Fostering stakeholders involvement for better governance and speeding up the development of health districts in Cameroon

Policy brief

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Acknowledgements
Funding
Global Health Research Initiative- International Development Research Centre – Ottawa, Canada
The Alliance for Health Policy and Systems Research (AHPSR) – Geneva, Switzerland
Conflicts of Interest
None
Internal Merit Review Process
This policy brief was reviewed by the research team of the Centre for Development of Best Practices in Health: Dr David Yondo, Dr François Colin Nkoa, Dr Jean Serge Ndongo, Mrs Cécile Renée Bonono-Momnougui.

PREAMBLE

The Centre for Development of Best Practices in Health (CDBPH) is a research unit established in June 2008 at the Yaoundé Central Hospital to foster Knowledge Translation and Exchange for Better Health in Africa with the financial support of a Global Health Leadership Award from the Canadian Global Health Research Initiative administered by IDRC - Canada. CDBPH is a knowledge brokerage unit designed to link health researchers with health decision-makers. This initiative serve researchers by collecting, synthesizing, re-packaging, and communicating the relevant evidence in user-friendly terms that stakeholders at many different levels can interact with and understand. CDBPH also intends to serve health decision-makers by providing capacity building opportunities, providing evidence summaries and identifying needs and gaps related to Evidence to Practice.

This policy brief on enhancing stakeholders' involvement for better governance and health district development in Cameroon is the third product prepared by CDBPH to synthesize and communicate research evidence backing particular policy options for the consideration of decision-makers. The policy options discussed in this document are not mutually exclusive interventions; that is some or all of the options could be adapted concurrently as they are complementary strategies to enhance stakeholders' involvement for better governance of health district systems in Cameroon. We do not intend to recommend any particular option rather than any other. It is left to decision-makers to choose one particular policy option rather any other, or to recommend all the options as a whole according to the actual decision-making process with the relevant stakeholders.

Key messages

What is the problem?

Bad governance which explains the poor ranking of Cameroon in the "Doing Business" annual report by the World Bank also undermines the performance of the health sector in spite of the activities of the National Governance Programme that have been implemented since the year 2000. The health sector has become money-minded, to have access to care and services the patients have to pay beforehand; badly paid, the health personnel adopt survival methods such as informal payments, illicit sale of drugs, enticement of patients to private clinics; never are the resources generated by health facilities managed in a transparent way; the beneficiaries/users rarely have a say in the management committees and the health committees; contracting and procurement procedures of hospitals are lengthy and not very transparent; conflicts of interests and conspiracies are frequent among top executives of hospitals and chairs of management committees. Among the 20 sectors most concerned by corruption in Cameroon, the health sector ranks 9th according to Transparency International in 2006. Cameroon occupies the 153rd rank in the 2009 World Human Development Report.

Are there any effective strategies to enhance stakeholders' involvement for better governance and speeding up the development of health districts in Cameroon?

Option I: Strengthening social control mechanisms by providing the different actors of local development with access to information relating to the populations' health condition, health determinants, available resources and creating the enabling environment that will enhance the proper participation of local development actors in the processes of priority setting, planning, budgeting and monitoring-evaluating the implementation of health initiatives. Deliberative forums and other consultative processes engaging various stakeholders, and giving the opportunity to populations/members of the committees to question the local health executives, have proved to be efficient strategies.

Obstacles to implementation are i) resistance to change of some providers and members of the management committees and ii) conflicts of interests and conspiracies between health care providers and the members of management committees.

Implementation strategies could be i) sensitization of the interested parties on the stakes, the challenges and the beneficial effects of good governance and the development of health districts as well as the deleterious consequences of bad governance; ii) setting up consultative groups on ethics, equity and monitoring-evaluation of health activities; iii) building the capacity of the community leaders to get involved in health promotion activities; iv) strengthening the capacities of services providers to interact with the communities in a more transparent and responsible way; v) strengthening the National Health Information System in the sharing of information with development actors.

