to unexpected situations

requiring quick action from the World Health Organization. It is evaluated at 1 (one) billion US dollars.

- The red related to emergencies is evaluated at 889 million US dollars. It is this part of the global budget that will be used in case of the advent of unexpected situations such as humanitarian crises, storms, and all sorts of natural disasters to provide the first emergency assistance to the needy population.
- The green dedicated to assistance to countries members is this part of the budget prepared to accompany the countries in the implementation of the global health politics enacted by the WHO and to intervene and strengthen the local health services facilities. It is also evaluated at 1 billion US dollar
- The light green which is the most important share of the program receiving the funding of the organization for the incoming year is the one consisting to enforce and promote universal health care coverage. It is this political planning to ensure to every citizen worldwide, regardless of his origin, religion, and various reattachment access to health care and facilities no matter where he finds himself around the world. This budget is evaluated at 1.36 billion US dollars.
- The grey color representing the share of the budget evaluated at 209 million US dollars represents the investment reserved for special programs decided by the governing body of the WHO.
- The blue one is dedicated to the amelioration of the health condition of populations worldwide. It is this part of the budget that will be mobilized to intervene in the development of health facilities worldwide such as the equipment of hospitals and the construction of these in case of necessities identified. It has been calculated at 432 million USS dollars.
- The yellow. This part of the budget program for the 2020-2021 period of action is reserved for the fight against poliomyelitis which is an illness that may handicap the victims. It is evaluated at 863 million US dollars.

It is evident that there is a budget program that has been validated for the 2020-2021 period and the said budget takes into consideration many points of health concern and interest worldwide. However, it is also evident to identify the nonexistence of Cameroonian health priorities in this budget program. More precisely, has been presented in the previous chapter the health situation in Cameron outlined the 10 most important causes of sanitarian emergencies in the country. Of all these 10 most important illnesses, none of them are intended to be addressed by the WHO in the future years.

### 5.3. The withdrawal of the USA from the World Health Organization

Taking into consideration the historical and permanent confrontation between China's internal ambition and the United States of America's unilateralism worldwide politics, the position of the USA towards the WHO can be understood from a double perspective. The first one is the critics raised by the Us against China which has been considered the main responsible for the outbreak of the said virus and suspected by the Us of having tried to silence the realities and the corrosively of the virus and so doing participated to spread and widen the virus worldwide. President Trump while qualifying the Covid19 was usually naming it the China Virus. The second aspect comes from the critics of Americans themselves towards their administration. They were accusing their government, and so did President Trump, of inactivity and inadaptability to counter the virus. According to them, their government not only has a too late reaction in front of the progression of the virus but also when it decided to react, the measures taken were not appropriate to curb the incidence of the virus which was spreading with a record daily renewed of victims. Taking into consideration presidential elections coming closer, it would have been urgent for US President Trump to react to maintain his chance to be re-elected as the US President. To do so, it was urgent to react. The immediate response found was to announce the withdrawal of his country from the WHO. The US administration accused the World Health Organization of the incapacity to address the Covid19 outbreak. According to American head agents, the WHO has rather transferred its competencies to China which in their point of view, not only was disqualified to intervene in the Covid19 virus but, being the main responsible for the case, should have rather fallen under international sanctions. It is the reason why an interruption of payment order has been ordered to evaluate the implication of the World Health Organization in the “transferring process” of the Covid19 medicinal research. From the perspective to materialize the said withdrawal by the year 2021. However, even though at the United Nations level, the said thread coming from the USA is not well understood and inspired a certain doubt on its real effectivity, it is important to underline the fact that it is only at the level of the WHO executive committee to evaluate the feasibility of the said withdrawal by presenting according to the statute of the Organization and the various relevant text founding the WHO the elements related to a potential withdrawal. Even if the diplomatic response from the UN secretariat had the initial intention to calm the situation by invoking the protocol related to any potential withdrawal condition which state that there should be a one-year notice and fully meeting the payment of assessed financial obligations, this precedent initiated by the USA has certainly risen and opened the door the questions related to the usefulness of the World Health Organization with regards to the health emergencies of countries members. Taking as an example the same procedure initiated some years ago by the same United States of America was for a double-time, the USA administration has intended twice to withdraw itself from the cultural and technical agency of the United Nations system called the UNESCO. The USA pointed an accusing

finger toward this cultural branch of the UN accusing the agency to adopt Marxist approaches and devoting itself more to the developing countries (with a special favor to China) concerns than standing on the neutrality and objectivity it is supposed to incarnate. It was on May 29 2020 that American president Donald Trump officially announced the intention of the American government to withdraw itself and put an end to the relationship between his country and the World Health Organization and reorient the budget that was initially allocated to the WHO to the national interest for the sake of Americans. According to the president of the USA, this budget would have been more useful if it was used to develop the research in the country and reinforce the medical system.

Despite the opposition and clearly and openly manifested position of more than 750 leaders of the domain of law and sciences who have tried to influence the United States Congress to impeach the controversial decision of President Trump, the United Nations General Secretary has been officially notified by the said intention on July 6$^{th,}$ 2020. During this period, it was recorded an aggravation of the incidences related to new infections of Coronavirus and lethality that was moving within more than half of the States of the United States of America. Due to the global presence and legitimacy of the World Health Organization, it is quite commonly shared that the projected withdrawal of the United States of America from the World Health Organization would drag several consequences for the country such as impacts on its national and international security, diplomacy and influence worldwide. One of the direct implications of the implementation of the said withdrawal will be the jeopardizing situation that would come out from the fact that the USA is too much engaged and embodied in the WHO structuration. It is more precisely the case of the PAHO known as the Pan American Health Organization which is one of the six regional offices constituting the WHO's global presence. The said PAHO has its headquarters in Washington DC, the capital of the Country. The United States of America is a signatory member of the main World Health organization treaties. The WHO constitution. The said WHO constitution indicates that the USA is the directing and coordinating authority on international health (Post, 2020). That simply implies that assisting in the withdrawal of the United States of America is assisting in the dismissal of the WHO coordinator itself. The consequences seem unexplainable.

Taking into perspective the willingness of the United States of America to reduce their financial participation in the global budget of the World Health Organization is taking into account the fact that less budget conveys to a diminishing of activities and financial support of international health programs. It is the case of the solidarity trial which is an internationally conducted research program initiated in early 2019 by the World Health Organization to contain the effects and impact of the Covid19 by driving research that might help to find adequate treatment. If the Covid19 research program might be impacted by the withdrawal of the United States of America, some other public health campaigns will be considerably handicapped if not deconstructed. It will be the case of the

international campaign to fight against tuberculosis which still affects a large range of populations around the world and impacts children's future. According to one specialist of the World Health Organization galaxy, Mr. Kuchar, the United States is so deeply involved in the functioning body of the WHO that if the country decides now to withdraw from the Organization, the principal party will have a lot to lose will be the USA itself. It is the reason why the specialist argues that taking into consideration the fact that the USA has a lot of control over the main action and international intervention of the WHO with the fact that the country is the first contributor to the global budget if the USA decides to finalize its withdrawal decision, the over the presence of the country in all the major aspect of the evolution of the WHO will be in disfavor of the US itself. It in short illustrates the image being at the origin of the loose of influence worldwide more precisely on the medical and sanitarian levels.

### 5.4. The pre-eminence of the P5

By the pre-eminence of the P5 also known as the Permanent 5 countries that share in common the veto power at the United Nations Security Council which is the governing body of the entire system of the UN. It is pointing a finger at the United State of America, China, Russia, the United Kingdom, and France. They are the main countries that won the first and the Second World War and that govern the world since 1920 with the creation of the League of Nations replaced in 1945 by the actual United Nations. It is what Bertrand Badie in his Diplomatie de Connivance has described as a pentarchic system with diplomacy among five close friends, the said friends piloting the world and orienting the international politics. The pre-eminence of the P5 suggests a criticism of the above-mentioned system here the majority remain silent and receive the dictate of this club of veto power owners. It is a system that is been criticized by third-world advocates authors such as Aminata Traore, Jean Ziegler, and Amine Amine. Apart from scholars, emergent countries' leaders when the occasion is being given to address the situation are also pointing a finger at this system by expecting a new era. It is the case of the Turkish president Recep Tayyip Erdogan as same Mohammad Kaddafi from Libya some years before who while addressing the international community during the annual address to the United Nations General Assembly, the president of the Republic of Turkey, one of the emerging country and regional leading country, was highlighting through his statement the word is bigger than five the fact that the international society should take into account the diversity of its members. According to this emergent country leader, the actual system is in disfavor of the global objectives targeted by the UN. Taking the case of the Syrian crisis that started in 2011 during what has been called the Arab spring recorded the dismissal of some Arab leaders such as Ben Ali from Tunisia, Kaddafi from Libya, and Hosni Mubarak from Egypt to only use these cases, the Turkish president is outlining the incapacity of the United Nations to consolidate the peace in the country.

The same observation is being made while taking into consideration the Palestinian crisis and the role that was expected of the United Nations played.

### 5.5. Alternatives to the multilateralism

Alternatives to multilateralism are understood as the settlement of a new model of international cooperation shifting the predominance of intergovernmental organizations to set a new approach to diplomacy. But before developing the said alternatives, let us explore the weaknesses of this multilateralism.

- ***The other aspects of the weaknesses of the multilateralism approach.***

The post-colonial theory principle gives as main information that the rules, norms, and international regulations existing nowadays have been enacted by the former colonial superpower and cannot be in favor of all the other member participants.

***An inefficiency of multilateralism on the military side***

One of the concrete examples of the weakness of multilateralism is the Democratic Republic of Congo War that has led recently to the death of an Italian Ambassador. In the Democratic Republic of Congo, there are thousands of United Nations peacekeeping mission elements but there is still an ongoing civil war in the country. The same example can be mobilized for the Central African Republic case where despite an international armed force presence in the country, this African country still experiments with repeated attempted coups to destabilize the democratically elected government. At the same, in the Central African Republic, the opposition between tribes and ethnic groups continuously proceed by the brutal extermination of the members of the other group without being stopped by the present soldiers. The justification given for their no intervention lies in the explanation that the mandate that has been delegated to them does not involve an intervention that is not like their identified duties in the country. Even though it is well known that there is not a strict boundary between the civil protection officially recognized by their mission order and the realities observed on the field, the fact is that the presence of these international forces doesn't dissuade the authors of instabilities in the above-mentioned countries to perpetrate their crime. By so doing it question the usefulness of their presence and the wider, utility of the international community. In Central Africa, there is still lethal opposition between the community and attempted coups to dismiss the democratically elected government. These examples are illustrating the weakness of IGO and so doing their inefficacy and inadequacy in the field.

***A weakness on the cultural side***

The impact of racism and anti-Semitism is also one of the points indicating the weakness of the multilateralism designed as the actual model of international cooperation. There is no

intergovernmental organization that is being specialized in the fight against racism and anti-Semitism even though it is well known that these two elements are destructive to international cohesion. The impact of racism is no more necessary to demonstrate. Despite the fact that some international organizations such as UNICEF or sports organizations such as the FIFA understood as the Football International Federation Association, on its official website and on the jersey of all the players during international football competitions mention *no racism,* these dehumanizing practices still cause important moral damage to the humanity. Taking its origin in the idea that every group has its privileges, this expression of the rejection of others because they differ from other entities has ruined many efforts to build a world based on equity, equality, and togetherness.

### 5.6. The challenges encountered

Producing and conducting this research that will constitute my Ph.D. thesis that will terminate and validate my 6 years' terms of education at the Karadeniz Technical University of Trabzon has not been an easy matter. It has been a long-lasting adventure that required from us, a lot of abnegation and patience, renewed perseverance, and an obligation to fetch deeply in us, the necessary energy to move forward. If we must once more underline the great impact of my supervisor Dr. Erol KALKAN, the psychological impact of Dr. Bulent SENER, Dr. Fatma Akkan GUNGOR, and the permanent assistance of Yuksel Kara whom we have already thanked in our first part of this document under the acknowledgment section, the challenges encountered are at the school level, the town of Trabzon and the conduct of the researches itself.

#### *The behavior of some students at the university library*

When we were in our first year at the university attending a Turkish introductive course which is the compulsory language course for all the newcomers to Turkey intending to pursue an academic life, we went to the school library and kept my books on a table and went out to look for something to eat. We spent something like 20 min and it was even raining. We came back running to the library and discovered my books (exercises and lessons) dropped outside under the rain and destroyed. We went and saw nobody in the place we were sited before expecting to find someone there and ask him why the school books that we were using and trying to use the translator at the library to understand what was required for us to do an assignment. We asked the students located beside my table but all of them were replying that they do not know. We must insist on the fact that they barely answered and just made a sign with their head. A distracted sign oh head. We called another African that mastered the language better than me to drive necessary investigations. Together we went to see the security guard at the gate expecting that at least he could have used the available cameras to isolate the scene and show us the persons that did that. But the only answer that he gave us was that he didn't know who did that and if we have important things that we want to protect, we

must carry them by us everywhere we go and that there is nobody responsible for other people's bags and books in the library. We expected him at least to feel sad for me for what has happened to me but nothing. Just that he did not know. We were obliged to order again the same books that came two weeks later. We refused to complain either at the university level or at the Turkish introductive course level. We just stayed quiet and moved on with my frustration expecting that tomorrow will be better.

***Living in the dorm and finding an apartment in city town***

The attitude of some workers and young students that were living with us was not easy for our concentration on our research and the quality of our peace of mind. At times they were making some noise and when you try to complain the immediate answer is that it is also their room so we should not bother them. When you complain to the security service of the dorms the only answer that they give to you is that you should write a request informing the administration of the disturbances. Some other Africans tried to pursue the administrative procedure but taking into consideration the fact that the answers that have been given to them were not suitable solutions and expected measures, we simply have decided to stay quiet and support the situation. On the other side, it seems that being an African is not easy and secure to look for and find a flat in the center of town. More precisely, when you call the contact number posted on the streets, the first thing that they ask you is if you are an African and a student. If you answer yes, you have almost the automatic answer telling you that there are no more available rooms. Or when there are rooms for you it will be if not the one at the entrance of the building, it will be the one on the roof. Many times, we tried to ask our Turkish friends to help us convince the flat owner to let us rent their flats. When they hear a familiar voice coming from a Turkish citizen, the replies are soft and nice but when we arrive there and they discover that we were the ones supposed to rent, not only do their face color and expressions immediately change, but also abort the transaction.

***The Covid19 disturbances***

The outbreak of Covid19 has been some disturbances. More precisely, because of this Coronavirus, there have been many meetings have been cancelled in Cameroon. While operating a collection of data on the field, because of this pandemic, there have been many health personnel that has not been available for us. The same absence has been registered when we wanted to collect data from the responsible persons of the Ministry of Health of the country and the Ministry of External Relations. The appointments have been cancelled and before getting into an office, there was a new protocol related to countering the evolution of the pandemic, that was turning difficult access to offices and so doing, to data. Initially going for two months to fetch the targeted information to build a defendable Ph.D. thesis, we have been obliged to spend more than 7 months on the field otherwise, we would have operated a non-beneficial trip.

# THESIS CONCLUSION

## 6. POSTCOLONIALISM AS A THEORY OF ANALYSIS

### 6.1 Introduction

This 6th and last chapter of this research is the concluding part of this scientific product based on the usefulness of intergovernmental organizations with the case study of the impact of the World Health Organization. The said case study has guided the verification of the said usefulness has been the Cameroonian Health Security System evolution. It has been essential, throughout this research, to understand the importance and the incidence of the intergovernmental organization on the promotion of the development of its country's members in general and more specifically the case of the health system improvement in Cameroon by the World Health Organization. Based on the research question trying to find out the issue for a country planning to be emergent by 2035, ***how can be evaluated the impact of the World Health Organization on the health security of Cameroon***, this central question has dragged some other related sub-questions. It has precisely been underlined the question to know concerning the above-questioned impacts, which credits should be granted to this World Health Organization in the health improvement process of Cameroon as a first step (a)? The second step of interrogative point guiding the research has been the question to know if the said credits were in favor of maintaining the ties between the country and the World Health Organization (b). The last side of sub-questions raised by the identified problem tried to understand if the multilateralism was still helpful for Cameroon (c)?

The suggested hypothesis to conduct our analysis in this research has been built on a dual-based planned analysis. The first one stipulated that the World Health Organization has been created to enhance, promote and strengthen the global and so doing, Cameroonians Health Security System. Based on a well-shaped agenda and planning of activities, the WHO has identifiable actions and realizations in Cameroon (1). The second hand of our hypothesis, in a sort of dualism and refutation approach, has pointed out the fact that the deep and concrete observation of the Health situation of the country drags out not only the World Health Organization limits in Cameroon but also raises the question of the finality of the philosophy and the conduct of the worldwide multilateralism. This one has invited us to a reflection on another model of international cooperation based on a post-multilateral era (2). Some important arguments have been indicated in this research. Out of them, the fact that the international organizations since their creation have been of some use to the future of humanity. We proceeded with a scaled assessment and a comparison between what should be

expected, what should be done, and what is concretely being done in the Cameroonian field. One of the other arguments laid on the fact that despite the ambitions of the World Health Organization to curb positively the rates figures and incidences of illnesses in Cameroon, the high level of these rather presents a sort of weakness from this transnational institution and so doing, plead against the maintain of participation of the country to this international health-based organization. One of the observations that have eased the construction of the defense of the selected arguments is the idea that the debate is being raised due to the apparent fact that the current system is rather in favor of keeping certain countries in a position of wait-and-see, followers, and being merely receptacles of general norms, principles, and laws that are almost imposed on them with no certitudes and guarantees that they will always be understanding or master the ins and outs of those principles. To give a theoretical background to the research, a theory has been mobilized and has been used to orient the finality and objectives of this thesis. It has been the question of the post-colonial theory with some stopover on some major concepts that give a wider sense to the selected theory.

The main theory that has been mobilized to understand the above-mentioned disillusion of multilateralism has been **the post-colonial theory** with a mention of a referent notion that is domination. It has been a question to analyze the mismatch of the WHO global interventions and the specific case of Cameroon health system expectations. It has been briefly indicated that post-colonialism gives details related to the political, economic, cultural, and social sides of the presence of the former European superpower in the administration and cooperation system with their former foreign territories. It is in a simple line the short explanation of the aftermath of western colonialism as explained by the Palestinian critic Edward Said. Concerning our research topic, the post-colonial theory has guided us in seeking of understanding why the international rules and global cooperation are still not of benefit for African countries and particularly, to Cameroon. The said theory has oriented our analyses in the will to understand why despite years of cooperation the Cameroon health security system is still in demand, why some basic illnesses are still prevalent, and why the country is still facing some diseases that should have been completely cured many years ago. Under the principles developed by Said, it has been demonstrated that through the actual form of international cooperation built by former colonizing superpowers, a former colony can't develop itself except, a new system of diplomacy is set up.

We have presented the principles of postcolonialism and underlined the fact that the main principle of neo-colonialism lies in the fact that the said notion is basing itself on another approach to international relations which contrary to the traditional hard power is the diplomatic approach known under the concept of soft power. In the same line, we have also presented the methods of post-colonialism. The said methods have been presented as basing the interference of a superpower country in the destiny of the formerly colonized entity by presenting itself as the guarantor of the future of the said territory. The second hand of the postcolonialism method is the subordination of

the State member to the global policy. The illustration mobilized was the case that all the member states of the World Health Organization should refer themselves to the annual policy prescript to them by the WHO. They should refer themselves to the said document as the guide to their health politic. To strengthen the importance of the post-colonial theory importance in our analysis, its objectives and its finalities are in line with the case study Cameroon have been presented. The objective and aim of postcolonialism are to maintain the former possessed territories under a stage of permanent and renewed expectations of foreign investments, foreign assistance, and foreign dependency. The said objectives will be more understood by developing some notions that are revolving around this concept of postcolonialism and that at their level of explanation give an overview of the goals, ambitions, and perspectives of the cooperation between the World Health Organization and the health security of Cameroon. It requires a reference to domination, a reference to imperialism, another reference to unilateralism, and finally a reference to colonialism.