Option 2: Promoting the health risk-sharing mechanisms which allow the reduction of direct payments in hospitals during illness and consequently reduce opportunities for corruption; the introduction of a third party payer brings in a witness that can correct the asymmetry in the information provided, and regulate the relation between the caregiver and the care receiver.

Implementation barriers are i) the shortcomings of the current framework to promote community based health insurance, ii) the lack of awareness and the suspicion vis-à-vis the existing Mutual Health Insurances, iii) 40% of the population is poor and cannot afford to pay the subscription premiums and the annual contributions.

Strategies: i) information, education and communication on the advantages of health risk sharing mechanisms as a means of fighting poverty and an instrument of economic recovery; ii) involvement of the municipal councils in promoting Mutual Health Insurances and Federations of Mutual Heath Insurances; iii) subsidizing premiums to reduce financial barriers that make it difficult for vulnerable populations to become members of Mutual Health Insurances; iv) promotion of a national Health Insurance scheme.

Report

How the present note has been prepared?

1. Prepared by the Centre for Development of Good practices in Health (CDBPH), this note is the fruit of the cooperation with the Technical Secretariat of the Steering Committee in charge of monitoring the implementation of the SSS thanks to the grant-in-aid n° ID 49 from the Alliance for Health Policy and Systems Research (AHPSR) located at the WHO's headquarters in Geneva. The adopted procedure includes a review of the legal and regulatory administrative documents, the appraisal of the health sectorial policy, the National Governance Programme and scientific publications on governance in French and English, the decentralization and development of health districts in Africa and Latin America.

Who is concerned by this note?

2. This policy brief is intended to actors of health development in general and in particular to administrative authorities, politicians, elected and non elected executives of the municipalities, technical and financial partners of the health sector, the civil society organizations and community leaders. The ongoing process of the updating of the health sector strategy to adapt to the MDGs agenda of 2015 sets the district health system development as a priority and at the same time the State launches the transfer of public health authority to municipalities. This policy brief aims at providing actors of health district development with a synthesis of relevant evidence to inform decision-making for the implementation of the updated health sector strategy 2001 – 2015.

What is the problem?

3. Bad governance which explains the poor ranking of Cameroon in the World Bank's classification also has a negative impact on the performance of the health sector in spite of the activities of the National Governance Programme (NGP) that have been implemented since the year 2000. The health sector has become money-minded, to have access to care and services the patients have to pay beforehand; badly paid, the health personnel adopt survival methods such as informal payments, illicit sale of drugs, enticement of patients to private clinics; never are the resources generated by health institutions managed in a transparent way; the beneficiaries/users rarely have a say in the management committees and the health committees; contracting and procurement procedures in hospitals are lengthy and not very transparent; overinvoicing is almost the rule; conflicts of interests and conspiracies are frequent among top executives of hospitals and presidents of management committees.

4. In 2006, Transparency International classified the health sector at the 9th rank among the 20 sectors most concerned by corruption in Cameroon. Although a NGP was set up as far as the year 2000 and that several initiatives put in place the 1990 decade within the health sector, the mechanisms of good governance are still too theoretical for most actors of the health sector and the success stories of some districts have remained at the pilot stage. One of the major causes of this failure is the mitigated involvement of the stakeholders in health committees' activities according to the mid-term evaluation report of the Health Sector Strategy 2001-2010. The analysis of health districts performance within the framework of the 2007 Systemic Quality Improvement Contest reveals that governance components have the worst scores and correlate with overall district final score.

5. Meanwhile, 40% of the Cameroonian population lives beneath the financial poverty line and households have to pay more than 80% of the total bill for health care and services through direct payment as high as 93.7% when they are sick. These amounts are spent mainly in health districts governed by district health committees and management boards and district hospitals management boards theoretically composed of the different stakeholders. In principle, the planning of health activities is under the authority of health committees established at local health area and at the district levels. The aim of these committees is to ensure good governance in order to achieve more equitable and timely access to health care and services. The average per capita annual health expenditure is above the threshold recommended by the Commission on Macroeconomics and Health (i.e. 34 USD) (WHO 2001). Unfortunately, this expenditure does not reflect in the health indicators, thus demonstrating the inefficiency of the health sector attributable to poor governance whose direct consequence is the regression of Cameroon to the 153rd rank in the global report on human development (UNDP 2009).

What is Governance?

6. For **USAID** (United States Agency for International Development), governance is the capacity of governments to manage public affairs in an efficient and transparent way, with the involvement of citizens. The **DFID** (United Kingdom Department for International Development) defines governance as the process through which the institutions – executive, legislative, judiciary and military – act interactively from the central to the local level, thus allowing the State, the communities and the private sector to develop a transparent way of managing public affairs (DFID 2001). The UNDP (United Nations Development Program) views governance as "the economic, political and administrative management of a country at all levels". For the NGOs (Transparency International, 2006), the governance can be defined as a regulating method, a process aiming at coordinating the actions of stakeholders, particular social groups and institutions that work together to reach the goals defined and adopted collectively in comminuted and risky environments.

7. The **good governance** is a multidimensional management process that can promote a favorable and rewarding environment for all the partners. The World Bank recommends good governance among the criteria that define a good public administration in countries submitted to structural adjustment plans (World Bank, 2000). Good governance includes institutional reforms for a better visibility of public initiatives, a greater sense of accountability of the leaders and the mobilization of management competences. The supporters of deconcentrated and decentralized powers think that good governance is justified by the fact that the communities are in total control of the management of social services. Among the indicators chosen to account for the countries efforts in the domain of good governance, we can mention i) social control, ii) governance and ethics incentives, iii) participative mechanisms of planning, iv) monitoring-evaluation and v) public/private, transectoral or inter-institutions partnerships.

Why bother about good governance in health districts?

8. The **governance concept** has become very important in the international community agenda since the publication of the 2003 UNDP report on human development, which demonstrated the close correlation between bad governance and the poor human development index. Governance is thus perceived as essential in improving the management of public affairs and guaranteeing more equity in the access to basic public services, in particular through a better consideration and participation of the people concerned. The efforts made to enhance good governance and to fight corruption also pave the way for an improved performance of the health system and in particular to reach the health related MDGs, especially the reduction of maternal and child mortality and fight against endemic diseases. As a matter of fact, bad governance and corruption are very critical in the health sector in Cameroon and elsewhere and can be summarized by their negative impact on i) the access to health care (delayed access, inefficient and expensive remedies), ii) the quality of health care (motivation, misallocation of resources), iii) the mortality (failure to render assistance to persons in danger), iv) the confidence in health personnel and v) the organization of the health care system (failure to comply with the benchmarks).

9. The mid-term evaluation of the 2001 – 2010 strategy deplores the fact that, for many actors of the health sector, the mechanisms of good governance have never gone beyond the theories and the implementation of the initiatives to promote good governance have remained at the pilot stage in some districts, without switching over to best practices, especially as concerns planning, social control and monitoring-evaluation. The stakeholders have the feeling that the established dialog structures (health management boards and health committees) are not sufficiently equipped to carry out their assignments and roles. The analysis of health districts performance within the framework of the 2007 Systemic Quality Improvement Contest reveals that governance components have the worst scores and that there exist a relationship between the final score and the notes obtained in the governance components. The involvement of the stakeholders, especially the civil society and community representatives, is limited to the sole activities of social mobilization during term campaigns organized by health staff at the peripheral level (health districts and health local areas).

What is the framework of the health sector governance in Cameroon?

10. The Constitution of 18 January 1996 transformed Cameroon into a decentralized unitary State, assuming that decentralization promotes an effective and efficient participation of the populations in the management of public affairs. The National Governance Programme (NGP) attached to the Prime Minister's Office has been operational since the year 2000, and its mission is to promote a culture of accountability and transparency in the management of public affairs related to economic and sociocultural development. Since the issuing of the Order N° 0019/PM of 13 February 2003, the ministerial committees have taken the relay of the NGP; among other objectives, they aim i) to promote partnership between public/private/civil society sectors and a culture of accountability in the management of public affairs, ii) to improve transparency in the government machinery and iii) to fight against corruption. The framework law N° 96/03 of January 1996 on the orientation of the health sector entrenches the decentralization of public health initiatives with the health district as the operational unit in conformity with the framework of primary health care. In line with the spirit of the Alma Ata Declaration (1978) and resolutions of the Council of Health Ministers of the WHO African Regional Office held at Lusaka (1987) and the Bamako Initiative, the objective of the national health policy is to improve the populations' health condition through universal access to comprehensive quality health care, with the full participation of the communities to the management and the financing of health activities. The health district constitutes the cornerstone of the national health pyramid.