***There has been a reference made to domination.***

With the mention of Karl Marx and his suggestion related to the end of every form or model of domination of thee populations based on dictatorship even the soft one, we wanted to indicate the fact that he was among the authors of the new revolutionaries' circles known as Circle of Light raised in France wishing to see a new design of relations in the society based on the mutual benefit and the common interest of the participants in the said society. According to Marx, a few groups of individuals are the ones controlling the entire society and are imposing on the large majority of participants their will even though it is not in line with the aspirations of the others. It is the dictatorship of a few numbers on the majority with a scene presenting the said few numbers taking some policies and enacting them without every time reassuring themselves if the common interest is being preserved. As same with Marx Karl, we have indicated the participation of Herbert Marcuse, another author of the theorization of domination who was suggesting the reinvention of the relations in the society to take into consideration the majority will for the global sake and the improvement of their ability to control the actions and decision produced. As same, Bourdieu, the other mobilized rhetorician of international relations, every domination process lies on the acceptability of dominated individuals bound with invisible ties because the domination is unconsciously accepted by the people under domination. Taking into consideration the WHO and the Cameroonian Health security, the domination has appeared in the obligation for the Cameroonian medical industry to refer itself to the obligatory authorization of the WHO before producing and making available Cameroonian medical treatment. The main consequences identified by this blockage have been that the local production couldn't have been boosted.

***There has been another reference made to unilateralism***

Presented briefly as a one-sided action or unique pole of decision, unilateralism has been presented as the practice that consists to do not take into consideration the observations suggestions, and points of view of the other party before taking any decision. Even though the said decision is supposed to be implemented by the actors other than the ones that are taking and putting into force the said decision.

***The reference made to the imperialism***

It was a question for us under this reference to imperialism to mention that as same like domination and unilateralism, the post-colonial theory refers itself in the philosophy and scientific approaches of social sciences to imperialism. According to the online dictionary Oxford language, imperialism has been presented as being *the state policy, practice, or advocacy of extending power and dominion especially by direct territorial acquisitions or by gaining political and economic control of other territories and peoples.* More simply, imperialism intends to widen its own rules and ambitions on other people or countries by the use of hard power methods such as military forces or by soft power technics such as culture and politics. Within this concept of imperialism, is embodied the idea of superiority and influence of an actor or group of actors. Imperialism is the seed creating the colonialism.

***The reference made to the colonialism***

Under this last reference, it has been of interest, for the researchers to point out that all the above-mentioned references wouldn't have had a sense without the origin of everything which is colonialism. Robert Young stipulates that colonialism implies the invasion of a specifically targeted territory by another one. The submission of its government and its populations to the regulations enacted by the invader. The control of its decision, the ruling of its politics, and the subordination of its sovereignty. The colonizer under this approach, is the builder, the one orienting, creating everything aside and the colonized territory is the one implementing the measure taken even if it doesn't match with its concrete expectations. Taking into consideration the Cameroonian case, without the express authorization of the WHO, there is no local medical invention that can be freely developed and experimented on Cameroonians even though the said medical invention can be useful and provable, and efficient for populations. There is the obligation to refer to the WHO which is the only international body that can validate a medicine and authorize its commercialization and consumption with the official justification of international health concerns and protection. We have collected data and this data collection and the analysis we made of them have been presented as follows.

**The data collection and analysis**

We have mobilized the dual approach of method of study, which focused on the interpretations of the experiments, tried to capture a concrete experience taking into account the fact that the World Health Organization has been created more than fifty years ago, a situation that gives us some necessary hindsight to be able to assess the impact, to assess the effectiveness in the well-being of Cameroonians. The choice of **the dual methodical qualitative and quantitative** approach as research methods is based on our willingness to seek out several truths that take into account the fact that we do not have a single approach to international organizations and that they do not deploy in the same way. To give a global account of the situation of efficiency or the advent of a post-multilateral world, we had both be in a positivist position which consists in recognizing the relentless realities about the visible and palpable concrete achievements of the WHO as unique and these IGO globally, but at the same time, we have adopted subjective positions in a **comparative method** that take into account our thoughts, our aspirations, our worldview, what it should be compared to what it is now.

Through the **comparative method**, the approach has consisted to collect and evaluate the data recorded in the health sector in Cameroon. This data compilation has been completed by a comparison between what was supposed to be the predictions of the different statutes, organizational charts, and any other organic and statutory devices that are the key objectives of this global health institution and the concrete achievements on the ground. The d**irect observation** mobilized permits us to step forward in the sense that we have had the privilege of being a citizen of the said country case study and have a practical experience of expectations, gaps, and necessities for the health sector in the country. We have mobilized to turn well compiled for this research our analysis of a set of methods and techniques quite specific. These methods have been quantitative, expressing the number of concrete, tangible achievements of these international organizations, as qualitative, information on quality, on the added value of the actions and achievements of these international organizations. The said model of research, which focused on the interpretations of the experiments, tried to capture a concrete experience taking into account the fact that most of these international organizations were created more than fifty years ago, gives us some necessary hindsight to be able to assess the impact, to assess the effectiveness in the well-being or cohesion of states. To give a global account of the situation of efficiency or the advent of a post-multilateral world, we had both be in a positivist position which consists in recognizing the relentless realities about the visible and palpable concrete achievements of these IOs, but at the same time, we have adopted subjective positions that take into account our thoughts, our aspirations, our worldview, what it should be compared to what it is now. This thesis has been organized into six chapters.

Chapter one entitled ***Research Questions and Hypotheses, multilateralism, and Outline of Chapters*** has been the introduction part of this research. It has been intended throughout this chapter to draw the general context and the environment of the study. Also has been developed the research question that underlines the principal problem identified by the chosen topic and the related hypothesis. These hypotheses could have been confirmed or rejected by the development of ideas and research conducted in the field and that finally, have been confirmed by the collected data. It has been proceeded and stated a clear understanding of the concept of multilateralism and finally, outlined the various chapters that will constitute the analyses. Chapter two entitled ***The Multilateralism as the symbol of togetherness*** underlined the fundaments of this model of international cooperation suggesting that the international society can be governed by institutions norms and principles that can bring together the global community. Has been presented several aspects of multilateralism such as the military multilateralism materialized by NATO, the cultural one like the one creating the Francophonie or the Islamic Cooperation Organization, or the one that directly fits with this research, the health multilateralism symbolized worldwide by the World Health Organization. Chapter three entitled ***Research Design, Methodology, Data Collection and Analysis*** has developed and explained the choice of our research design. This chapter has presented the selected methodology of research and outlined the various technics mobilized to collect the data exploited to conduct this research. Chapter four related to ***The World Health Organization in Cameroon*** has drawn the history of the cooperation between the two partners, Cameron aside and the World Health Organization on another side. It has also been of interest to identify the trajectories of relationships linking the above-mentioned partners and the various concrete realizations of the said international organization in Cameroon. This chapter has identified the concrete acts and identifiable deeds of the WHO in the country during the framework of the study. Chapter fifth named ***The alternative to multilateralism*** has been the logical consequence of the previous chapter four has identified the acts and the deeds of the WHO in Cameroon. Chapter five has set the path to the post-multilateral era by suggesting an alternative to the actual multilateral form of international cooperation. The final chapter, the chapter sixth entitled ***Thesis Conclusion,*** has been the one concluding the research and presents our findings by taking a definitive position, on whether our suggested hypothesis has been confirmed or retouched. It has been the final part of our development that has stated the final direction given to this thesis.

### 6.2. Major findings of the study

Analyzing the Multilateralism as implemented in the newly independent countries by taking a specific case study, the World Health Organization and the health security of Cameroon from 2008 till mid-2020, has raised as main outcome some results that can be organized around points summarized in this part entitled findings of this thesis. The said research has precisely dug out two

major findings that are summarizing this research in the field. These findings are both on the Cameroonian health system and on the World Health Organization itself in deeds in Cameroon.

- ***On the Cameroonian health system***

The operations in the field have permitted us to discover the reality of the Cameroonian health system above the information that one can find in books or some media. We have needed to identify the gaps between the expectations of the population, the medical personnel, and the health authorities of the country and the realities of the health facilities throughout the country. We have discovered that there is an inadequate redistribution of the medical personnel around the country with some regions that do not have a sufficient quantity of doctors or specialists according to the requests and needs of the local population. Collecting concrete data on the field has been an occasion to witness by ourselves the daily conditions of medical doctors and related assistants in their struggle to curb the rates and figures of health inconvenience in the country. We discovered that some doctors have been officially appointed in two distinct medical facilities and so doing, they cover at least two sub-regions and that at a time are obliged to organize their timetable to round the concerned cities. To do so, they often have to travel from afar city to another one, despite the general conditions of transportation in the country and the road quality, risking their own life while being on the road to respond to the demand of the patients from the other city. We discovered that the quality of the formation of some medical personnel is insufficiently related to the mutation of illness and the evolution of bacteria and remains to update. There is not an equal qualification of the personnel according to the fact that we are in urban cities and main capital town and when we are in rural areas. The medical doctors and nurses and all the equipment that intervene in far located zones most of the time are not meeting the requirement of updated information and formation related to the national strategy to counter some major illnesses. They are keeping implementing the former protocol with the consequences of failing to ameliorate the conditions of the citizens.

We discovered that at times, the medicines are lacking in some health facilities obliging the patients to move despite their state and illness to other medical hospitals. It is at the time, the case of pregnant women who, despite their pregnancies and the imminence of delivering their babies, are obliged to be transferred to other medical points with all the risk for the future baby. This reality points out at the same time, the equipment of some health centers visited during the data collection on the field. The equipment of some health centers does not permit the medical personnel to work with competence and with the targeted results. The fact that at the time the simple thermometer can be lacking is not a motivating factor in the purpose of boosting the level and the quality of hospital production in the country.

***On the World Health Organization in deeds in Cameroon***

The discovery of the fragility of the Cameroonian health system has driven another discovery that can partially explain the first and above-described situation. It is the World Health Organization in deeds in the country. According to the data collected at the Ministry of External Relations of Cameroon and the information available at the Ministry of Health of the same country, it exists a formal and official tie between Cameroon's government and the World Health Organization. The country is part of the 194 member states that constitute the General Assembly of the World Health Organization. There is a local representation of the World Health Organization in Cameroon and this representation is in charge of monitoring the good implementation of the international health politic decided by the WHO in Cameroon for a specific period. It is this representation that signs in concert with the local authorities the various document indicating the purpose goals and mission that the organization intends to achieve in the country for a specific time and in a specific geographic area. The representation of the WHO is basing its intervention on a specific document called the National Health Development Program for the period going from 2016 to 2020 also known as NHDP 2016-2020. This document which is the national strategy to develop the health system in the country for the specific time of implementation mentioned is taking into consideration the global decennial ambition 2016-2027 of the Ministry of Health of Cameroon and the 12th World Health Organization general plan of work and strategic priorities. Despite the presence of the WHO in Cameroon, the country still records an important cause of health issues and a degraded health environment which underlines the inadequacy between the country's needs and the execution of the World Health Organization Cameroon Policy.

- ***On health multilateralism in the country***

The multilateralism as implemented is not in favor of the emergence of former colonized African countries and more precisely, Cameroon. Building a post-multilateral era appears as the main issue that might correct the situation.

### 6.3. Contributions of the study

The contributions of this study are identifiable on a double basis. As same as a contribution on a theoretical side is being outlined, a contribution on the scientific domain is also suggested to turn this thesis into useful production.

- ***On a theoretical basis***

The contribution of this research on the theoretical basis intends to revitalize the post-colonial theory by outlining its importance in the understanding of international policies toward Africa in general and Cameroon in particular. The aim of this reference to this theory considered as

the theory describing the legacy of colonialism on the former possessed territories is to outline the correlation between a theoretical perception of reality and the concrete materialization of that reality on the field. This theory as expected has presented the incidences and the explanations of the Cameroonian health system's actual status concerning the clarified deployment of the World Health Organization in the country. The other contribution of this theoretical basis is to demonstrate the actuality of this post-colonialism. It is to suggest its adaptation to the Cameroon realities and so doing, demonstrate its validity to explain the international unfavorable context that are undergoing the underdeveloped countries.

- ***On a scientific basis***

The scientific-based contribution of this research is to propose an additional tool of analysis to the doctrine of political sciences and one of international relations. This thesis intends to participate in the scientific debate related to the usefulness of intergovernmental organizations and the concrete impact of multilateralism. Being entitled to ***Multilateralism as implemented in the newly independent countries. Case of the World Health Organization and the Health Security in Cameroon from 2008 to mid-2020,*** the intention on a scientific basis has been set. Not only has been enriched to doctrinal controversy on the health security of Cameroon by suggesting additive data and facts but also, has been introduced as an additive critic to the related literature, questioning the role that plays the World Health Organization in the sustainability of the health realities of its countries members. The other significant contribution of this research is on the debate related to the importance of multilateralism and more precisely on the end of multilateralism for the advent and the erection of a post-multilateral era.

### 6.4. The Post-Multilateral Era

This part entitled the post multilateral era is the part reserved for one important step of this research. It is the section suggesting the approach to correct and so doing, reinvent international cooperation. But before starting this perspective of international collaboration. Let us redefine the actual system. The actual system is based on some characteristics that constitute the essence of critics formulated against this system and the inoperability of the adopted politics in the field.

- ***The actual system is giving a large power to the intergovernmental organizations***

In fact, with the end of the cold war and the remodeling of the international relationships with the end of the duo holistic organization of the world with the two distinguished colors. The capitalist countries by one side and the communist ones by the other. But with the demolition of the Berlin wall in the 1990 years, the option that has emerged is the multiplication of intergovernmental organizations and the transfer to these institutions a subsequent part of the responsibilities exclusively reserved before to countries. It is the case of the military side where the UN Security Council is the

only organ in the world that can decide on international intervention in a conflict. It is this organ that judges the opportunity of action at the place of States. The same principle is being observed with the International organization in charge of trade in the world. It is this institution at the place of the state that determines the international, politic that should be implemented in the field of trade worldwide. The same example can be used for the tourism sector, the fishing sector, football, and almost all the sectors of life. The immediate incidence of this approach of cooperation is the diminishing of the power of states due to the transfer of a symbolic part of their sovereignties to international organizations.

- ***The actual system reduces the reactiveness of States***

By reactiveness of States is understood as the ability of one state to decide to intervene in a situation regarding international security and global peace. Countries are in the expectation. They are now depending on IGO and so doing are expecting the Inter-governmental organization to act in their place. It is the principle that is responding to the idea stating the necessity to fulfil the expectation of the ability to act. When occurring a health situation, everyone is awaiting the reaction of the Health organization to counter the illness. That means that this automatic expectation of the populations from the WHO indicates the dependency that has been created on these IGO. But the reality has shown that these International Governmental Organizations are not always able to face the situation and at the final point, the solutions are coming from these states that are principle not authorized to act at the place of the IGO responsible for the sector of intervention.

- ***Being a member of IGO is almost an obligation to have an international recognition***

To be recognized by the other States members, a country should take part in intergovernmental organization activities the principle is that you belong to these IGO or you will not have sovereignty internationally accepted by many entities worldwide such as the Saharan state in Africa or Palestine in the Middle East fight to be recognized by these inter-governmental organizations.

- ***The actual system weakens the States***

With the transfer done to intergovernmental organizations of a part of its power of decision on some points of international life, the consequence is the depreciation of these states in favor of a supra-state that most of the time does not take decisions that are not favorable to all the members. With the right of intervention recognized to these intergovernmental organizations, the possibility has been given to these IGO to intervene in national politics by criticizing the decision taken by a legitimate government and obliging them to modify their orientation unless international sanctions can rain on them. It is the reason why on most of the constitutions worldwide, it is stipulated that an

international treaty that has been ratified by a national parliament has superiority over national law and is becoming part of the national legislation with the obligation of immediate implementation.

- ***The intergovernmental organization has the last decision***

The logical inference of the above-painted realities such as the fact that the actual system transfers the power to the intergovernmental organization weakens the States and weakens them when occurs a situation that in normal conditions they could have handled without the concern of any other entity. Under the subsidiary power, which indicates the fact that States decide to give the possibility of action to a supra institution to act on a specific domain with the expectation that this IGO will be more capable of achieving good results than the State itself, the last decision has been given to IGO. They are the ones deciding the final action to be taken regardless of the incidence of these in the States. It has been the case of Libya where the UN security council has authorized the blockage of the aerial space of Libya officially to protect the populations from the assault of Khadafy or the decision that has been taken at the same UN security in 2003 with the second war of Iraq that has caused the destabilization of this country that from 2003 till 2020 hasn't still been able to re-up and function at the normality the way it was moving at the time of the late Saddam Hussein. From the example above mentioned it seems obvious that giving the last decision the inter-governmental organization is not necessarily in favor of the country member and can the opposite be a source of destabilization in some parts of the world.

***How will be designed the post-multilateral era?***

The post-multilateral era will be designed on a philosophical approach that will obey a certain organization in the field.

- ***The philosophical approach of the post-multilateral era***

By philosophical approach of the post-multilateral era is understood as the theoretical fundament constituting the basement of the said new era. It is the theoretical approach stating the orientation and designing the configurations and settings of the new conception of international cooperation. Before getting operationalized, it is obvious that an idea should lay on a theoretical background that will guide the construction that will be organized around the said concept. In the case of this post-multilateral era, with regard to the insufficiency unveiled by liberalism and neoliberalism dominating the actual context and determining the orientations of multilateralism, this research promotes the return to **realism**. Not the realism in the sense of the selfishness of States worldwide, where the superpowers dominate the powerless or less represented countries, but a realism understood as the ability recognized to every entity to decide for itself and according to its own orientations.

Having always been presented as the theory of individualism as opposed to liberalism in the social sciences, the realism that is being identified as the theoretical and philosophical background of our post-multilateral era et itself on the realpolitik determining the existence and the choice of international politics of sovereign entities. The post-multilateral era will at the same time take into consideration the three aspirations of realism. At first, this projected era with regard to classic realism will make itself at the idea that it is in human nature to think about self-determination and freedom to select the actions and activities that one considers as useful for his well-being and stabilized future. In this sense, as same as classic realism state that there is no entity that might be superior to the states themselves, one can easily conclude the logical inference outlining the fact that multilateralism cannot dictate to countries the national or international politics they should adopt. It is not the European Union, the United Nations, or in this precise case, the World Health Organization that can decide on the final orientation of the international policies of a country. At the same, classic realism outlines the importance of inner politics in the consolidation of the sovereignty of states worldwide. It is also one of the reasons leading Hans Morgenthau in *Politics among nations* to indicate the importance to have a consolidated central power at the level of a sovereign state in order to conduct international politics. Classic realism places the state at the most important level of the intelligentsia and the coordination of the international relations on the top of other actors of these international relations which are the sub-government entities, the individualism, the multinational firms or the intergovernmental organizations. By pursuing their national interest, these states are more prompt to defend the interest of their citizens and so doing, the interest of the state itself.

On the second hand, the post-multilateral era will take into consideration the aspirations of neorealism which highlight the importance of the changing nature of human beings. This is to explain the importance to adapt or readapt the adopted international politics of the nations with the evolution of the national politics and opinion of these citizens composing this nation. If it is certain that neorealism indicates the importance to set international norms that will govern the relations among countries worldwide, the said norms are not to be considered as above the national laws but as a guideline of good conduct among sovereign entities. In fact, neorealism is same as the classic realism identifying the state as the main actor orienting international politics. The only difference residing between these two components of the realism theory resides in the fact that neorealism, by taking into consideration the selfishness the human nature and the pretension of this one to dominate the other and edict principles at its only advantages, instruct the importance of international regulation to canalize the aspirations of nations in the international context. More precisely, in order to contain the ambition of nations to impose their visions on the other states which might not be set on the same configuration of power, neoliberalism identifies the international law and the various international instruments capable of protecting and harmonizing the international cooperation as the main guarantor of the good, safe and mutually beneficial practices of international relations. The said

multilateral era which will take into consideration the existence of commonly accepted (no more imposed) regulations, will design a model of cooperation putting forward the interest of every country taking into consideration regardless of its seizes historical background and diplomatic importance.

In a third line, the post-multilateral era will be set on the idea developed by authors such as Gideon Rose who analyses the international context under the prism of classic neorealism which constitute the third approach or third segment of the realism theory. This third segment can be presented as the neck point or the fundament of the suggested post-multilateral era. More precisely, the present research on the deception of multilateralism has as one of the principal targets to settle the reinvention and the return of the sovereign state. This state not only being the main actor of the international system but also being the one that by promoting its self-determination is the one that conducts international relations according to its own aspirations. Neoclassical realism points out the main point that justifies the dysfunction of the international society. **Many states worldwide ignore their power and their abilities**. Many states worldwide ignore their potential and so are exposed to the influence of superpowers which through international organizations are maintaining their dominations.

As an illustration, there are still many countries worldwide that are detaining an important stock of unexploited minerals such as diamonds, gold or petrol. It is most of the time foreign entities that inform them of the capacity of their belonging. It is therefore obvious to conclude that it will be impossible for a country that is not capable of identifying its strength and its weaknesses by itself and adopt the consequent policy to expect to be among the nations governing the international system. The reinvented sovereign state is this state capable of knowing itself, controlling its belonging, and developing technologies that will be helpful to control and maintain its sovereignty. According to the rhetorician of neoclassical realism, in order to attain the balance of power worldwide and have the international relations state aware of their importance and capabilities, some points must be outlined. It is what the doctrine has identified as the 4 determinants and aspects of the balanced forces. At the first point, the state should struggle in order to implement an appropriate balance of power. The appropriate balance of power is the situation where a country is able to identify the aspirations of its opponent when they are exchanging or coopering in international relations. It will not be possible for a state to develop mutually beneficial relations with another one if the said country does not develop the capability to identify the orientations and the incidences of the international relations engaged with other countries. Besides the exigence of a suitable balance of power resides the consequences of a non-well identified balance of power. It is the case when the information gathered related to the intention of the opponent state is not in line with the concrete projections of the said state. This imbalance of perception can lead to the implementation of

inappropriate politics that in the end might be a disadvantage to the country that intended the pre-emption. The same situation might be observed in case of misjudgement or neglecting some aspect of the targeted objectives of the opponent while cooperating. The fourth situation indicates simply the incapacity of the country to balance. It might be due to economic situation, political instability, or level of development that might not be favorable for the said country to develop the politic or ambition to expand itself and express its sovereignty. In a short way, as same as indicated by the philosopher Socrates, the most difficult point to set its value and determine the role that a country wishes to play is the difficulty to identify its advantages and circles its weaknesses *Know yourself first.*

The post-multilateral era is an era where there is no more intergovernmental organization. In an era where there will no more be the African Union that will decide the validity or not of elections held in an African country or the legitimacy or not of a national government. There will no more be a European Union that will decide on the place of European countries in the politic they have to adopt or not. To decide on their agriculture politic, their environmental orientations, or their civil rights deliberations. There will no more be the International Monetary Funds that will determine the level of credibility of a country. To determine if a country deserves to obtain a foreign investment or not and if the country is a friendly one or not. There will not be the World Trade Organization that will decide on sanctions to apply or not on a country that decides to adopt its own rules of trade according to its specific productions and capacities of exportations by a side and its obligations or necessities of importations by the other. There will no more be the World Bank which will determine the level of credibility of a country. The level of development of this one and organize change classifications to rank countries worldwide. There is a point that seems important to underline. It is the fact the adopted criteria for evaluation of the credibility of a country at the time, do not match the reality of all the countries. There is a sort of subjectivity that undermines the acceptability of the results proposed by these intergovernmental organizations. It is the case of a compared effectiveness of politics related to the democratic revolution of the countries worldwide. There is a sort of unique pole of analysis or unilateralism culturalism around the world. To be listed among democratic countries, there must be an implementation of the practice as same in western countries regardless of the realities of each country. Countries are not the same, they do not have the same level, the same history, the same advantages, and the same facilities for life. Some countries are exposed to the sea that can easily practice fishing or commercial activities with a littoral side. Others are depending on others for their importations due to their lack of maritime route and access.

The same, there are some countries where the level of natural and mineral products such as petrol or gold is low and they are depending on foreign investment to develop. These countries that are not the same should not be obliged to share the same principles and values without taking into

consideration their nature and their realities. We have suggested the post-multilateral to terminate with the predominance of the WHO which is the only authorized administration on an international basis that decides whether a vaccine can be administered or not or whether a medicine can be distributed to the population or not. This predominance has as a main consequence on the local basis to undermine the evolution of traditional medicine which at times corresponds the best to the need of the population. One should just refer to the result of this traditional medicine in some local populations in the rural areas where modern hospital facilities do not exist. The results of this traditional option turn at times around 95 percent of results. In the traditional system, women are delivered without the necessity of undergoing surgery or any medicinal intervention. The local doctors with local medicine, with their experiences, have always the solution to the submitted cases. But, with the predominance of the World Health Organization, all the efforts are being taken to demotivate the citizens to opt for this cheaper model of medicine and prioritize modern hospitals. In the post-multilateral era, a country will not exist because it has been recognized by the other states. But will exist because it has the future and the concern of its population in regard. It will exist for the sake of the well-being of its citizens not for international recognition.

- ***The concrete operationalization of the post-multilateralism era in the field***

There is mentioned in every treaty ratified by countries members a clause related to the withdrawal process, including the feasibilities, the principles, and conditions related to this action. The post-multilateral era or era of confidence will be this era based on bilateralism where the country will decide, based on their willingness and personal orientation on the partnership they wish to develop with other countries. The post-multilateral era is an era where the sovereignty of States will be restored and they will be the ones deciding at the final stage of the orientation they wish to give to their foreign relations and their diplomacy.

Four main points describe the concrete operationalization of the post-multilateral era in the field. More precisely, the projected post-multilateral era lays on the following four basements. Besides the role that will play the international law in this new system of international cooperation, the suppression of any structural form of intergovernmental organization is explained and bilateralism as a unique model of international cooperation is promoted. But all of them will not be efficient without a reinvented sovereign state.

***A reinvented sovereign state***

The projected new era cannot be made with the same configuration and settings that are demonstrating their weaknesses nowadays. The ambitioned new era is an era where the state is more conscious of its nature and its national and international importance. The new era is an era where the state will be reinvented and its sovereignty redefined. The redefinition of sovereignty hereby

mentions the importance and obligation for all countries to be more aware of their capabilities. Countries under the post-multilateral era will be countries able to identify their belongings and will be countries able to defend themselves nationally and internationally without the intervention or interference of a third country. The reinvented sovereign state will no more only be sovereign by definition but by fact. This implies the sovereignty on the creation of its own currencies and the definition of its international values, every state will determine the price of its goods such as fuel or cocoa without having an international structure defining the cost at the time in disfavor of the producer of the good. The reinvention of the sovereignty also concerns the ability that every state should develop to determine with precision the size of its fossil energy, every state will be able to transform locally natural goods such as wood, food, fisheries, animals, or mine products. In short, the reinvented sovereign state, being more confident in its potential and handling its destiny by itself without the domination of any country or external intergovernmental organization will freely decide the politic its wishes to implement and the role it intends to grant to the international law.

***The role of international law.***

The role of international law is understood as the place where an internationally agreed code of conduct among states will be displayed and observed. As same as the actual disposition giving the possibility to every country to incorporate international law in its own legislation, the reinvented sovereign state will grant certain importance to international law. It will be more precisely the case of law known under the Latin concept of *jus cogens.* The jus cogens are understood as this international norm and regulation prescribing some act to prohibit by humanity and that can be considered as non-negotiable. It is the case of the right to freedom of expression, the prohibition of genocide, the freedom to set oneself where desired, the freedom to be educated, and related freedom. The jus cogens indicate some practices that the inobservance might be considered a crime against humanity. More practically, it will be at the level of national legislation that every country will take into consideration those prescriptions in order to avoid the erection of a world where the jungle nature coexist, where the superpowers exterminate the less powerful. This point related to the role of the international has its importance in the sense it indicates that despite the fact that this part of the research intends the set a post-multilateral era, everything related to multilateralism is not cancellable. If it is important to maintain and so doing, strengthen the international law by embodying them in the national laws, the suppression of every form of factual intergovernmental organization is not negotiable.

***The suppression of IGO***

As entitled in the denomination of this research, this analysis based itself on the disillusion with multilateralism. The notion of disillusion indicates a sort of disappointment, a deception due to

the gap between the initial expectations and hope dragged by the intergovernmental organizations and the concrete realizations in the fields. Having taken the case study of the World Health organization, the literature review outlining the critics raised against this international organization, as same as the data collected on the Cameroonian field pleading in disfavor of this IGO logically conduct to the suppression of intergovernmental organization in the projected new era. The reinvented sovereign state, which will take into consideration the non-negotiable principles of international law should be able to conduct its international negotiations without the inference of IGO which has not been able to face the competencies of the duties recognized by its founding statutes. The post-multilateral era will be an era without intergovernmental organizations.

***Bilateralism is a unique model of international cooperation***

The suppression of intergovernmental organizations implies the remodelling of international relations among countries worldwide. In the actual system that has demonstrated its weaknesses, the intergovernmental organizations are playing a central role in the conduct of relations among sovereign entities. They are the ones that at the time decide on an agenda, decide on the choice of international politics, and decide the code of conduct of countries. In this case, the opinion of the citizens, despite the fact that they belong to countries that are part of those IGO, is not always taken into consideration. If they were consulted, or if it was regularly organized a national referendum on some questions of international politics, there would have been the most of time the opposite decision would have been adopted. It is the case of the 2005 referendum in France related to the adhesion of France to the project of a European constitution. More precisely, up to 55 percent of French citizens on the 29 of May 2005 voted against the European ambition to impose on all the European members state a constitution that would have organized the social-political, and cultural life of European regardless of the disposals of their respective constitution. The same rejection has been recorded on the 1st of June 2005. Considered an attack against the principle of self-determination defended by the rhetorician of the post-colonial theory, this ambition raised by IGO to dictate an approach of international cooperation is not always in favor of the desire of the concerned citizens. It is the reason why in the projected post-multilateral new era, countries will be the main responsible and conductors of their foreign policies.

## REFERENCES


Ahmed Mohamed Gandhi, (2013), ***The long walk of Africa towards the integration and the development and politic modernity***, Paris 2013 l'Harmattan.

Allotey, P. Rejdpath, D. D., Yasin, S., Chan, C. K., De Graft Aikins, A., (2011), ***Rethinking health care systems, A focus on chronicity.***

Bauchspies, W. (2008), ***Science, Technology and Society, A sociological approach,*** Willey Blackwell, 168 p.

Berdal, M. R., (2008), The United Nations, Multilateralism and International Order, in G. Andreani and P. Hassne ed. ***Justifying War? From Humanitarian Intervention to Counterterrorism.*** (The Sciences Po series in international Relations and Political Economy). Palgrave Macmillan.

Bertrand Badie, (1976), ***Stratégie de la grève, Pour une approche fonctionnaliste du Parti communiste français***, Paris, Presses de Sciences Po.

_____, (1979), ***Sociologie de l'État*** (avec Pierre Birnbaum), Paris, Grasset.

_____, *(*1987*), Les Deux États : pouvoir et société en Occident et en terre d'islam*, Paris, Fayard; rééd. Seuil, coll. « Points Essais », Paris.

_____, (1992), *L'État importé : essai sur l'occidentalisation de l'ordre politique*, Paris, Fayard.

_____, (1995*),* ***La Fin des territoires*****,** Paris, Fayard.

_____, (1999), *Le* ***Retournement du monde : sociologie de la scène internationale*****,** avec Marie-Claude Smouts, Presses de Sciences Po / Dalloz (coll. « Amphithéâtre »), Paris , 3e éd.

_____**,** (1999), ***Un monde sans souveraineté***, Paris, Fayard.

_____, (2001), ***Le Défi migratoire : questions de relations internationales***, avec Catherine Wihtol de Wenden, Paris, Presses de la Fondation nationale des sciences politiques.

_____, (2002), ***La Diplomatie des droits de l'Homme : entre éthique et volonté de puissance*****,** Paris, Fayard.

_____, (2004), ***L'Impuissance de la puissance ; essai sur les incertitudes et les espoirs des nouvelles relations internationales***, Paris, Fayard.

_____, (2007), ***Le Multilatéralisme*** (avec Guillaume Devin), La Découverte.

_____, (2007), ***Le Multilatéralisme***, La Découverte.

_____, (2008), *Le Diplomate et l'Intrus*, Paris, Fayard.

_____, (2008), ***L'État du monde*** (dir. avec Sandrine Tolotti), La Découverte, 2007, réed.

_____, (2008), *L'État du monde*, La Découverte, réed.

_____, (2009), *Le Grand Tournant - L'état du monde 2010*, La Découverte.

_____, (2011), ***International Encyclopedia of Political Science*** (ed. Avec D. Berg-Schlosser et L. Morlino), Sage, 8 vol.

_____, (2011), ***Nouveaux acteurs, nouvelle donne - L'état du monde*** *2012*, La Découverte.

_____, (2012), ***La Cassure - L'état du monde 2013*** (dir. avec Dominique Vidal), La Découverte.

_____, (2013), ***La diplomatie de connivence: Les dérives oligarchiques du système international***, La découverte, Paris, 251 p.

_____, (2013), ***Quand l'Histoire commence***, éditions du CNRS.

_____, (2013). ***Puissances d'hier et de demain - L'état du monde 2014***, La Découverte.

_____, (2014), ***Le Temps des humiliés. Pathologie des relations internationales***, Odile Jacob.

_____, (2014), ***Nouvelles guerres - L'état du monde 2015***, La Découverte, 2014.

_____, (2016), ***Nous ne sommes plus seuls au monde***, La Découverte.

_____, (2016), ***Political Science: A Global Perspective,*** with L.Morlino and D.Berg-Schlosser, Sage.

_____, (2017), Michel Foucher, ***Vers un monde néo-national*** ?, CNRS éditions.

_____, (2018), ***Quand le Sud réinvente le monde. Essai sur la puissance de la faiblesse***, Paris, La Découverte.

_____, (2019), ***L'Hégémonie contestée. Les nouvelles formes de domination internationale,*** Paris, Odile Jacob.

_____, (2020), ***Rethinking International Relations***, Londres, Elgar.

Bouopda Pierre Kamé, (2018), ***La crise anglophone au Cameroun***, L'Harmattan, Paris, 184 p.

Bourdieu, P. (1979), ***La distinction. Critique sociale du Jugement,*** Paris, Les Editions de Minuit.

Brummer, Chris (2014), *"**Managing Minilateralism", Minilateralism**, Cambridge University Press, pp. 165–198,*

Burci, Gian Luca; Vignes, Claude-Henri (2004), *World Health Organization. Kluwer Law International. ISBN 978-90-411-2273-5. Archived from the original on 12 January 2017.*

Caraballo H, (2014), « Emergency department management of mosquito-borne illness, Malaria, Borne Dingue, and West Nile Virus" *Emergency Medicine Practice* 16, pp 1-23

Carpenter, Ted Gallen, (1997), ***Delusions of Grandeur: The United Nations and Global Intervention.*** Washington, D.C.: Cato Institute.

Caude Rivière, "domination" Encyclopedia universalis,

Claude, Inis L. (1984). ***Swords into plowshares: The problems and progress of an international organization.*** Random House.

Coralie Delaume, (2017), David Cayla, ***The end of the European Union***, Michalon Edition, 254 p.

Cox, R (1992*, **Multilateralism and World order. Review of international studies,*** 18, 161-180

_____. (1992). Multilateralism and world order. ***Review of International studies***. 18, 161-180.

_____ (1997). "An Alternative approach to multilateralism for the Twenty-Frist Century"**.** ***Global Governance,*** 3 (1), 103-116.

David Fidler**,** (2020), ***The who and pandemic politics, the good, the bad, and the ugly future for global health***, on think global health.org.

Davut Ates, (2019), ***Uluslararası Örgütler: Devletlerin Örgütlenme Mantığı*** Dora Yayıncılık; 5. Basım, 412 pages.

Dore Gold, (2004*) **Babel Tower, How the United Nations has fuelled the global chaos,*** New York, Three Rivers Press.

Douek DC, (2009), “Emerging Concepts in the Immunopathogenesis of Aids”, Annual Review of Medicine 60, 2009

Edward Newman, (2007), ***Crisis of Global Institutions?: Multilateralism and International Security***, Global Institutions.

Edward Newman, John Tirman, (2007), ***Multilateralism under Challenge? Power, International Order, and Structural Change***.

_____ (2006), ***Multilateralism Under Challenge*** (Tokyo: United Nations Press,).

Eisinger Robert W, (2019), “HIV viral load and transmissibility of HIV infection. Undetectable equals untransmutable” ***JAMA*** 321, pp 451-452.

Fokunang, C. N. (2006), ***Traditional Medicine, Past, Present, and future research and development prospects and integration in the National Health System of Cameroon.***

Fouccault, M. (1975), ***Surveiller et Punir, Naissance de la Prison***, Editions Gallimard.

Franz Fanon, (1961), ***The Wretched of the Earth, Harmondsworth***. Penguin 251 p.

_____, (1967), ***Black Skins, White Masks,*** Grove Press, 222 p.

Fred Eboko, Marc Eric Gruenais, (2002), ***Un système de santé en mutation : le cas du Cameroun*****,** lit Verlag Munster, 179 p.

Fukuyama Francis (1992). ***The end of History and the Last Man,*** Free Press.

Gallo RC, (2020), « isolation of human T-cell leukemia virus in acquired immune deficiency syndrome (AIDS) ***Science***, pp 865-867.

Haltiwanger, John *(8 July 2020). "Trump says he's withdrawing from WHO while the pandemic rages, but he can't without Congress". Business Insider. Retrieved 3 November 2020.*

Hampson, F.O., and Heinbecker, P. (2011). The New Multilateralism of the twenty-first century. ***Global Governance,*** 17, 299-310.

*Handbook of Political Science*, (2020), Los Angeles, Sage, 3 vol, (ed. Avec D.Berg-Schlosser et L.Morlino)

Hans Schweizer, (1985),Encyclopædia Universalis, vol. 10 : *interférences libertins*, Malesherbes, France S.A, 1247 p., p. 29-31.

Harper K, (2011), « the changing disease scape in the third epidemiological transition*"* *International Journal of Environment Research and Public Health*, 675-97.

Harris Mylonas and Emirhan Yorulmazlar, (2012), "Regional multilateralism: The next paradigm in global affairs", *CNN*.

Healy W; Bronner A, (1936), ***New Light on Delinquency and its Treatment,*** New Haaven, CT, Yale University Press for the Institute of Human Relations.

Herington, J. Lee K., (2014), The limits of global diplomacy, Taiwan's observer status at the World Health Assembly, ***Global Health,*** 10. 71.

Hurd, I. (2020). ***International organization, Politics, Law, Practice***, 4th Edition, Cambridge, Cambridge University Press.

Hurin Kowo, Larissa Pessidjo, Charifa Fouwou Njoya, Larry Tangie Ngek, Larissa Tangan, Christelle Nguemo, Marthe Alogo, Larissa Ntsama, Oudou Njoya, Firmin Ankouane Andoulo. (2021), "Prevalence, clinical characteristics and related mortality of cirrhosis in a tertiary hospital setting in Sub Saharan Africa." *Open Journal of Gastroenterology and Hepatology*, 4:43.

James P Muldoon Jr, (2010), ***The New Dynamics of Multilateralism: Diplomacy, International Organizations, and Global Governance.***

Jean Louis Clergerie Gilbert Wassermann, (2005), *les conséquences du non*, Editions d'organisation, 84 p.