11. The main pillar of the health district system is the community participation to the design, planning, implementation and monitoring-evaluation of health activities. Besides promoting the decentralized management of health services in view of a greater involvement of the communities and health professionals to the financing and management of services, the law stresses on the necessity to develop the partnership between public authorities, the recipient communities and all the other stakeholders in the domain of health in order to tackle more rapidly the needs of the communities, bring greater transparency and accountability and less corruption while improving health care and services delivery.

12. The **decentralization of public health services** is embedded in the 1996 Constitution which devotes a whole chapter to decentralized territorial collectivities of the Republic and constitutes the foundation of the laws on decentralization enacted the 22 July 2004. The political agenda of the Head of State considers as priorities the promotion of democracy at local level, the birth of a performing local administration, and strengthening the autonomy of municipalities is seen as a guarantee for the full participation of the citizens to the management of municipalities. The principles governing the implementation of the decentralization process are the non-dissociation of the State global reform, the decentralization as a vector of social change, the prior deregulation of economic and social activities and the sustainability. Reforming local administration should involve the designation of the local executive, the functional autonomy and the decentralization which are synonyms of effective and efficient participation of the population to the management of public affairs and facilitating the emergence of democracy at the local level. The decentralization process is based on the principles of subsidiarity, equality and progressivity; each level of public interest must be managed by the nearest entity, and what cannot be managed efficiently should be transferred to the superior level. As a result of the scarcity of resources of the decentralized territorial collectivities, the principle of subsidiarity calls for a pragmatic implementation, the dispatching of competences depends on the effective capacity of the collectivities to carry them out, thus the requirement of a progressive implementation. The principle of equality requires that the State endows territorial collectivities of the same category with the same competences whatever their size or economic viability.

13. In the **health sector,** transfer concerns among other things, the creation, equipment, management and maintenance of municipal or regional health centers in conformity with the health map; the involvement in the organization and the management of essential drugs, reagents and medical devices supplies in conformity with the national health policy; the organization and management of the assistance to the needy. To ensure the supply of services and health care necessary to bring in the results that will contribute to reach these MDGs, the main production unit is the **viable health district** (VHD) whose optimal performance is essential. Because the district is the interface between the populations and the

health sector, it is the privileged site for the interventions of development partners and non governmental organizations. To be viable, a health district should dispose of a network of health facilities whose infrastructures and equipments meet the required standards, and of manpower quantitatively and qualitatively in compliance with the requirements imposed, given the context, by the implementation of the Minimum Package of Activities and the Complementary Package of Activities. **The development of the health district** is the process through which each health district must become technically, economically and institutionally autonomous. **Technical autonomy** is the capacity of the health system at district level to supply quality health care and services considering the concerns and expectations of the populations and the personnel. **Economic autonomy** is the capacity of the components of the district health system to defray all the costs, individually and collectively, with the generated incomes and other sources of financing. **Institutional autonomy** is the capacity of stakeholders to manage the health district in conformity with the role assigned to each of them. However, the founding principles of the primary health care – community involvement, multisectoral action, selection and availability of the appropriated technologies, equity and social justice – remain intangible.