Jervis, R. (1998). Realism in the study of World Politics. ***International Organization***, 52 (4), pp. 971-991.

Jessica Lynne Pearson, (2018) ***The colonial politics of global health, France and the United States in postwar Africa***, Harvard University Press, 250 p.

Joachim, K. (2004). Multilateralism, Behind Europeans Views, ***The Washington Quarterly***, 27.2, 43-59.

John Ruggie, (1992), "Multilateralism: the anatomy of an institution, "*International Organization*, 46:3, pp 561-598.

Julie Gilson (2019) ***EU-Japan Relations and the Crisis of Multilateralism*****,** The University of Sheffield/Routledge Japanese Studies Series.

Kahler M., (1992), "multilateralism with Small and Large Numbers" *International Organizations*, 46,3, 681 pages.

_____. (1998). Rationality in International Relations, ***International Organizations***, 52 (4), 919-941.

Kamradt Scott, A. (2016). WHO is to Blame? The World Health Organization and the 2014 Ebola outbreak in West Africa, ***Third World Quarterly,*** 37.3, 401-418.

Kathryn C. Lavelle, (2020) ***The Challenges of Multilateralism*****,** New Haven: Yale University Press

Katie Laatikainen and Karen Smith, (2020) *Group Politics in UN Multilateralism* (Diplomatic Studies).

Katzenstein, P., Keohane R, Krasner, S (1998). International Organization and the study of World Politics. ***International Organization,*** 54, 645-685.

Keohane, Robert O.. "Multilateralism: An Agenda for Research." International Journal, 45 (Autumn 1991), 731.; see for a definition of the special features of "regional multilateralism" Michael, Arndt (2013). India's Foreign Policy and Regional Multilateralism (Palgrave Macmillan), pp. 12-16.

Kher U., (1982), « A name for the Plague" *Time*.

Kingsley Lyonga Ngange et Moki Stephen Mokondo, (2019), « Understanding Social Media's Role in Propagating Falsehood in Conflict Situations: Case of the Cameroon Anglophone Crisis », ***Studies in Media and Communication*****,** vol. 7, n° 2, p. 55.

Langenhove, L. V. (2010), ***The transformation of Multilateralism Mode 1.0 to 2.0.***

Lena Partzsch, (2020), ***Alternatives to Multilateralism: New Forms of Social and Environmental Governance*** (Earth System Governance).

Mah-Mungyeh E, Chiabi A, Tchokoteu FL, Nguefack S, Bogne JB, Siyou H H, Fru FS, Enoh J, Mbonda E, Tchokoteu PF, (2014), Neonatal mortality in a referral hospital in Cameroon over seven years: trends, associated factors, and causes. ***Afr Health Sci.*** Dec;14(4):985-92.

Marcuse, H. (1941), ***Reason and Revolution.***

Mario Telò**, (**2011**),** ***Multilateralism and global governance*** (Documentos de trabajo del Instituto Universitario de Estudios Europeos de la Universidad CEU San Pablo. Serie Unión Europea, Band 48).

**_____, (2014),** ***Globalisation, Multilateralism, Europe: Towards a Better Global Governance?*** (Globalisation, Europe, Multilateralism**)**.

Martin, L. (1992). Interests, Power and multilateralism, ***International Organization,*** 46 (4), 765-792.

Marx, K, (1843), ***Argent, Etat et Proletariat.***

_____, (1847), ***Liberalism and Revolution.***

Mathurin Kowo, Larissa Pessidjo, Charifa Fouwou Njoya, Larry Tangie Ngek, Larissa Tangan, Christelle Nguemo, Marthe Alogo, Larissa Ntsama, Oudou Njoya, Firmin Ankouane Andoulo, (2021), Prevalence, clinical characteristics and related mortality of cirrhosis in a tertiary hospital setting in S*ub Saharan* ***Africa.Open Journal of Gastroenterology and Hepatology*****,** 4:43.

Mayjon Wildman, Jeff Richardson, Lain K Robertson, (2003), ***A critique of the World Health Organisation, evaluation of health system performance***, al health econ, 4 criteria.

McCarthy, Michael (2002*).* "A brief history of the World Health Organization". The Lancet. 360 (9340).

Ndombo PK, Ekei QM, Tochie JN, Temgoua MN, Angong FTE, Ntock FN, Mbuagbaw L. (2017), ***A cohort analysis of neonatal hospital mortality rate and predictors of neonatal mortality in a sub-urban hospital of Cameroon***. Ital J Pediatr. ;43(1):52

Neba Ndenecho, E. (2011), Traditional Health Care system and Challenges in Developing Ethnopharmacology in Africa, Example of Oku in Cameroon, ***Studies on Ethno-medicine***, 5.5, 133-139.

Ngwakongwi, E., Bi Suh Atanga, M., Quan, H., (2014), Challenges to implement a national Health information System in Cameroon, Perspectives of stakeholders, ***Journal of Public Health Africa***, 5 (1), 322.

Nicola Contessi, (2014), "Multilateralism" in Joel Krieger (ed.) *Oxford* ***Companion to International Relations,*** New York, NY: Oxford University Press, pp. 96–101.

Nicolas Sauger, Sylvain Brouard et Emiliano Grossman, (2007), « Pourquoi un référendum en France ? », dans ***Les Français contre l'Europe ?*** Paris, Presses de Sciences Po.

Nkwi, Paul Nchoji. (1994) "Perceptions and Treatment of Diarrhoeal Diseases in Cameroon." *Journal of Diarrhoeal Diseases Research*, vol. 12, no. 1, icddr,b, pp. 35–41, http://www.jstor.org/stable/23498234.

Ongolo Zogo, C., (2020), ***The case of Research Production and Use in Cameroon.***

Owona Essomba, R., Bryant, M., Bodart, C., (1993), The reorientation of primary health care in Cameroon, rationale, obstacles and constraints, ***Health Policy and Planning,*** Vol 8, Issue 3, 232-239.

Pathogenic Microorganisms Associated With Childhood Diarrhea in Low-and-Middle Income Countries: Case Study of Yaoundé – Cameroon

Pouliot, V. (2011). Multilateralism as an End in Itself, ***International Studies Perspectives***, Vol 12, Issue 1, 18-26.

*Regionalism and Multilateralism: Politics, Economics, Culture* in the international magazine (Globalisation, Europe, and Multilateralism)– 23 July 2020.

Ritchie, J., and L. Spencer. (1994) "Qualitative data analysis for applied policy research." In ***Analyzing qualitative data***, edited by A.Bryman and R. G. Burgess, Londen: Routledge, 173–94.

Robert Keohane, *Multilateralism: An Agenda for Research* International Journal, 45

Routledge Advances, (2020) *Contested Multilateralism 2.0 and Asian Security Dynamics, in* International Relations and Global Politics, 1st edition.

Ruggie, J. (1992). ***Multilateralism, the anatomy of an institution. The international organization,*** 46, 561-598.

Ruggie, John, (1992), Multilateralism, the anatomy of an Institution" *International Organization*, 46.3, Summer, pp 561-598.

Sabeel, R. (2002). Another new world order? Multilateralism in the aftermath of September 11th, ***Harvard International Review***, Cambridge, 40-44.

Said, E. (1993), ***Culture and Imperialism,*** Fayard Edition, 555 p.

_____. (1994), ***Nationalism, Colonialism, and Literature. Yeats and decolonisation***, Presse Universitaire de Lille, 104 p.

_____. (2004), ***Humanism and Democratic Criticism,*** Editions Fayard, 251 p.

Sallares R, (2002), ***Malaria and Rome, A History of Malaria in ancient Italy***, Oxford University Press.Shimkin, Michael B. (1946*).* "The World Health Organization". **Science**. ***104*** *(2700): 281–283.*

Smith, M. (2018), The EU, the US and the crisis of contemporary multilateralism, ***Journal of European Integration,*** 40.5, 539-553.

Smouts, M.C. (1999), Multilateralism from Below, A prerequisite for global Governance, ***Future Multilateralism.***

Sobngwi-Tambekou J, Bhatti J, Kounga G, Salmi LR, Lagarde E. (2010), Road traffic crashes on the Yaoundé-Douala road section, Cameroon. Accid Anal Prev. 2010 Mar;42(2):422-6. doi: 10.1016/j.aap.2009.09.003. Epub.

Ssyed Muhammad, I., Razum, O., Ndiforchu, V., Martiny, P., (2001***), Coping Strategies of health personnel during an economic crisis, A case study from Cameroon.***

Stanley Hoffmann, "World governance: beyond utopia," Daedalus, 132:1, pp 27-35.

Stéphane W. Gondoin, ***Chateaux forts, assiéger et fortifier au moyen âge***, Editions Cheminements, 2005, 339 p.

Stone R. W., Branislav, L., Slantchev, London T. R., Choosing how to cooperate, A repeated public goods model of international Relations***, International Studies Quarterly***, Vol. 52, Issue 2, 335 – 362.

Surdej, A. (2020), Multilateralism and international governmental organizations, Principles, and instruments, ***Transforming Government, People, Process*** and Policy, Vol. 14 no 3, 337-350.

Sylvain Schirmann, (2008), ***Robert Schuman et les Pères de l'Europe : Cultures politiques et années de formation, Publications de la Maison de Robert Schuman***, vol. 1, Peter Lang, 361 p.

Tandi, T. E., Cho, Y., Akam A. J. C., (2015), Cameroon public health sector, Shortage and inequalities in the geographic distribution of health personnel, ***International Journal Equity Health*** 14, 43.

*The Globe and Mail Inc., (2020),* "European governments working with the U.S. on plans to overhaul WHO, health official says". *Reuters.* Archived *from the original on 20 June 2020. Retrieved 19 June 2020.*

The Lancet, (2009), ***Who runs global health?*** Vol. 373, Issue 9681, p 2083.

*The Washington Post*, (2020), **Trump administration sends letter withdrawing the US from World Health Organization over coronavirus response.**

Timsit, Anabel; Hui, Mary (2020), "Taiwan's status could disrupt the most important global health meeting of this pandemic". ***Quartz.*** Archived *from the original on 6th June 2020. Retrieved 6 June 2020.*

Traité européen (2008), Que s'est-il passé ? Du référendum de 2005 à la ratification de 2008 », ***L'Humanité.***

Traore, A (1995), ***Femmes d'Afrique, douloureux ajustements***, Editions Actes Sud.

_____ (2002), ***Le viol de l'immaginaire***, Editions Fayard.

_____ (2008***), L'Afrique humilie***, Fayard Edition.

_____ (2012), ***l'Afrique mutile***, Taama Editions.

Tsala, S., Onomo, C., Mvogo, G. and Ohandja, L. (2020) Elaboration of Explanatory Factors of Accidents in Cameroon by Factorial Correspondence Analysis. *Journal of Transportation Technologies*, **10**, 280-290.

Viktor Jakupec, Max Kelly, and Jonathan Makuwira. (2020), *Rethinking Multilateralism in Foreign Aid: Beyond the Neoliberal Hegemony*, Routledge Explorations in Development Studies.

Vladimir Lenin, (1917), ***Imperialism the highest stage of Capitalism***.

Wanko Keutchafo, E. L., Kerr, J., (2019), difficulties of Unit managers in selected district hospitals in Cameroon, Curationis, 42 (1) e1- e7.

Weiss RA, (1993), "How do HIV cause Aids" ***Sciences***, 260.

WHO, (2019), ***World Malaria Report 2019***, Switzerland World Health Organization 4-10.World Health Organization, (2018), ***World Road Safety Situation Report***. WHO, Geneva, 20 p.Yves Beigbeder, (1998), ***Organisation Mondiale De la Sante QSJ 3234*** **(Que Sais-Je ?)**.

Ziegler, J (1964), ***Sociologie de la Nouvelle Afrique,*** Edition Gallimard.

_____ (1973), ***Le pouvoir Africain,*** Editions du Seuil.

_____ (1978), ***Main Basse sur l'Afrique***, Nouvelle Edition.

_____ (1983), ***Contre l'ordre du Monde, les Rebelles,*** Edition du Seuil.

_____ (1988), ***La victoire des vaincus, Oppression et résistance Culturelle***, Edition du Seuil.

**Treaties**

Cf. Article 1 de l'annexe 16 B de l'acte final de Vienne. Cf. Charte de l'Organisation du Traité de Sécurité Collective. Publications André Lewin, « De Gaulle et l'Organisation des Nations Unies » consultée le 8 janvier 2020 à 9h14.

« CNN filme une vente aux enchères de migrants réduits en esclavage », SudOuest.fr, 16 novembre 2017.

Cf. Article 1 de l'Annexe 16 B de l'acte final de Vienne.

Cf. Charte de l'Organisation du Traité de Sécurité Collective.

Cooperation Strategy of WHO and the Republic of Cameroon, 2017-2020. Geneva: World Health Organisation; 2017. License: CC BY-NC-SA 3.0 IGO.

Cooperation Strategy of WHO and the Republic of Cameroon, 2017-2020. Geneva: World Health Organisation; 2017. License: CC BY-NC-SA 3.0 IGO.

BMJ, (1994), ***The World Health Organization, WHO in crisis***, 309. 1424.

**Webography**

https://cggrps.com/fr/la-commission-du-golfe-de-guinee/

https://senejournal.com/2020/05/11/covid-organics-le-problme-cest-que-a-vient-dafrique-ditandry-rajoelina-sur-rfi/

https://washdata.org/sites/default/files/documents/reports/2018-01/JMP-2017-report-final.pdf

https://www.cameroonweb.com/CameroonHomePage/politics/Lutte-contre-la-Covid-19-lOMS-offre-14-v-hicules-au-Cameroun-508747

https://www.un.org/fr/sections/history-united-nations-charter/1943-moscow-and-teheranconferences/index.html « get US out of the UN » [archive], Sur le site de la John Birch Society.

https://www.cameroonweb.com/CameroonHomePage/politics/Lutte-contre-la-Covid-19-l-OMS-offre-14-v-hicules-au-Cameroun-508747 visited on the 14th of May 2020 at 4.18 pm.

https://cggrps.com/fr/la-commission-du-golfe-de-guinee/ consulted on May 15th, 2020 at 8.41 pm.

"Global health sector strategy on HIV/AIDS 2011–2015" (PDF). WHO. 2011.

"History". www.who.int. Archived from the original on 22 March 2020. Retrieved 18 March 2020.

"Japan PM Abe calls for Taiwan's participation in WHO as coronavirus spreads". english.kyodonews.net. Kyodo News. Archived from the original on 30 January 2020. Retrieved 30 January 2020.

"Programme Budget, 2012–2013" (PDF). WHO. Archived (PDF) from the original on 17 June 2012. Retrieved 26 March 2012.

"Programme Budget, 2012–2013" (PDF). WHO. Archived (PDF) from the original on 17 June 2012. Retrieved 26 March 2012.

"Robert Mugabe's WHO appointment condemned as 'an insult'". BBC News. 21 October 2017. Archived from the original on 21 October 2017. Retrieved 22 October 2017.

"Trump administration moves to formally withdraw US from WHO". The Hill. 7 July 2020. Archived from the original on 7 July 2020. Retrieved 7 July 2020.

"US election: Joe Biden pushes forward with plans for office". BBC News. 8 November 2020. Retrieved 8 November 2020.

"WHO Constitution, BASIC DOCUMENTS, Forty-ninth edition" (PDF). Archived (PDF) from the original on 1 April 2020.

"World Health Organization". The British Medical Journal. **2**(4570): 302–303. 7 August 1948. doi:10.1136/bmj.2.4570.302. JSTOR 25364565. PMC 1614381.

"World Health Organization Philippines". WHO. Archived from the original on 25 April 2012. Retrieved 27 March 2012.

« CNN filme une vente aux enchères de migrants réduits en esclavage », SudOuest.fr, 16 novembre 2017.

Centre for Disease Control and Prevention, July 2019.

Howard-Jones, Norman (1974). "Introduction". The scientific background of the International Sanitary Conferences, 1851–1938(PDF). World Health Organization. pp. 9–11. Archived (PDF) from the original on 20 August 2017. Retrieved 3 January 2018.

https://borgenproject.org/deadliest-diseases-in-cameroon/

https://en.wikipedia.org/wiki/Foreign_policy_of_the_Recep_Tayyip_Erdo%C4%9Fan_government#UN

https://senejournal.com/2020/05/11/covid-organics-le-problme-cest-que-a-vient-dafrique-dit-andry-rajoelina-sur-rfi/ consulted on 12th May 2020 at 7. 28 pm.

https://washdata.org/sites/default/files/documents/reports/2018-01/JMP-2017-report-final.pdf

https://www.exed.hbs.edu/hbs-experience/learning-experience/case-study-method

https://www.journalducameroun.com/en/cameroon-road-accidents-cause-at-least-1200-deaths-yearly/

https://www.methodspace.com/blog/case-study-methodology

https://www.sciencedirect.com/science/article/pii/S1201971219300967

https://www.un.org/fr/sections/history-united-nations-charter/1943-moscow-and-teheran-conferences/index.html visited the 15th of May 2020 at 20h49.

https://www.washingtonpost.com/world/trump-united-states-withdrawal-world-health-organization-coronavirus/2020/07/07/ae0a25e4-b550-11ea-9a1d-d3db1cbe07ce_story.html,Date accessed: July 7, 2020.

https://www.wisdomjobs.com/e-university/research-methodology-tutorial-355/case-study-method-11496.htm.

# ANNEXES

## Annex 1: Cameroon population-based HIV impact assessment Camphia 2017

The Cameroon Population-based HIV Impact Assessment (CAMPHIA), a household-based national survey, was conducted between July 2017 and February 2018 to measure the status of Cameroon's national HIV response. CAMPHIA offered HIV counseling and testing with the return of results and collected information about households and individuals' backgrounds, and uptake of HIV care and treatment services. This survey is the first in Cameroon to estimate national HIV incidence and viral load suppression. The results provide information on national and regional progress toward control of the HIV epidemic.

CAMPHIA was led by the Government of Cameroon under the Ministry of Health, Division of Health Operations Research (DROS), and National AIDS Control Commission (NACC), and through the National Institute of Statistics (INS). The survey was conducted with funding from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and technical assistance through the U.S. Centers for Disease Control and Prevention (CDC). The survey was implemented by INS and ICAP at Columbia University in collaboration with local partners, including the Centre Pasteur Cameroon (CPC), Global Health Systems Solutions (GHSS), National Early Infant Diagnosis Reference Laboratory, Mutengene, National Public Health Lab (NPHL) and Centre International de Reference Chantal Biya (CIRCB).

KEY FINDINGS

95% CI (confidence interval) indicates the interval within which the true population parameter is expected to fall 95% of the time.

Viral load suppression is defined as HIV RNA <1,000 copies per ml of plasma among HIV-positive adults; incidence measurement based on MDRI of 130 days. For incidence estimates, N denotes the number of individuals tested for recent infection to obtain an incidence estimate. Although only HIV-positive individuals were tested for recency of infection, the annual incidence estimate is for the entire adult population of the sample. The "N" for the prevalence and viral load suppression categories reflects the number of people tested to obtain the estimates reported in the row. The annual incidence of HIV among adults aged 15-64 years in Cameroon is 0.27%: 0.45% among females and 0.09% among males.

The prevalence of HIV among adults aged 15-64 years in Cameroon is 3.7%: 5.0% among females and 2.3% among males. This corresponds to approximately 500,000 people living with HIV (PLHIV) ages 15-64 years in Cameroon. The prevalence of viral load suppression (VLS) among HIV-positive adults ages 15-64 years in Cameroon is 44.7%: 45.6% among females and 42.5% among males.

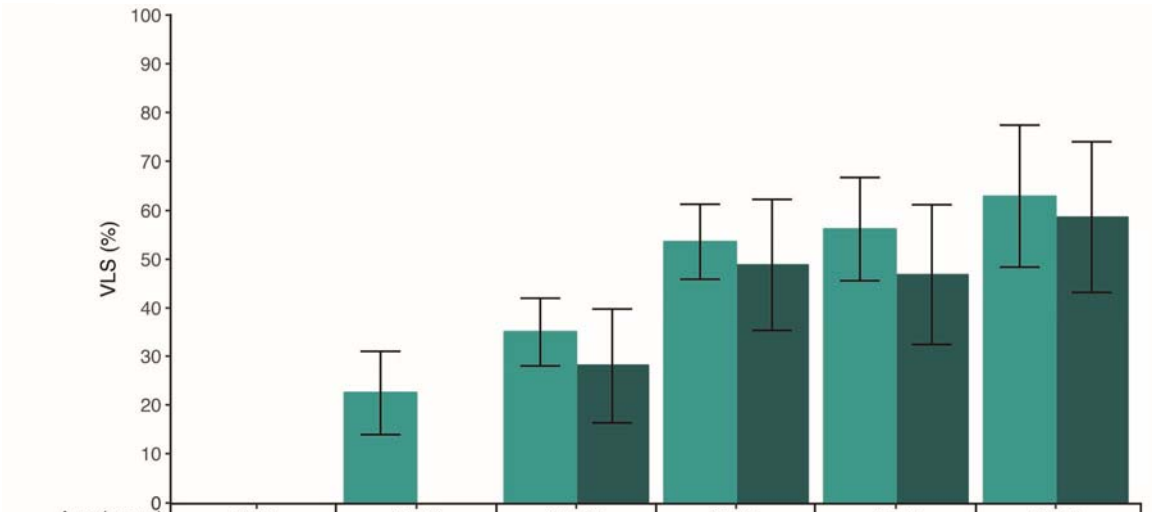
**HIV PREVALENCE, BY AGE AND SEX**

Among adults aged 15-64 years, H I V prevalence among adults varies by region, ranging from 6.3 percent in t h e South Region to 1.5 percent in the Far North Region.

**VIRAL LOAD SUPPRESSION AMONG HIV-POSITIVE PEOPLE, BY AGE AND SEX**

Viral load suppression among HIV-positive individuals in Cameroon is highest among older adults, with 63% of females ages 55-64 virally suppressed, and 59% of males ages 55-64 virally suppressed. There is little gender disparity in viral load suppression among adults, with 56% of females ages 45-54 virally suppressed and 47% of men in the same age group virally suppressed.

**Table 17 :** Viral Load Suppression among HIV positive people by age and sex in Cameroon




| Age (years) | 0–14 | 15–24 | 25–34 | 35–44 | 45–54 | 55–64 |
|---|---|---|---|---|---|---|
| Female | * | 22.5 | 35.0 | 53.6 | 56.2 | 62.9 |
| Male | * | * | 28.1 | 48.8 | 46.8 | (58.6) |

Source: Minsante 2018.

Estimates for males and females aged 0-14, and males ages 15-24 are based on a very small number (less than 25) of unweighted cases and have been suppressed. Estimates in

parentheses are based on a small number of unweighted cases (25-49) and should be interpreted with caution.

By 2020, 90% of all PLHIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy (ART), and 90% of all people receiving ART will have viral suppression.

In Cameroon, 46.9% of PLHIV aged 15-64 years report knowing their HIV status: 49.4% of HIV-positive females and 41.2% of HIV-positive males know their HIV status. On Treatment Among PLHIV aged 15-64 years who know their HIV status, 91.3% self-report current use of ART: 91.1% of HIV-positive females and 92.0% of HIV-positive males who know their HIV status self-report current use of ART Virally Suppressed.

Among PLHIV aged 15-64 years who self-report current use of ART, 80.0% are virally suppressed: 79.2% of HIV-positive females and 82.1% of HIVpositive males who self-report current use of ART are virally suppressed. Error bars represent 95% confidence intervals. Inset numbers are conditional proportions. For example, 46.9% of people who tested positive for HIV in the survey reported they already knew their positive status. Of those who knew their positive status, 91.3% were in treatment. Of those in treatment, 80% were virally suppressed.

PREVALENCE OF HEPATITIS B SURFACE ANTIGEN BY SEX, AGE, AND HIV STATUS

National HIV incidence is 0.27% among the population ages 15-64. Four out of 5 new HIV infections are among women ages 15-64. Going forward, the national HIV program can focus efforts on reducing the rate of new infections, especially among women. •Out of every 100 HIV-positive people, 47 report knowing their status. Among those who report knowing their status, more than 90% report being on treatment. Among those on treatment, 80% are virally suppressed. Cameroon should intensify efforts to identify new cases while sustaining the success of treating the diagnosed. •H IV prevalence for the populations' ages 0-14, 15-49, 15-64 are 0.2%, 3.4% and 3.7%, respectively. The prevalence for 0-14 years is the first direct measurement among that age group and merits more targeted research to better understand HIV epidemiology in children.

Of 12,417 occupied households that were visited, 92% completed a household interview. Of 15,419 eligible women and 13,216 eligible men ages 15-64 years, 95% of women and men were interviewed and tested for HIV. Overall adult response rate (which combines household, individual interview, and blood draw response rates) was 84%. Of 8,018 eligible children ages 0-14 years, 90% were tested for HIV. A representative subsample of 1,962 adults ages 15-64 was tested for hepatitis

B surface antigen. HIV prevalence testing was conducted in each household using a serological rapid diagnostic testing algorithm based on Cameroon's national guidelines, with laboratory confirmation of seropositive samples using a supplemental assay. A laboratory-based incidence testing algorithm (HIV-1 LAg avidity plus viral load) was used to distinguish recent from term infection, and incidence estimates were obtained using the formula recommended by the WHO Incidence Working Group and Consortium for Evaluation and Performance of Incidence Assays, with time cutoff (T)=1.0 year and residual proportion false recent (PFR)=0.00. Survey weights are utilized for all estimates. The mark "CDC" is owned by the US Dept. of Health and Human Services and is used with permission. Use of this logo is not an endorsement by HHS or CDC of any particular product, service, or enterprise. This project is supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through CDC under the terms of cooperative agreement #U2GGH001226. The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the funding agencies.

**Annex 2: Constitution of the World Health Organization.**

The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States (*Off. Rec. Wld Hlth Org*., 2, 100), and entered into force on 7 April 1948. Amendments adopted by the Twenty-sixth, Twenty-ninth, Thirty-ninth, and Fifty-first World Health Assemblies (resolutions WHA26.37, WHA29.38, WHA39.6, and WHA51.23) came into force on 3 February 1977, 20 January 1984, 11 July 1994, and 15 September 2005 respectively and are incorporated in the present text.

THE STATES Parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations, and security of all peoples:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all.

Unequal development in different countries in the promotion of health and control of disease, especially communicable diseases, is a common danger.

The healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all peoples of the benefits of medical, psychological, and related knowledge is essential to the fullest attainment of health.

Informed opinion and active co-operation on the part of the public are ofthe utmost importance in the improvement of the health of the people.

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures.

ACCEPTING THESE PRINCIPLES, and for co-operation among themselves and with others to promote and protect the health of all peoples, the Contracting Parties agree to the present Constitution and hereby establish the World Health Organization as a specialized agencywithin the terms of Article 57 of the Charter of the United Nations.

## CHAPTER I – OBJECTIVE

*Article 1*

The objective of the World Health Organization (hereinafter called the Organization) shall be the attainment by all peoples of the highest possiblelevel of health.

## CHAPTER II – FUNCTIONS

*Article 2*

To achieve its objective, the functions of the Organization shall be:

(a) to act as the directing and coordinating authority on internationalhealth work;

(b) to establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups, and such other organizations as may be deemed appropriate;

(c) to assist Governments, upon request, in strengthening health services;

(d) to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of Governments;

(e) to provide or assist in providing, upon the request of the United Nations, health services and facilities to special groups, such as the peoples of trust territories;

(f) to establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services;

(g) to stimulate and advance work to eradicate epidemic, endemic and other diseases;

(h) to promote, in co-operation with other specialized agencies where necessary, the prevention of accidental injuries;

(i) to promote, in cooperation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions, and other aspects of environmental hygiene;

(j) to promote cooperation among scientific and professional groups which contribute to the advancement of health;

(a) to propose conventions, agreements and regulations, make recommendations concerning international health matters, and perform such duties as may be assigned thereby to the Organization and areconsistent with its objective;

(b) to promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment;

(c) to foster activities in the field of mental health, especially those affecting the harmony of human relations;

(d) to promote and conduct research in the field of health;

(e) to promote improved standards of teaching and training in the health, medical and related professions;

(f) to study and report on, in cooperation with other specialized agencies where necessary, administrative and social techniques affecting public health and medical care from preventive and curative points of view, including hospital services and social security;

(g) to provide information, counsel, and assistance in the field of health;

(h) to assist in developing an informed public opinion among all peopleson matters of health;

(i) to establish and revise as necessary international nomenclatures of diseases, causes of death, and public health practices;

(j) to standardize diagnostic procedures as necessary;

(k) to develop, establish and promote international standards concerning food, biological, pharmaceutical, and similar products;

(l) Generally, to take all necessary action to attain the objective of the Organization.

## CHAPTER III – MEMBERSHIP AND ASSOCIATE MEMBERSHIP

*Article 3*

Membership in the Organization shall be open to all States.

*Article 4*

Members of the United Nations may become Members of the Organization by signing or

otherwise accepting this Constitution followingthe provisions of Chapter XIX and following their constitutional processes.

*Article 5*

The States whose Governments have been invited to send observers to the International Health Conference held in New York, in 1946, may become members by signing or otherwise accepting this Constitution following the provisions of Chapter XIX and following their constitutional processes provided that such signature or acceptance shall be completed before the first session of the Health Assembly.

*Article 6*

To the conditions of any agreement between the United Nations and the Organization, approved according to Chapter XVI, States which do not become Members following Articles 4 and 5 may apply to become Members and shall be admitted as members when their applicationhas been approved by a simple majority vote of the Health Assembly.

*Article 7*

If a Member fails to meet its financial obligations to the Organization orin other exceptional circumstances, the Health Assembly may, on such conditions as it thinks proper, suspend the voting privileges and services to which a Member is entitled. The Health Assembly shall have the authority to restore such voting privileges and services.

*Article 8*

Territories or groups of territories which are not responsible for the conduct of their international relations may be admitted as Associate Members by the Health Assembly upon application made on behalf of such territory or group of territories by the Member or other authority having responsibility for their international relations. Representatives of Associate Members to the Health Assembly should be qualified by their technical competence in the field of health and should be chosen from the native population. The nature and extent of the rights and obligations of Associate Members shall be determined by the Health Assembly.

CHAPTER IV – ORGANS

*Article 9*

The work of the Organization shall be carried out by:

(m) The World Health Assembly (herein called the Health Assembly);

(n) The Executive Board (hereinafter called the Board);

(o) The Secretariat.

CHAPTER V – THE WORLD HEALTH ASSEMBLY

*Article 10*

The Health Assembly shall be composed of delegates representing Members.

*Article 11*

Each Member shall be represented by not more than three delegates, oneof whom shall be designated by the Member as chief delegate. These delegates should be chosen from among persons most qualified by their technical competence in the field of health, preferably representing the national health administration of the Member.

*Article 12*

Alternates and advisers may accompany delegates.

*Article 13*

The Health Assembly shall meet in regular annual sessions and such special sessions as may be necessary. Special sessions shall be convened atthe request of the Board or of a majority of the Members.

*Article 14*

The Health Assembly, at each annual session, shall select the country orregion in which the next annual session shall be held, the Board subsequently fixing the place. The Board shall determine the place where a special session shall be held.

*Article 15*

The Board, after consultation with the Secretary-General of the United Nations, shall determine the date of each annual and special session.

*Article 16*

The Health Assembly shall elect its President and other officers at the beginning of each annual session. They shall hold office until their successors are elected.

*Article 17*

The Health Assembly shall adopt its own rules of procedure.

*Article 18*

The functions of the Health Assembly shall be:

(a) to determine the policies of the Organization;

(b) to name the Members entitled to designate a person to serve on the Board;

(c) to appoint the Director-General;

(d) to review and approve reports and activities of the Board and the Director-General and to instruct the Board regarding matters upon which action, study, investigation, or report may be considered desirable;

(e) to establish such committees as may be considered necessary for the work of the Organization;

(f) to supervise the financial policies of the Organization and to review and approve the budget;

(g) to instruct the Board and the Director-General to bring to the attention of Members and of international organizations, governmental or non-governmental, any matter concerning health that the Health Assembly may consider appropriate;

(h) to invite any organization, international or national, governmental or non-governmental, which has responsibilities related to those of the Organization, to appoint representatives to participate, without right of vote, in its meetings or those of the committees and conferences convened under its authority, on conditions prescribed by the Health Assembly; but in the case of national organizations, invitations shall be issued only with the consent of the Government concerned;

(i) to consider recommendations bearing on health made by the General Assembly, the Economic and Social Council, the Security Council or Trusteeship Council of the United Nations, and to report to them on the steps taken by the Organization to give effect to such recommendations;

(j) to report to the Economic and Social Council following any agreement between the Organization and the United Nations;

(k) to promote and conduct research in the field of health by the personnel of the Organization, by the establishment of its institutions, or by co-operation with official or non-official institutions of any Member with the consent of its Government;

(l) to establish such other institutions as it may consider desirable;

(m) to take any other appropriate action to further the objective of the Organization.

*Article 19*

The Health Assembly shall have authority to adopt conventions or agreements concerning any matter within the competence of the Organization. A two-thirds vote of the Health Assembly shall be required for the adoption of such conventions or agreements, which shall come into force for each Member when accepted by it following its constitutional processes.

*Article 20*

Each Member undertakes that it will, within eighteen months after the adoption by the Health Assembly of a convention or agreement, take actionrelative to the acceptance of such convention or agreement. Each Member shall notify the Director-General of the action taken, and if it does not accept such convention or agreement within the time limit, it will furnish a statement of the reasons for non-acceptance. In case of acceptance, each Member agrees to make an annual report to the Director-General following Chapter XIV.

*Article 21*

The Health Assembly shall have the authority to adopt regulations concerning:

(a) sanitary and quarantine requirements and other procedures designed toprevent the international spread of disease;

(b) nomenclatures concerning diseases cause of death and public health practices;

(c) standards concerning diagnostic procedures for international use;

(d) standards concerning the safety, purity, and potency of biological, pharmaceutical, and similar products moving in international commerce;

(e) advertising and labelling of biological, pharmaceutical, and similarproducts moving in international commerce.

*Article 22*

Regulations adopted according to Article 21 shall come into force for all Members after due notice has been given of their adoption by the Health Assembly except for such Members as may notify the Director-General of rejection or reservations within the period stated in the notice.

*Article 23*

The Health Assembly shall have the authority to make recommendations to Members concerning any matter within the competence of the Organization.

CHAPTER VI – THE EXECUTIVE BOARD

*Article 24*

The Board shall consist of thirty-four persons designated by as many Members. The Health Assembly, taking into account an equitable geographical distribution, shall elect the Members entitled to designate a person to serve on the Board, provided that, of such Members, not less than three shall be elected from each of the regional organizations established according to Article 44. Each of these Members should appoint to the Boarda person technically qualified in the field of health, who may be accompanied by alternates and advisers.

*Article 25*

These Members shall be elected for three years and may be re-elected, provided that of the Members elected at the first session of the Health Assembly held after the coming into force of the amendment to this Constitution increasing the membership of the Board from thirty-two to thirty-four the term of office of the additional Members elected shall, insofar as may be necessary, be of such lesser duration as shall facilitate the election of at least one member from each regional organization in each year.

*Article 26*

The Board shall meet at least twice a year and shall determine the place of each meeting.

*Article 27*

The Board shall elect its Chairman from among its members and shall adopt its own rules of procedure.

*Article 28*

The functions of the Board shall be:

1. to give effect to the decisions and policies of the Health Assembly;
2. to act as the executive organ of the Health Assembly;
3. to perform any other functions entrusted to it by the Health Assembly;
4. to advise the Health Assembly on questions referred to it by that body and on matters assigned to the Organization by conventions, agreements, and regulations;

5. to submit advice or proposals to the Health Assembly on its initiative;
6. to prepare the agenda of meetings of the Health Assembly;
7. to submit to the Health Assembly for consideration and approval a general program of work covering a specific period;
8. to study all questions within its competence;
9. to take emergency measures within the functions and financial resources of the Organization to deal with events requiring immediate action. In particular, it may authorize the Director-General to take the necessary steps to combat epidemics, to participate in the organization of health relief for victims of a calamity, and to undertake studies and research the urgency of which has been drawn to the attention of the Board by any Member or by the Director-General.

*Article 29*

The Board shall exercise on behalf of the whole Health Assembly the powers delegated to it by that body.

CHAPTER VII – THE SECRETARIAT

*Article 30*

The Secretariat shall comprise the Director-General and such technical and administrative staff as the Organization may require.

*Article 31*

The Director-General shall be appointed by the Health Assembly on thenomination of the Board on such terms as the Health Assembly may determine. The Director-General, subject to the authority of the Board, shall be the chief technical and administrative officer of the Organization.

*Article 32*

The Director-General shall be ex officio Secretary of the Health Assembly, of the Board, of all commissions and committees of the Organization and conferences convened by it. He may delegate these functions.

*Article 33*

The Director-General or his representative may establish a procedure byagreement with Members, permitting him, to discharge his duties, to have direct access to their various departments,

especially to their health administrations and to national health organizations, governmental or non-governmental. He may also establish direct relations with international organizations whose activities come within the competence ofthe Organization. He shall keep regional offices informed on all matters involving their respective areas.

*Article 34*

The Director-General shall prepare and submit to the Board the financialstatements and budget estimates of the Organization.

*Article 35*

The Director-General shall appoint the staff of the Secretariat following staff regulations established by the Health Assembly. The paramount consideration in the employment of the staff shall be to assure that the efficiency, integrity, and internationally representative character of the Secretariat shall be maintained at the highest level. Due regard shall be paidalso to the importance of recruiting the staff on as wide a geographical basis as possible.

*Article 36*

The conditions of service of the staff of the Organization shall conform as far as possible with those of other United Nations organizations.

*Article 37*

In the performance of their duties, the Director-General and the staff shall not seek or receive instructions from any government or any authority external to the Organization. They shall refrain from any action which might reflect on their position as international officers. Each Member of the Organization on its part undertakes to respect the exclusively international character of the Director-General and the staff and not to seekto influence them.

CHAPTER VIII – COMMITTEES

*Article 38*

The Board shall establish such committees as the Health Assembly maydirect and, on its initiative or the proposal of the Director-General,may establish any other committees considered desirable to serve any purpose within the competence of the Organization.

*Article 39*

The Board, from time to time and in any event annually, shall review thenecessity for continuing each committee.

*Article 40*

The Board may provide for the creation of or the participation by the Organization in joint or mixed committees with other organizations and for the representation of the Organization in committees established by such other organizations.

CHAPTER IX – CONFERENCES

*Article 41*

The Health Assembly or the Board may convene local, general, technical or other special conferences to consider any matter within the competence of the Organization and may provide for the representation at such conferences of international organizations and, with the consent of the Government concerned, of national organizations, governmental or non-governmental. The manner of such representation shall be determined by the Health Assembly or the Board.

*Article 42*

The Board may provide for representation of the Organization at conferences in which the Board considers that the Organization has an interest.

CHAPTER X – HEADQUARTERS

*Article 43*

The location of the headquarters of the Organization shall be determinedby the Health Assembly after consultation with the United Nations.

CHAPTER XI – REGIONAL ARRANGEMENTS

*Article 44*

(a) The Health Assembly shall from time to time define the geographical areas in which it is desirable to establish a regional organization.

(b) The Health Assembly may, with the consent of a majority of the Members situated within each area so defined, establish a regional organization to meet the special needs of such area. There shall not be more than one regional organization in each area.

*Article 45*

Each regional organization shall be an integral part of the Organization following this Constitution.

*Article 46*

Each regional organization shall consist of a regional committee and a regional office.

*Article 47*

Regional committees shall be composed of representatives of the Member States and Associate Members in the region concerned. Territories or groups of territories within the region, which are not responsible for the conduct of their international relations and which are not Associate Members, shall have the right to be represented and to participate in regional committees. The nature and extent of the rights and obligations of these territories or groups of territories in regional committees shall be determined by the Health Assembly in consultation with the Member or other authority having responsibility for the international relations of these territories and with the Member States in the region.

*Article 48*

Regional committees shall meet as often as necessary and shall determine the place of each meeting.

*Article 49*

Regional committees shall adopt their own rules of procedure.

*Article 50*

The functions of the regional committee shall be:

(a) to formulate policies governing matters of an exclusively regional character;

(b) to supervise the activities of the regional office;

(c) to suggest to the regional office, the calling of technical conferences andsuch additional work or investigation in health matters as in the opinionof the regional committee would promote the objective of the Organization within the region;

(d) to co-operate with the respective regional committees of the United Nations and with those of other specialized agencies and with other regional international organizations having interests in common with the Organization;

(e) to tender advice, through the Director-General, to the Organization on international health matters which have wider than regional significance;

(f) to recommend additional regional appropriations by the Governments of the respective regions if the proportion of the central budget of the Organization allocated to that region is insufficient for the carrying-out of the regional functions;

(g) such other functions as may be delegated to the regional committee by the Health Assembly, the Board, or the Director-General.

*Article 51*

Subject to the general authority of the Director-General of the Organization, the regional office shall be the administrative organ of the regional committee. It shall, in addition, carry out within the region the decisions ofthe Health Assembly and the Board.

*Article 52*

The head of the regional office shall be the Regional Director appointedby the Board in agreement with the regional committee.

*Article 53*

The staff of the regional office shall be appointed in a manner to be determined by agreement between the Director-General and the Regional Director.

*Article 54*

The Pan American Sanitary Organization[1] represented by the Pan American Sanitary Bureau and the Pan American Sanitary Conferences, and all other inter-governmental regional health organizations in existence before the date of signature of this Constitution, shall in due course be integrated with the Organization. This integration shall be effected as soon as practicable through common action based on mutual consent of the competent authorities expressed through the organizations concerned.

## CHAPTER XII – BUDGET AND EXPENSES

*Article 55*

The Director-General shall prepare and submit to the Board the budget estimates of the Organization. The Board shall consider and submit to the Health Assembly such budget estimates, together with any recommendations the Board may deem advisable.

Renamed “Pan American Health Organization” by decision of the XV Pan American Sanitary Conference, September-October 1958.

*Article 56*

Subject to any agreement between the Organization and the United Nations, the Health Assembly shall review and approve the budget estimates and shall apportion the expenses among the Members following a scale to be fixed by the Health Assembly.

*Article 57*

The Health Assembly or the Board acting on behalf of the HealthAssembly may accept and

administer gifts and bequests made to the Organization provided that the conditions attached to such gifts or bequests are acceptable to the Health Assembly or the Board and are consistent with the objective and policies of the Organization.

*Article 58*

A special fund to be used at the discretion of the Board shall be established to meet emergencies and unforeseen contingencies.

CHAPTER XIII – VOTING

*Article 59*

Each Member shall have one vote in the Health Assembly.

*Article 60*

Decisions of the Health Assembly on important questions shall be made by a two-thirds majority of the Members present and voting. These questions shall include the adoption of conventions or agreements; the approval of agreements bringing the Organization into relation with the United Nations and inter-governmental organizations and agencies following Articles 69, 70, and 72; amendments to this Constitution.

Decisions on other questions, including the determination of additional categories of questions to be decided by a two-thirds majority, shall be made by a majority of the Members present and voting.

Voting on analogous matters in the Board and committees of the Organization shall be made under paragraphs (*a*) and (*b*) of this Article.

CHAPTER XIV – REPORTS SUBMITTED BY STATES

*Article 61*

Each Member shall report annually to the Organization on the action taken and progress achieved in improving the health of its people.

*Article 62*

Each Member shall report annually on the action taken concerning recommendations made to it by the Organization and concerningconventions, agreements, and regulations.

*Article 63*

Each Member shall communicate promptly to the Organization important laws, regulations, official reports, and statistics abouthealth that have been published in the State concerned.

*Article 64*

Each Member shall provide statistical and epidemiological reports in a manner to be determined by the Health Assembly.

*Article 65*

Each Member shall transmit upon the request of the Board such additional information about health as may be practicable.

CHAPTER XV – LEGAL CAPACITY, PRIVILEGES, AND IMMUNITIES

*Article 66*

The Organization shall enjoy in the territory of each Member such legal capacity as may be necessary for the fulfillment of its objective and the exercise of its functions.

*Article 67*

(a) The Organization shall enjoy in the territory of each Member such privileges and immunities as may be necessary for the fulfilment of its objective and the exercise of its functions.

(b) Representatives of Members, persons designated to serve on the Board, and technical and administrative personnel of the Organization shall similarly enjoy such privileges and immunities as are necessary for the independent exercise of their functions in connection with the Organization.

*Article 68*

Such legal capacity, privileges, and immunities shall be defined in a separate agreement to be prepared by the Organization in consultation with the Secretary-General of the United Nations and concluded between the Members.

CHAPTER XVI – RELATIONS WITH OTHER ORGANIZATIONS

*Article 69*

The Organization shall be brought into relation with the United Nations as one of the specialized agencies referred to in Article 57 of the Charter of the United Nations. The agreement or agreements bringing the Organization into relation with the United Nations shall be subject to approval by a two-thirds vote of the Health Assembly.

*Article 70*

The Organization shall establish effective relations and co-operate closely with such other inter-governmental organizations as may be desirable. Any formal agreement entered into with such

organizations shall be subject to approval by a two-thirds vote of the Health Assembly.

*Article 71*

The Organization may, on matters within its competence, make suitablearrangements for consultation and cooperation with non-governmental international organizations and, with the consent of the Government concerned, with national organizations, governmental or non-governmental.

*Article 72*

Subject to the approval by a two-thirds vote of the Health Assembly, theOrganization may take over from any other international organization or agency whose purpose and activities lie within the field of competence of the Organization such functions, resources, and obligations, as may be conferred upon the Organization by international agreement or by mutually acceptable arrangements, entered into between the competent authorities ofthe respective organizations.

CHAPTER XVII – AMENDMENTS

*Article 73*

Texts of proposed amendments to this Constitution shall be communicated by the Director-General to Members at least six months in advance oftheir consideration by the Health Assembly. Amendments shall come into force for all Members when adopted by a two-thirds vote of the Health Assembly and accepted by two-thirds of the Members following their respective constitutional processes.

CHAPTER XVIII – INTERPRETATION

*Article 74*

The Chinese, English, French, Russian and Spanish texts of this Constitution shall be regarded as equally authentic.

*Article 75*

Any question or dispute concerning the interpretation or application of this Constitution which is not settled by negotiation or by the HealthAssembly shall be referred to the International Court of Justice in conformity with the Statute of the Court unless the parties concerned agree on another mode of settlement.

*Article 76*

Upon authorization by the General Assembly of the United Nations or authorization following any agreement between the Organization and the United Nations, the Organization may request the International Court of Justice for an advisory opinion on any legal question

arisingwithin the competence of the Organization.

*Article 77*

The Director-General may appear before the Court on behalf of the Organization in connexion with any proceedings arising out of any such request for an advisory opinion. He shall make arrangements for the presentation of the case before the Court, including arrangements for the argument of different views on the question.

CHAPTER XIX – ENTRY-INTO-FORCE

*Article 78*

Subject to the provisions of Chapter III, this Constitution shall remain open to all States for signature or acceptance.

*Article 79*

(a) States may become parties to this Constitution by:

(i) a signature without reservation as to approval;

(ii) signature subject to approval followed by acceptance; or

(iii) Acceptance.

The amendment to this Article adopted by the Thirty-first World Health Assembly (resolution WHA31.18) has not yet come into force.

(b) Acceptance shall be effected by the deposit of a formal instrumentwith the Secretary-General of the United Nations.

*Article 80*

This Constitution shall come into force when twenty-six Members of theUnited Nations have become parties to it following the provisionsof Article 79.

*Article 81*

Following Article 102 of the Charter of the United Nations, theSecretary-General of the United Nations will register this Constitutionwhen it has been signed without reservation as to approval on behalf of oneState or upon deposit of the first instrument of acceptance.

*Article 82*

Governments represented at the Conference Other States have become parties to this Constitution.

IN FAITH WHEREOF the undersigned representatives, having been duly authorized for

that purpose, sign this Constitution.

**Annex 3 : World Health Organization general factsheet on Cameroon**

Cooperation for Health

The Minister of Public Health has created a directorate of cooperation for the coordination of partners. The health sector benefits from technical and financial assistance from several development partners whose actions vary in different domains. Several of those partners with the improvement of cooperation with WHO. The interventions of WHO and partners are aligned with the orientations of national strategic and/or operational plans (SSH, NHDP) UNDAF, the United Nations development assistance framework for Cameroon which is ongoing for the 2013-2017 period, has selected three intervention areas for assistance: support for strong, sustainable and inclusive growth, support for the promotion of decent employment, and support to governance and the strategic management of the State. Foreign aid from the main financial partners represents 20% of the funding of the health sector. Multilateral cooperation is predominant and is done through the main specialized agencies of the United Nations System, the European Union, the World Bank, the African Development Bank and the Islamic Development Bank, the Global Fund for the Fight against ADIS, tuberculosis, and Malaria, UNITAID and the Clinton Foundation. Several NGOs also intervene, essentially in the implementation of health programs. A concertation framework of health partners for the implementation of the health sectoral strategy has been set up.

**Health Policies and System**

To achieve national and international objectives in matters of health (MDGs, GESP) and progress toward Universal Health-care Coverage, Cameroon has equipped itself with a Strategy for the Health Sector (SSH) 2016-2027. Its vision is as follows: “A country wherein universal access to quality health services is guaranteed for all social groups by 2035 with the full participation of communities”. It will be translated into the strengthening of the health system and the implementation of essential basic and specialized priority health intervention packages. This policy relies on government documents, especially GESP and the 2035 vision for the emergence of the country by 2035. The health system is organized at three levels: the operational level (health district), the intermediary level of technical support, and the central level in charge of the design of strategies for health development. The health system has a certain number of problems. The needs for quality health care and services remain unsatisfied, the coverage of minimum packages and complementary packages of health activities remaining poor, and specialized care remaining expensive. Despite efforts to recruit staff, the quantitative and qualitative deficit in health-related human resources remains very important. This problem is aggravated by non-optimal management of personnel, with the low rationalization of the use of personnel, and retention in areas with

difficult access and motivation (sources of unethical behavior of personnel). The institutional and organizational framework of the national health information system for the management of health services remains poor and is translated in the nonexistence of a document on management procedures and the multiplicity of sub-systems of information and data collection tools. The National Board of Supply in Essential Drugs witnesses a loss of steam for which an evaluation is necessary, and there is no autonomous system for the regulation of the pharmaceutical sector permitting to have quality medical products (including vaccines). Households continue to be the main source of funding for health, followed by the government and technical and financial partners (TFP). The sharing of the disease risk is still embryonic. Health expenditures of households are constituted by about 97% of direct payments at contact points. The health sector witnesses insufficient funding, as well as a poor use of funds made available. There is no national strategy for funding health. The strategic and operational piloting of the health sector has weaknesses in planning, coordination, supervision, monitoring, and evaluation.

**Health Situation**

Cameroon has a population that is estimated at 22 million with 44% below 15 years of age, a population growth rate of 2.6%, and a life expectancy at birth of about 51 years in 2011. With a human development index (HDI) of 0.504, Cameroon was 152nd out of 187 countries evaluated in 2013. In 2014, 37.5% of the population lived below the monetary poverty line. The epidemiological profile remains dominated by communicable diseases. HIV/AIDS, malaria, and tuberculosis represent about 23.7% of total morbidity and 25% of deaths. The prevalence of HIV is estimated at 4.3% with numerous differences between regions, age groups, and sexes. For youths from 15 to 24 years, it stood at 1.7% in 2011. In 2012, the number of people living with HIV is estimated at 550 000. The evolution of tuberculosis is in partial drop with a decreasing number of declared cases of HIV since 2001. Malaria remains the main cause of morbidity and mortality in children below 5 years. Non-communicable diseases are emerging strongly because of changes in people's lifestyles and eating habits, especially those of people in urban areas. The disease table is dominated by cardiovascular diseases, cancers, accidents, and traumas. These diseases represent about 14% of the illness weight and 23.3% of general mortality. As concerns mother and child health, infant and the juvenile mortality rate has gone from 144‰ to 103‰ living births between 2004 and 2014, while maternal mortality has gone from 430 to 782 deaths per 100 000 living births between 2004 and 2011. Potentially epidemic diseases (cholera, meningococcal cerebrospinal meningitis, yellow fever, measles), worsen the morbidity and mortality of the population from time to time, even though some of them have decreased over the 2011-2015 period. The upsurge of health emergencies is generally related to epidemics, traumas, movements of populations, and floods. Food insecurity due to the Sahel crisis, armed conflicts and terrorist attacks in the Far North region, and the influx of refugees running away from armed conflicts in the CAR and Nigeria, also

constitute other humanitarian crises.

### Annex 4: Overview of the Cameroonian Health System

| | |
|---|---|
| WHO region | Africa |
| World Bank income group | Lower-middle-income |
| **Child health** | |
| Infants are exclusively breastfed for the first six months of life (%) (2014) | 28.2 |
| Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%) (2016) | 85 |
| **Demographic and socioeconomic statistics** | |
| Life expectancy at birth (years) (2015) | 57.3 (Both sexes)<br>58.6 (Female)<br>55.9 (Male) |
| Population (in thousands) total (2015) | 23344.2 |
| % Population under 15 (2015) | 42.5 |
| % Population over 60 (2015) | 4.8 |
| Poverty headcount ratio at $1.25 a day (PPP) (% of the population) (2007) | 9.6 |
| Literacy rate among adults aged >= 15 years (%) (2007-2012) | 71 |
| Gender Inequality Index rank (2014) | 132 |
| Human Development Index rank (2014) | 153 |
| **Health systems** | |
| Total expenditure on health as a percentage of gross domestic product (2014) | 4.10 |
| Private expenditure on health as a percentage of total expenditure on health (2014) | 77.13 |
| General government expenditure on health as a percentage of total government expenditure (2014) | 4.26 |
| Physicians density (per 1000 population) (2010) | 0.083 |
| Nursing and midwifery personnel density (per 1000 population) (2010) | 0.52 |
| **Mortality and global health estimates** | |
| Neonatal mortality rate (per 1000 live births) (2016) | 23.9 [17.3-32.6] |
| Under-five mortality rate (probability of dying by age 5 per 1000 live births) (2016) | 79.7 [61.9-102.9] |
| Maternal mortality ratio (per 100 000 live births) (2015) | 596 [ 440 - 881] |
| Births attended by skilled health personnel (%) (2014) | 64.7 |

| Public health and environment | |
|---|---|
| Population using safely managed sanitation services (%) () | |
| Population using safely managed drinking water services (%) () | |

**Annex 5: The World Health Organization Cooperation strategy agenda 2017-2020**

WHO COUNTRY COOPERATION STRATEGIC AGENDA (2017–2020)

Strategic Priorities Main Focus Areas for WHO Cooperation

STRATEGIC PRIORITY 1:

Support for the fight against communicable and non-communicable diseases •

Improvement of access to interventions contributing to the morbidity and mortality of priority communicable diseases (HIV-AIDS, tuberculosis, malaria, hepatitis) following the indications of world strategies for the fight against those diseases

• Improvement of support for the implementation and monitoring of interventions for the fight against neglected tropical diseases (NTD)

• Improvement of access to systematic vaccination for populations with low vaccination coverage, and implementation and monitoring of activities for the elimination of measles and rubella

• Improvement of access to interventions aiming at preventing and taking care of non-communicable diseases and traumas (including mental disorders and problems related to the consumption of psychoactive substances), as well as the risk factors of those illnesses (including nutritional ones)

STRATEGIC PRIORITY 2:

Improvement of health indicators at all stages of life and promotion of safe behavior •

Broadening of access to interventions aiming at improving the health of women

• Broadening of access to interventions aiming at improving the health of the newly born baby, the child, and the adolescent

• Promotion of safe behavior and environment for the conservation of health at all stages of life, including aging in good health.

STRATEGIC PRIORITY 3:

Improvement of health security

- Surveillance of epidemiologic tendencies at the different levels of the health pyramid
- Implementation of the 2015 International Health Regulation
- Implementation of the WHO program for the management of health emergencies at the country level
- Support the country for the effective implementation of the plan for the eradication of polio

STRATEGIC PRIORITY 4:

Strengthening of the health system

- Support the country in the design of strategic documents, norms, and criteria to make the health system viable and procedures for the management of health programs
- Support to the country for the improvement of service and care packages targeting the person at the peripheral level of the health system
- Support for the integration of the different health information systems for the harmonization of the collection and treatment of health data
- Improvement of the supply of essential medicines, vaccines, blood products, and other safe, efficient, and adapted health technologies
- Improvement of communication in matters of public health

STRATEGIC PRIORITY 5:

Efficient and results-oriented WHO team

- Improved coordination of health partners
- Training of WHO staff in the framework of the transformation program, the mobilization of funding, the new policy for the management of emergencies, and other topics permitting the improvement of their performances
- Improvement of the system for the evaluation of the performances of staff
- Improvement of measures for the monitoring of the management of programs, logistics, equipment, and different materials, ICT, and finances
- Elaboration of security measures within the premises and during WHO intervention.

**Annex 6: Cameroon Country Report**

Data collected by PASCAR for the World Heart Federation's Cardiovascular Diseases Scorecard project in Africa are presented. We summarize the strengths, threats, weaknesses, and priorities identified from the collected data, which need to be considered in conjunction with the associated sections in the accompanying infographic. Data sets that were used include open-source data from the World Bank, World Health Organization, and government publications. *Cardiovasc J Afr* 2020; **31**: 103–110 DOI: 10-5830-CVJA-2020-015 On behalf of the World Heart Federation (WHF), the Pan-African Society of Cardiology (PASCAR) coordinated data collection and reporting for the country-level Cardiovascular Diseases (CVD) Scorecard to be used in Africa.[1] The objective of the scorecard is to create a clear picture of the current state of CVD prevention, control, and management, along with related non-communicable diseases (NCD) in 12 African countries. The Cameroon Cardiac Society, a member of PASCAR and the WHF, along with Professors Dzudie (scientific secretary) and Kingue (president), assisted in collating and verifying these data.

Part A: Demographics.

According to the World Bank (2018), Cameroon is a lower-middle-income country with 44% of its people living in rural areas. In 2014, 23.8% of the population was living below the US$1.9-a-day ratio. Life expectancy at birth in 2018 was 58 and 60 years for men and women, respectively. The general government health expenditure was 0.6% of the gross domestic product (GDP) in 2017, while the country GDP per capita was US$1 533.7 in 2018. Department of Internal Medicine, Yaoundé Faculty of Medicine and Biomedical Sciences, Yaoundé, Cameroon Anastase Dzudie, MD Samuel Kingue, MD Pan-African Society of Cardiology, Cape Town, South Africa Part B: National cardiovascular disease epidemic. The national response to CVD and NCD. In 2012, Cameroon's premature death rate attributable to CVD (age 30–70 years) was similar to its neighboring country, Nigeria, at 12%.[3] In 2017, the age-standardized total CVD deathrate was high at 11.85%, although much lower than the 31.8% for the global burden of disease (GBD) data. The percentage of disability-adjusted life years (DALYs) resulting from CVD for men and women was 5.0 and 5.03%, respectively, which is lower than the GBD at 14.66% for both genders. The prevalence of atrial fibrillation (AF) and atrial flutter was 0.13%, while that of rheumatic heart disease (RHD) was 0.78%, which is higher when compared to the GBD RHD prevalence of 0.53%. The total RHD mortality rate was 0.02% of all deaths, which is lower than the GBD data (0.51%).

**Tobacco and alcohol.**

The prevalence of tobacco use in adult men and women (15+ years old) was 43.8 and 0.9%, respectively. Comparative Global Health Observatory (GHO) data are 36.1% for men and 6.8% for women. No data are available for adolescent tobacco use (13–15 years old) and the estimated annual direct cost of tobacco use is also not known. The premature CVD mortality rate attributable to tobacco is 2% of the total mortality rate, which is much lower than that of the global 10%. The three-year (2015–17) average recorded alcohol consumption per capita (15+ years) was 6.5 liters (Table 1).

**Raised blood pressure and cholesterol.**

In 2015, 31.3% of men and 30.8% of women had raised blood pressure (BP) levels (systolic BP ≥ 140 mmHg or diastolic BP ≥ 90 mmHg), which is higher than the GHO level of 24.1 and 20.1% for men and women, respectively, and Africa's 27.4% for both. In a screening study, only 31.7% of participants were found to be aware of their hypertension status, 59.9% of them were on treatment, and of these, 24.6% had controlled BP levels. In another study, Kingue *et al*. found a prevalence of 29.7%, with 14.1% awareness. The percentage of individuals with raised total cholesterol levels (≥ 5.0 mmol/l or currently being on medication for raised cholesterol) was 26% compared to GHO data (38.9%). In 2017, the percentage of DALYs lost because of hypertension was 3.14%, whereas the mortality rate caused by hypertensive heart disease (0.64%) was lower than the 1.65% for global data (Table 1).[4] Physical activity. No data were available for 11–17-year-old adolescents who were insufficiently active (< 60 minutes of moderate- to vigorous-intensity physical activity daily). However, the age-standardized estimate for adults who were insufficiently active (< 150 minutes of moderate-intensity physical activity per week, or < 75 minutes of vigorous-intensity physical activity per week) was 28.5%, which is higher than GHO data at 27.5

**Overweight and obesity.**

In 2017, the prevalence of overweight [body mass index (BMI) ≥25 to < 30 kg/m$^2$] in adult men 25 years and older was 15.3% and in women 19.4% (May measurement month 2017 unpublished, permission granted). For obesity (BMI ≥ 30 kg/m$^2$), the prevalence was 7.7 and 18%, for men and women, respectively (May measurement month 2017 unpublished, permission granted). Cameroon's obesity prevalence for adults is lower (12.9%) compared to the global prevalence of 13.1%, as is that for the prevalence of overweight at 17.3 versus 38.9% globally (Table 1) Diabetes. The percentage of the population (adults 18 years and older) defined with fasting glucose ≥ 7.0 mmol/l or on medication for raised blood glucose levels (age-standardized) in 2014 was 6.5% for men and 6.9% for women.[5] In 2019, the prevalence of

age-adjusted (20–79 years) diabetes was 6.0%, which is higher than that of Africa (3.9%) but lower than the global level of 9.3% (Table 1).

**Part C: Clinical practice and guidelines Health system capacity**

The country had 0.9 physicians and 0.058 nurses per 10 000 of the population in 2011 and 2013, respectively, while there were 13hospital beds for every 10 000 people in 2010.[10] No data for locally relevant clinical tools to assess CVD risk or national guidelines for the treatment of tobacco dependence were available by 2018.[11] However, locally relevant clinical guidelines for the management of acute rheumatic fever (ARF) and RHD are available. Cameroon is involved in the INVICTUS (Investigation of Rheumatic Atrial Fibrillation Treatment using Vitamin K Antagonist, Rivaroxaban or Aspirin Studies) clinical trial, a comprehensive evaluation of RHD, including a multi-center hospital-based registry. Cameroon was one of 12 sub-Saharan countries that participated in the VALVAFRIC study, a multi-center international hospital-based. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city, or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement. This publication does not necessarily represent the decisions or policies of WHO.

WHO/CCU/18.02/Cameroon Updated May 2018.

**Annex 7: The Cameroon Health System Capacity**

The detection and management of atrial fibrillation. The detection and management of acute rheumatic fever. The detection and management of rheumatic heart disease. The detection and management of diabetes. CVD prevention (within the last 5 years). A system to measure the quality of care provided to people who have suffered acute cardiac events. Cardiovascular Disease Governance A national strategy or plan that addresses: CVDs and their specific risk factors. NCD and their risk factors. Rheumatic heart disease prevention and control as a priority. A national surveillance system that includes CVDs and their risk factors. Stakeholder action Non-governmental organizations' advocacy for CVD policies and programs. Civil society is involved in developing and implementing of national CVD prevention and control plan.

WHO NCD Document repository

Country-specific publications

Retrospective registry of hospitalized RHD patients with valvularlesions. International guidelines are followed regarding the detection and management of AF and pharyngitis.

Cameroon does have national guidelines on diabetes mellitus management or treatment. **Essential medicines and interventions** The availability and affordability of essential CVD medicines were investigated in a study by Jingi *et al*. Availability was higher in the urban informal sector, with 63.6% of these medicines available. Aspirin was the most affordable medicine and available at 70% of the study sites. Metformin and insulin are not generally available in the public health sector. Warfarin, clopidogrel, ACE inhibitors, beta-blockers, and statins, which are mostly unaffordable, were not available. No data were available for CVD risk stratification in primary healthcare facilities, total cholesterol measurement at the primary healthcare level, and secondary prevention of ARF and RHD in public sector health facilities.

**Secondary prevention and management.**

Of the hypertensive persons, 11.5% are receiving medical treatment, while oral anticoagulants are prescribed in 34.2% of high-risk patients with AF. The percentage of people with a history of CVD taking aspirin, statins and at least one antihypertensive agent is unknown. Part D: Cardiovascular disease governance. The National Integrated and Multi-sector Strategic Plan for the Control of Chronic NCD (NIMSPC-CNCD) of 2011–2015 included CVD and risk factors, such as hypertension, diabetes, tobacco use, unhealthy diets, physical inactivity, and the harmful use of alcohol. Although a unit for NCD is in place in the Ministry of Health, no dedicated budget is available to ensure implementation. Preventing and controlling RHD as a priority in Cameroon was also included in the NIMSPC-CNCD, but this plan was never published or distributed. Ten-year NCD/CVD surveillance programs have been reported, based on the STEPS approach and others. However, a more comprehensive surveillance system for NCD was suggested. Cameroon follows the World Health Organization (WHO) best-buy policies regarding tobacco use and has formulated a national tobacco control plan and multi-sectoral coordination mechanism for tobacco control. Developing the National Health Development Plan (NHDP) 2016–2020 was a collaborative project between the Ministry of Health and non-health ministries, which included NCD, of which CVD is prominent. The health system is severely underfunded with NCD not prioritized and therefore affecting dedicated CVD funding, which has to rely on privately funded donors and out-of-pocket payments. Cameroon was part of the WHO-CHOICE project, which incorporated a cost-effectiveness modelling tool that gathers national data to be used for developing the most effective interventions for leading causes of disease burden. The model can be adjusted according to the specific needs of the country and assist policymakers in planning and prioritizing services at a national level. Assessment of policy response Legislation that mandates health financing for CVD/NCD is lacking, as is that of essential CVD medicines at affordable prices. Jingi *et al*. noted aspirin was the most affordable CVD medicine with 70% availability and suggested improving access to affordable

medicines through policy options, which include cost containment and promoting generics. No judicial orders protecting patients' rights and mandating improved CVD interventions, facilities, health-system procedures, or resources have been implemented, although a few policies address individual interventions, such as tobacco and alcohol use, and physical activity. According to Cameroon's Framework Convention on Tobacco Control (FCTC) report, tobacco policy addressed the creation of smoke-free zones, warnings on tobacco products, a ban on advertising, and tax increases. There were no measures to protect tobacco control policies from tobacco industry interference. The country does not have policies that ensure equitable nationwide access to healthcare professionals and facilities or screening of high-risk CVD individuals. However, the public sector provides most of the healthcare, which is burdened by a lack of funding. Sustainable funding is also not available for CVD from taxation of tobacco and/or other 'sin' products. There are no taxes on unhealthy foods or sugar-sweetened beverages. The percentage of the excise tax of the final consumer price of tobacco products in Cameroon was 19%, while that of the final consumer price of alcohol products was rated 25% in 2015. No legislation exists on banning the marketing of unhealthy foods to minors or mandating clear and visible warnings on foods that are high in calories/sugar/saturated fats. Cameroon developed a food and nutrition policy to improve food and nutrition, as well as one that addressed physical inactivity through mass media awareness.

**Stakeholder action.**

In Cameroon, non-governmental organization (NGO) advocacy for CVD policies and programs as such has not been demonstrated. However, NGO involvement in NCD policies has been reported, for example, the multi-sectoral expert group on tobacco. Clinical Research Education, Networking, and Consultancy (CRENC) is the most active cardiovascular research organization in the country. Its primary goal is to educate young researchers, linking them and translating research findings into practice to improve healthcare programs and improve the well-being of people. The Cameroon Heart Foundation and the Foundation Coeur et Vie also play an active role in Cameroon. No involvement of patients' organizations in the advocacy for CVD/NCD prevention and management has been reported, and no evidence was found regarding advocacy champions and/or patient engagement for RHD groups. The involvement of civil society organizations (CSO), such as the National Multi-sectoral Committee for Tobacco Control, in the development and implementation of a national tobacco control plan was mentioned in the FCTC report. Cameroon contributed to the Mapping of NCD Civil Society Organisations in Francophone sub-Saharan Africa, initiated by the NCD alliance with a focus on NCD, more specifically diabetes and CVD. CSO involvement in the national multi-sectoral coordination mechanism for NCD/CVD was documented by Juma *et al.* An example is the

Cameroon Civil Society NCD Alliance that empowers CSO through capacity building, unified action and stakeholder consultations, along with promoting evidence-based advocacy in preventing and controlling NCD. No specific activities by cardiology professional associations were reported that aim at a 25% reduction in premature CVD mortality rateby 2025, although Cameroon was represented at the 65th WorldHealth Assembly in 2019. BP screening by businesses has proved to be an effective strategy in early detection and monitoring of hypertension. However, in Cameroon BP screening has not yetbeen addressed. Based on the data collected for Cameroon, the following strengths, threats, weaknesses, and priorities are summarised.

**Strengths**

Cameroon ratified the WHO FCTC in 2006, which motivated the development of policies to curb tobacco use and control NCD. Taxation of cigarettes also emerged from the FCTC. Policies that address WHO best-buy interventions include thoseon the prevention of tobacco and alcohol use as well as physical inactivity and inadequate nutrition. Promoting physical activitythrough mass media and public education and awareness has been reported. The CAMBoD (Cameroon Burden of Diabetes) survey provided data for implementing a program on diabetes and hypertension as these risk factors had emerged as public health problems.[35] May measurement month (MMM), an initiative started by the International Society of Hypertension is a cross-sectional BP survey of volunteer adults age ≥ 18 years. Screening at public locations, including sponsorship from business entities, requesting their corporate responsibility, is promoted. Organisations co-ordinating the MMM in Cameroon are the Cameroon Cardiac Society (CCS), CRENC, a non-profit research organization, and the Fondation Coeur et Vie. Upgrading of the Shisong Cardiac Centre at St Elizabeth Catholic General Hospital ensured improved treatment of patients with heart diseases. Total CVD death rates were lowerthan other West African countries, Mauritania (16.6%) and Senegal (16.9%), but higher than that of bordering Nigeria(7.7%)

**Threats**

Cameroon with its high mortality rate attributable to infectious diseases, inadequate health system characterized by absence of health insurance, and lack of healthcare professionals, is also burdened by an increase in NCD and specifically CVD.[35] Increasedrisk factors are obesity, hypertension, and hyperglycemia, with heart failure (HF) being the most significant form of CVD impacting on young, economically active individuals. In urban Cameroon, the hypertension prevalence is high, with very low awareness, which is attributed to the rapid urbanization along with high obesity, physical inactivity, diabetes rates, increased salt consumption, and tobacco use. In hypertensive patients, HF is common and often associated

with co-morbidities. Hypertension accounted for 43.9 and 54.49% ofHF in sub-Saharan Africa (SSA) and Cameroon, respectively. Ina hospital study, HF was the reason for 5.77% of all admissions at the turn of the century, with a prevalence of 30% and an overall mortality rate of 9.03%. RHD also remains a significant cause of HF in SSA and is the third most common cause of HFafter hypertension and cardiomyopathies. Recent data from another hospital-based study confirmed hypertension (54.79%) to be the foremost risk factor associated with HF, along with diabetes (17.12%) and smoking (15.75%), as the most common co-morbidities. As elsewhere in Africa, HF carries a poorprognosis with one out of five patients with HF in Cameroon dying, and one out of four hospitalized within one year. The rising burden of hypertension among people living with HIV/AIDS is another threat, with at least 20% of HIV-infected individuals found to be hypertensive. As in the general population,awareness, detection, treatment, and control of hypertension are inadequate in these people.

**Weaknesses**

Although the NIMSPC-CNCD was developed as a reference document for preventing and controlling NCD, it was never implemented as a comprehensive, preventative intervention strategy. In the early 2000s, national programs were introduced with a focus on controlling hypertension, CVD, diabetes and other NCD. Discrepancies among the varioustobacco control policies regarding implementation also exist, possibly because of the absence of a comprehensive tobacco- prevention control program. As in most sub-Saharan countries, funding for health is insufficient, and no national strategy is available to secure funds. Only in the 2016–2027 health sector strategy paperwere funds allocated for NCD prevention and control, and optimal management of these resources could be sacrificed as there is no national multi-sectoral committee on NCD. The NCD prevention policy is hampered by the absence of effective monitoring and evaluation plans, causing a risk of neglect. No autonomous system exists for regulation of the pharmaceutical sector, allowing quality medical products at affordable prices. Although policies have been developed and the government showed interest in establishing an NCD unit in the Ministry of Public Health, no implementation is seen regarding regulations intended for alcohol, physical activity, and diet. According to recent data, no community screening of RHD has been done in Cameroon. Therefore, the true prevalence of RHD is possibly higher than recorded because patients are morelikely to seek medical attention only when symptoms present.

Baptist Hospital,Bamenda, to increase accessto HIV management forchildren and adolescents Practice 3:"Community Conversation": an effective practice to improve the use ofRH/PMTCT services in the Lolodorf Health Area, South Cameroon. TUBERCULOSIS. In Cameroon, the National Tuberculosis Control Programme set the goal of screening more patients by

targeting vulnerable groups (HIV+, inpatients, children, refugees, and displaced populations). During the year 2016, the WHO office in Cameroon provided a consultant to evaluate the National Tuberculosis Control Programme and provided technical support for the implementation of pharmacovigilance for the use of two new anti-tuberculosis drugs (Bedaquiline and Delamanide). The office also provided technical assistance to Equatorial Guinea in organizing the management of multidrug-resistant tuberculosis and facilitated the signing of an MOU for collaboration between the programs of the two countries.

A seasonal malaria chemoprevention campaign was organized in the North and Far North regionsto address the regular increase of malaria cases during the rainy season in these regions. In 2015, malaria morbidity was 37 % in the Far North region and 35 % in the North Region for a national average of 30 %; hospital malaria mortality rates were 39% and 37 % respectively for a national average of19 %. Funded by the Ministry of Public Health, with technical support from WHO, UNICEF, and the involvement of national NGOs: Malaria No More, Plan Cameroon, Malaria Consortium - Cameroon Coalition Against Malaria (MC-CCAM), and Fresco, about 1,500,000 children aged 3 to 59 months received a monthly dose of Amodiaquine-Sulfadoxine Pyrimethamine in August, September and October 2016. If the expected targets, 85.6 % (1,326,366) of the children received the three treatment doses, 8.3 % (128,975) received two, 47,864, or 3.1 % received only one. Mortality dropped by 74 % and 59 % respectively in the Far North and North Regions compared to the previous years during the same period. The technical support of WHO was crucial, with the provision of a team of international experts.

Trachoma:

Of the 16 endemics HDs mapped in 2012, 5 HDs reached the interruption of trachoma transmission in 2014 and 2 in 2015. - 9 HDs continued the mass distribution ofAzithromycin in 2016 to which were added 2 new HDs with a prevalence between 5 -10% with a 95% treatment coverage and 1000 casesof trichiasis operated upon. 66%. The survey was conducted in 2016 and confirmed the end of lymphatic filariasis transmission in 31 health districts of the Far North and North Regions. The Regional Review Group of the NTD Control Programme that validated the survey report recommended continued treatment in co-endemic districts with onchocerciasis. VACCINE-PREVENTABLE DISEASES To support the country in the implementation of its national child immunization policy under the EPI, WHO provided the Ministry of Healthin 2016 with: Technical, financial and logistical support to respond to epidemics resulting from vaccine-preventable diseases; Funding of USD 23,316 for a survey on the reasons for non-vaccination of children in the large cities of Yaoundé and Douala, where about 64% of unvaccinated children are concentrated; USD 3,050,232,197 in support of eight additional immunization activities; Continuous financial support for epidemiological surveillance activities by surveillance focal points at all levels; Technical support for the preparation and

implementation of the activities of the regional routine EPI data validation meetings; Technical and financial support for the organization of the workshop on the use of DVDMT in health districts and their implementation, and the improvement of the EPI data management system in HDs, regions concerned and at the national level; Consultants to support surveillance andimmunization activities in 9 of the 10 regions of the country. Through the vaccination registries, consultants deployed in the country facilitated investigations and implementation of responses to the measles epidemic in 7 health districts, Lagdo, Ngaoundere rural, Tigner, Mbonge, Kolofata, Mora, and Poli. These various response campaigns resulted in the vaccination of 109,771 children aged 9 months to 15 years on an initial target of 101,990, which helped to stop these epidemics.

As part of preventive actions, WHO facilitated the organization of two rounds of Maternal and Child Health and Nutrition Action Weeks (MCHNAW) intending to provide high-impact interventions on the survival of women and children, and promote the benefits of immunization at all ages. The first round took place in April throughout thecountry and a second in December in six regions (Adamawa, East, North, Far North, West, North-West). Five of them received funding from WHO for Local Polio Immunization Days. Finally, switching from tOPV to bOPV in the EPI wasdone in April 2016 under the "Switch" framework. At the end of the first MCHNAW held in April 2016, 6,051,878 (97%) children aged 0 -59 months were vaccinated against polio on a target of 6,221,136 and 5,221,778 (92.9%) children aged 6 - 59 months supplemented withvitamin A and 4,654,470 (93%) children aged 12 - 59 months dewormed with Mebendazole. The second MCHNAW organized in 6 regions helped to supplement 3,448,436 children aged 6 - 59 months in VITAfor a target of 3,569,009 children. In addition, 3, 072,485 children aged 12 - 59 months were dewormed for a targetof 3,179,647 children.

As part of routine EPI and data management, training offered by WHO to district management teams on the mastery of DVDMT made it possible to generalize its use for reporting immunization data and improving the completeness of the data in general and particularly that of the health facilities that vaccinate. The country has not been able to achieve the objectives assigned to the routine EPI, that is, 90% national coverage and 80 % of HDs with at least 80 % IC in DTP3. The IC in PENTA 3 was about 83 % in 2016 compared to 84% in 2015 during the same period (January-December) and only 4 regions (Adamawa, East, North, and West) reached the 90 % recommended this year. The Littoral and Northwest regions recorded the lowest performances in Penta 3 with less than 70 % of immunization coverage. Immunization coverage in large cities continues to be problematic and is hampering the country's overall performance. The study on the reasons for the non-vaccination ofchildren in the cities of Yaoundéand Douala under routine EPI revealed that there are almost20 points of difference betweenthe administrative coverage of these cities and that found in thefield. EPI data recording systemin these districts does not fully capture vaccinated childrenwho attended several differenthealth facilities. To fill this gap,

WHO, in collaboration with theMinistry of Health, has set up apilot project for electronic registration of vaccinated children inroutine EPI pending funding.With this system, all children visiting a health facility in the pilot city will be registered. Overall, performance improved for five anti- gens compared to the same period in 2015. Results of the last two antigens introduced into routine EPI (Rota 2 and IPV) were better in 2016 although still below 90% required by GVAP. The large gap observed in IPV between 2015 and 2016 is explained by its introduction in mid-2015 and therefore some children were not able to benefit from the vaccine at the beginning of the year.

NONCOMMUNICABLE DISEASES

WHO provided technical and financial support for the 6th round of data collection for the Global Tobacco Control report as well as for the 2016 Alcohol Data Collection Survey. WHO Country Office also provided technical and financial support for World No Tobacco Day and World Health Day, celebrated on 7 April 2016 on the fight against diabetes theme.

NUTRITION

Technical and financial support from WHO helped to strengthen interventions to monitor growthin children under 5 years of age through the training of 10 national trainers and 50 health workersfrom 15 health facilities with large attendance, and the development and dissemination of 3 visual aids (posters) on monitoring the growth of children. Scaling up this surveillance will ensure the detection and early management of malnourished and/or HIV-infected children. Parallel with these actions, WHO collaborated with other agencies of the United Nations system and civilsociety organizations to develop the Action Plan and the 2017-2021 Common Results Framework for Nutrition in Cameroon.

## 4.1NATIONAL HEALTH POLICIES, STRATEGIES, AND PLANS

In Cameroon, the health system is essentially markedby the adoption in January 2016 of the 2016-2027 Health Sector Strategy and the development of the 2016-2020 National Health Development Plan (NHDP) as well as its monitoring/evaluation plan beingfinalized. For the realization of these strategic documents,WHO made consultants available to the MOH and provided financial support for the start of the implementationactivities of the 2016-2027 Health Sector Strategy. WHOalso supported the validation of the frameworks of theHealth District Development Plans (HDDP) and the Regional Consolidated Health Development Plans (RCHDP) as well as the development of a simplified computer application in line with the policies of the HDDP and theRCHDP. In addition, WHO support continued through the training of a pool of national and regional trainers on thetools and methodology used for the development of the DDP and RCHDP. Through the technical and financial support of WHO, OASIS's study to assess Cameroon's health financing system and propose options and changes to improve its performance was carried out. This

study showed a great fragmentation in the three functions of health financing and a very low impactin terms of the population covered and the package of services offered. It recommends the development of a coherent strategy for health financing, on the one hand, greater mobilization of resources and risk pooling, and on the other hand, guaranteeing an essential packageof health services to the largest number and especially the most vulnerable. Through this same support, the study on the architecture of health financing in Cameroon was carriedout and the scenario retained validated. The recommended architecture takes into account the national context, past experiences with health protection in Cameroon, and lessons learned from international experiences. This scenario is based on the introduction of a compulsory basic system for the general population by offering a basket of common care and, on the other hand, the pooling of financial resources and certain technical functions within a national management structure with local task shifting (purchase, control of services) to specialized institutions.

ACCESS TO DRUGS AND HEALTH TECHNOLOGIESAND STRENGTHENING REGULATORY MEANS WHO contributed to the financing of the pre-assessment mission of 3 laboratories for inclusion in the SLIPTA accreditation process. The Country Office also provided technical and financial support to the high-level conference of ministers in charge of health in the CEMAC zone. The meeting resulted in the adoption by the Ministers of the 2016-2020 plan of action on the coordinated control of counterfeit drugs and illicit channels in CEMAC countries. Technical and financial support was also provided for the validation of normative documents on pharmacovigilance, the validation and translation of the national strategic plan for the development of medical analysis laboratories, and the revision of the National Blood Transfusion Strategic Plan. WHO also contributed to strengthening quality management in the laboratory of viral hemorrhagic fevers (CentrePasteur of Cameroun) and the National Public Health Laboratory. In addition, WHO facilitated the printing of documents on the Guide to the Management and Destruction of Drugs and other Pharmaceutical Products unsuitable for consumption as well as the National Strategic Plan for the Development of Medical Analysis Laboratories. INFORMATION AND DATA ON HEALTH SYSTEMS.

During the year 2016, WHO Regional Office for Africa launched a specific program in somecountry offices, including Cameroon, related to the strategic information system and the African Health Observatory, to strengthen support to the country in the production and dissemination of health information for decision-making in public health (Evidence-based for decision making). To this end, the WHO Office of Cameroon provided technical and financial support for the launching ofthe Cameroon Health Data Collaborative, a collaboration and sharing platform for health data actors and producers in Cameroon. The official launch took place on 21 December 2016 at the Hilton Hotel by the Representative of the Minister of Public Health. Concerning the dissemination of the DHIS2, two executives from the Health Information Unitof the Ministry of

Public Health were trained at the DHIS2 academy of French-speaking countries in Lomé. In addition, Cameroon's 2016 health profile was achieved through technical and financial support from WHO to the National Public Health Observatory (NPHO).The bureau provided support for the training of two senior staff of the directorate of Family Planning and the Health Information Unit of the Ministry of Public Health on the codification of the causes of death SMOL-10 (Startup Mortality LIst)». This training took place in Tanzania. The Country Office also invested in the design and validation of the data collection tools of the Chemoprevention of seasonal malaria (CPS) campaign and the realization of the situation analysis and the road- map of the National Public Health Observatory (NPHO) with a view to its revitalization. The Office also provided support to the National Civil Status Bureau (BUNEC) for the complementary evaluation of the Civil Registration and Vital Statistics (CRVS) in the mapping of its processes within the framework of the GFF, in drafting the national policy on the issue, and their Business Process Mapping (BPM) within the framework of the GFF. It also supported the drafting of the national strategic plan of BUNEC following the guidelines of APAI-CRV, and the surveysand collection of SMART, CAMPHIA, and Demographic dividend data. In addition, the WHO Office provided technical support for the follow-up of individuals and laboratoryresults during the avian influenza epidemic of May 2016.

### 5.1 ALERT AND INTERVENTION CAPACITIES

As part of emergency preparedness, WHO contributed to the analysis of the health risks of Cameroon aswell as the country's capacity to manage these risks, in collaboration with a dozen ministries involved in the management of disasters and health emergencies, several directorates of the Ministry of Public Healthand other partner organizations (CDC, MSF, Red Cross). This exercise continued with the capacity building of 349 actors in the Far North Region in Public Health Emergencies, notably in the preparation of hospitalplans for the management of the mass influx of victims, training in first aid and war surgery followed by a simulation exercise. The trained personnel were able to better manage more than 500 injured victims of terrorist attacks in the Region during the year. In the Centre region, similar training was delivered to about 350 actors with a focus on managing mass influxes of casualties. This training led to better management of the train accident in Eséka in October, which resulted in 78 deaths and 597 injured persons, as well as better medical coverage of the 2016 Women's AFCON. Emergencies contributed to the strengthening of the health system in the East and Adamawa regions, which host more than 250,000 refugees. Hence, WHO supported thetraining in the management of health data of 19members of the health district teams in the Adamaoua Region. This training enabled the regionto improve its completeness of data transmissionand to analyze them at the district level beforetransmission. Support continued through the training of 40 trainers at the regional and health district levels in the use of flow charts, which facilitated the provision of these tools in health facilities in eastern Cameroon.

WHO also supported the training of 20 laboratory technicians from health facilities in the East-Adamawa emergency zone in the fixation and spreading of blades, resulting in a significant reduction in cases of the lost-to-follow-up TB treatment and improvingthe recruitment capacities of refugees placed on tuberculosis treatment. WHO supported the Regional Health Delegations of the East and Adamawa in the implementation of the second evaluation on the functionality of health facilities in the emergencyareas. It showed that the gaps remain persistent despite the improvements brought by the government with the support of partners. Thus, ofthe 40 health facilities surveyed, 40% had partiallydamaged buildings, 15% had no laboratory, 28% had no cold chain, 80% had no PEP kit and only4% had health personnel with the capacity tomanage rape survivors. In addition, only 1.8% of health personnel in the emergency area were trained in the management of mental health issues and psychosocial support. In the Far North Region, which has been under at-tack by the terrorist sect Boko Haram and whichhosts many Nigerian refugees and internally dis- placed persons, WHO supported the training of 170 community relay workers at the Minawao Refugee Camp in community-based epidemiological surveillance. 35 vaccination service providers from the camp and its surroundings: 14 pharmacy clerks from the health facilitiesof the Mokolo Health District including theMinawao Camp. 212 volunteers from the Cameroon Red Cross as part of the project to strengthencommunity surveillance in the 4 health districts of the Logone and Chari Division. This project helped improve the detectionof AFP cases in this division in 2016 (that is, 19 cases compared to only 3 cases detected in 2015).

MANAGEMENT CRISIS AND RISKS ASSOCIATED WITH EMERGENCIES

In line with the Global Polio Eradication Strategy, the Office contributed to the withdrawal and destruction of tOPV in the country's health facilities as part of the End Game. It also supported the vaccine response to casesof cVDPV and WPV in Nigeria; contributed to the improvement of the polio vaccination campaign data collection system at the national level; strengthened surveillance in border health districts with Nigeria including the 4 HDs of the Lake Chad Basin and the less performing health districts and large hospitals. It also contributed to the improvement of the system for archiving data on the investigation of AFP cases in the sites, the extension of environmental surveillance in new regions and the establishment of regional reception centers of AFP samples and other VPD cases, and support to the country in the development and implementation of tOPV Phase 2 containment activities. All these actions enabled Cameroon to successfully implement, within the framework of the Switch, the withdrawal, and destruction of tOPV in all health facilities that vaccinate in the country. The WHO data collection, summary, and analysis approach to obtain regular feedback (3 per day) during the independent evaluationenabled the presence of tOPV to be detected on time in the health facilities and to take swift corrective actionin the health areas, health districts or problem areas. All the bottles found were brought back for destruction. The discovery of new casesof WPV in Nigeria in May 2016 led Cameroon and the other countries in the Lake Chad basin to organize fivesynchronized

vaccination campaigns between August and December 2016 against WPV and a campaign to respond to the cVDPV type 2 in December 2016. WHO supported the operational technical costs of these campaigns, independent evaluations by an independent monitoring and LQAS, as well as the evaluation of the withdrawal of monovalent OPV type 2 from health facilities inthe four HDs concerned by the campaign. The administrative results ofthe five rounds of the polio campaigns were generally satisfactory because for all these campaigns at least 95% of the target population was reached. In addition, AFP surveillance showed that the reported cases had a sufficient level of immunity through the numberof vaccine doses received. By conducting detailed analyses of the results of these independent evaluations, less- performing HDswere identified and invited to review their strategies on the field during the campaigns. This allowedthe country to fall below the 5% threshold of missed children in households in April 2016 and to maintain it during the entire response. Through the technical support of WHO, the EPI can now have administrative data from thePolio campaigns by health areas at the national level. In addition to immunization response, WHO funded activities to strengthen AFP surveillance in the 17 border health districts with Nigeria in the northern part of the country. This activity had a training component where nearly 1,569 actors were trained (Figure xx) on VPD surveillance and retrospective retrieval of AFP cases. The results are found in the table below. **T**he support of WHO technicians inthe regions helped increase the level of validation of AFP cases in the country, from less than 30% in 2015to 65% by the end of 2016. Environmental monitoring of polio expanded from 3 to 7 regions with the enrollment of Adamawa, Far North, East,and South-West in 2016, and the number of sites increased from 16 to 30. Thefirst regions were the Centre, Littoral, andWest.Four regions opened regional samplereception centers (PREBs) (Littoral, East,Adamawa, and the Far North) through WHO advocacy. This should reduce thetime required to transport AFP samples. From the field to the laboratory and reach the standard of at least 80% of AFP samples reaching the laboratory within a maximum of 3 days. In 2016, WHO made FCFA 120 million available to the EPI for this activity. The archiving system of AFP investigation cases improved at the operational level in the country by the productionand dissemination of standardized registries with counterfoils of AFP surveillance forms and other vaccine- preventable diseases. With the retention of consultants in the field and the implementation of a deployment strategy based on the real needs in the field, the number of HDs without AFP notification reduced to its lowest level in 10 years. The regularity of site visitsand the regular monitoring of the work done by each consultant made it possible to get as many HDs out of the silence. The contribution of consultants is measured by thelevel reached in 2016 forthe main AFP surveillance indicators. The annual non-polio AFP rate was 8.3 (against 5.6 in 2015) andstool quality was 89.7% (against 86.1% in 2015). The country is approaching the 90% standard for stoolquality. Overall, there were136/189 (72%) HDs thatachieved the two major indicators of AFP surveillance against 104/189 (55%) in2015.

6.1 SUPPORT TO PROGRAMMES (Country Support Unit)

Throughout the year, the UHC unit provided administrative, logistical, and financial support for the implementation of activities. Their supportresulted in an implementation rate of 73 % ofthereceIvedfinancial resources, equalIng to USD15,096,853. Progress was made in terms of financial management and internalcontrol, improving theworkplace environment and security, human resources management, logistics, and information and communication technologies. The country support unit regularly monitored the Key Performance Indicators (KPIs), which improved significantly in areas such as finance, human resources (PMDS), donor reporting, and direct management of implementation. HUMAN RESOURCES. Over the year, the administration conducted the recruitment for several positions, including Programme Budget and Finance Assistant, IVE Programme logistician, NPO (National Health Observatory, NPO (DPC), and Human Resource Assistant. In addition, the HRs also supported the recruitment of SSAs, Consultants, and APIs. However, some essential positions are still occupied by SSAsor staff borrowed from other programs, notably traveland procurement assistant, and program assistant and logistician for the country support unit, all resulting in a significant increase in the burden of work. Two office staff members, Dr. MBAM MBAM and Mrs. ZOUA Jeanne went on retirement. To strengthen the cohesion of WHO staff to improve the performance of the WHO Cameroon Office, a staff retreat was organized in LIMBE from 24 to 26 March 2016. It enabled the identification of performance factors and the setting up of an internal CoachingTask Force. The Internal Coaches were trained to lead the roadmap for achieving high performance. Thus 4 teams were set up, to achieve a strategic axis :

Justification of funds (DFC/DI) Management of staff travel Human Resources Management Mobilization of resources. In addition to achieving the goals of the strategic axes, each team embodies and promotes values of excellence, humility, integrity, impartiality, and effective work ethic. FINANCIAL MANAGEMENT AND INTERNALCONTROL Resource Mobilization The office set up a resource mobilization task forcewhich mobilized USD 2, 811, 250. Two workshops were held during which 6 projectswere presented for funding, of which 4 were successful. At the end of 2016, an implementation rate of 73 %was achieved. Programmes Emergencies: 71.6% IVE: 28.4% Throughout 2016, funding for the activities of the Ministry of Health (DFC and DI) amounted to FCFA5,124,929,905, that is, USD 9,753,733, representing 75% of the expenses. This financial support was mainly achieved through Direct Transfer to the Ministry of Health (DFC): 117 DFC for a total amount ofXAF 4,748,022,564, that is, USD 9,112,465 Financial implementation by the Country Office (DI): 28 direct implementations for a total amount of FCFA 376, 907, 341,that is, USD 641, 268 Support through DirectImplementation decreasedby more than half. We had 151 DI for a total amount of USD 3,123,064 over the 2014-15 biennium. In 2016 we are at 28 DI. This is because the office issues DIs only for specific activities, such as those related to the implementation of

immunization campaigns and surveillance. Efforts were made by the Country Office in the transmission of the DI justifications. At the end of the year, there were 6 unjustified DIs, representing 78 % justification to which we must add the 65 unjustified DFCs from the previous years which were regularized during the year. On the other hand, DFC justification remains a major challenge; the number which remained unjustified was at 80 by the end of 2016. In terms of Internal Control, the office helped in: Strengthening the procurement committee and the development of the terms of reference with a clarified workflow process for procurement of goods and services ranging from expression of the need to delivery and payment. Improving empress management with the effective reconciliation of the Empress account and clearing of all outstanding items. Travel management remains a major challenge. In 2016, 777 TRs were issued of which 68% were less than10 days before travel. It must also be noted that there was an improvement in the submission of mandatory supporting documents, such as security clearances. The country office went from 10% of TRs with supporting documentation to 98% by the end of 2016. IMPROVEMENT OF THE WORKING ENVIRONMENT Maroua and Yaounde. Following the recommendations of the security officials in Geneva, the WHO Field Office in Maroua moved to new premises. The new offices were equipped and made functional, which improved safety and working conditions Opening a cyber café in the library re-opened its doors to students and researchers. To provide first aid in the event of malaise or slight discomfort, a first aid room was set up at the Yaounde office.

6.3 INFORMATION ANDCOMMUNICATION TECHNOLOGIES

In The area of ICT, several improvements have been made with the modernization of equipment and support to staff. Implementation of the "one staff one device"rule by replacing all old desktops with laptopswith dockings stations The availability of a cybercafé in the library, Fibre optic internet connection between the field offices of Maroua, Bertoua, and Douala, Introduction of an ultra-modern videoconferencing system in the Yaoundé office. Introduction of a videoconferencing system inDouala and Maroua offices. Program Support (Country Support Unit) Several GSM training workshops were organized to enable the staff to be familiarized with the new modules integrated into GSM. COMMUNICATION SUPPORT PROGRAMMES Communication activities were conducted across all the programs. Thus, during the avian influenza epidemic of May 2016, sensitization was carried out at the Mfoundi market, where 60 chicken sellers and23 chicken feather removers were engaged in sensitizing their peers. To strengthen routine immunization, transport unions posted 35,000 vaccination calendar stickersin taxis in Douala and Yaoundé. Concerning communication at the country office illuminated display signs,kakemonos, and bulletinboards were put in place. Several country office activities also benefitted from media coverage. HIV: The major obstacles and constraints that hampered WHO's actions are mainly decreased capacity and inadequate human resources at the Ministry of Health and the long deadlines for activities. TUBERCULOSIS: Low or no funding for TB

control activities; Poor access to GeneXpert for the diagnosis of tuberculosis in some risk groups (HIV+ persons,prison population, refugees, and children); Inadequate infection control in specialized multi-drug resistant tuberculosis treatment centers. NTDs: low availability of funds for scaling up screening and free treatment of NTDs, intensive case management (HAT, leprosy, Buruli ulcer, and leishmaniasis), whose mapping is not yet complete.

REPRODUCTIVE AND MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH: Growing insecurity linked to attacks by the terrorist sect Boko Haram in the Far North region, making it difficult to implement interventions Conflicts of the schedules of heads of Health Facilities. HEALTH SYSTEM Insufficient funding for HSS implementation activities; Insufficiency of staff in the Technical Secretariat of the Steering Committeeof the Health Sector Strategy. ACCESS TO MEDICINES AND HEALTH TECHNOLOGIES: Weak mobilization and motivation of the staff of the DPML and the NBTP for the timely realization of theprogrammed activities.
FACTUAL INFORMATION AND DATA ON HEALTH SYSTEMS: Still very low funding and not systematic in the monitoring and evaluation systems and health information, need for integration and convergence of program activities actions to achieve catalytic results that will impact theHIV/AIDS: Emphasis will be placed in 2017 on the intensification of the "Treat All" strategy, particularly concerning strengthening the links between PMTCT and ARV treatment as well as the retention of patients on ART.

Tuberculosis: In terms of TB control, the following three major interventions were envisaged: The mid-term review of the 2015-2019 NSPTBC; Intensification of active tuberculosis screening in vulnerable groups; Monitoring of the resistance of BK to anti-tuberculosis in all cases to have retreated.

**CURRICULUM VITAE**

serving as Chief of Service of the Social Cooperation and the Solidarity among the 88 members States of the International Organization of the Francophonie (OIF) at the Ministry of External Relations of Cameroon.

John Madi Madi is holding a double master's in International Relations, Option Diplomacy and Political Sciences with a degree obtained in International Relations Strategic and Political Studies.