14. The **legal and regulatory framework** of the health sector governance in Cameroon and especially of the health districts is based on more than a dozen texts among which:

i) Decree N°68-Df-Of 15th October 1968 laying down the structural organization and the organic operation of health establishments in Cameroon; published before the Alma-Ata Declaration and the Bamako Initiative, this text which describes the operation of hospitals from the first to the last echelon of hospital structure according to a geographic and medico-technical ranking does not include any reference to community involvement, nor to the concept of management committee.

ii) Decree N° 93-229-PM of 15th March 1993 laying down the conditions of management of the funds allocated for the operation of public health establishments. This decree sets down management committees whose members are representing the community, the caregivers, the mayors of municipalities covered by the hospital and the representatives of health and finance administrations.

iii) Decree N° 94/303/PM of 14th June 1994 laying down the conditions of allocating shares of the payments to some medical and paramedical staff working in public health establishments. Sections 5, 6 and 7 of this decree lay down the conditions of allocating shares to beneficiaries and provides for a support to initiatives aiming at improving the performance and productivity of some public health establishments, as well as the conditions of financing and managing the welfare fund.

iv) Decree N° 95/013 of 7th February 1995 organizing the basic health services in health district. Section 2 of this decree provides that the health district is a socioeconomic entity supplying quality health services accessible to all with the full participation of the beneficiaries. Section 3 also refers to the integration of dialogue structures and to community involvement in the health district.

v) Law N° 96/03 of 4th January 1996 making provision for a framework law in the health sector; besides the objective of the health national policy which is to improve the populations' health condition by enhancing universal accessibility to holistic and quality care with the full participation of the communities to the management and financing of health activities, the said law makes provision for the promotion of decentralized management of the health services in order to: i) further involve the communities and health professionals in the financing and management of the services; ii) streamline the health management system and the financing of the sector through the development of a partnership between the public authorities, the communities beneficiaries as well as all the other stakeholders in the domain of health, iii) marshal complementary resources and, iv) control expenses.

vi) Order N° 35-A-MSP-CAB of 8th October 1999 laying down the conditions of creation, organization and operation of health districts. Section 2 and 4 provide that the health district equates to an administrative unit and can cover several subdivisions. In view of its effective operation, a commission composed of representatives of the community, the health executives, the decentralized local collectivities and the territorial administration makes recommendations prior to any decision to establish a health district. Incidentally, there are ministerial notes organizing health committees and management committees at the health area, health district and region levels.

Who finances health expenditures in Cameroon?

15. The financing of health in Cameroon lies on the State and its partners and predominantly on the households who pay more than 80% of the health expenditures, 93.7% of which are paid directly during sickness. These amounts are spent in health districts placed under the responsibility of management committees, guarantors of good governance within the health district system. The average per capita annual expenditures on health in Cameroon are well above the threshold of 34 USD/year/capita recommended by the Macroeconomics and Health Commission (WHO 2001). Unfortunately, these expenditures do not reflect in the health indicators, essentially because of the inefficiency of the expenditure to such an extend that, on the 6% of the GDP spent for health purposes, the drugs and health care technologies represent more than 80%.

Who are the actors of governance at the health district level?

16. According to the arsenal of legal and regulatory texts, the actors of governance at the health district level are the administrative authorities, especially local representatives of Territorial Administration and Finance, local representatives of Education, Social Affairs, Women's Empowerment and Family, Water, Rural Development; the State health care and service providers, non-profit organizations and private for-profit sector; the representatives of communities organized in associations, CIGs and other development committees, high ranking politicians, traditional authorities. At the provincial level, the welfare fund to promote health, provincial committees to fight endemic diseases, at the level of the district: the district management board and the district health committee; at the level of the health area, the local health area committee.

How does bad governance show-up in the health sector?

17. The **performance of the health sector is undermined by bad governance** particularly in three aspects: i) the informal payments which bring a too heavy load on households, and particularly on the poorest; ii) irregular procurement practices, illicit sale of drugs, overpricing that pave the way for an inflation of the production costs of the care to be born by the patient and iii) a rather administrative approach of the management of districts focused on controls, non-transparent management of human resources, low salaries that frequently induce the actors into several forms of fraudulent use of public property.

18. In **public hospitals,** there are several forms of unethical practices: racketing – extortion through threats, violence or blackmail – nonofficial payments in public services – according to ECAM II fulfilled by NIS in 2003,the major form of corruption in the health sector the forced payment of non statutory medical expenses – unregistered billing – extra-billing of real or presumed complementary services for their supposed rapidity or quality – payment for services which in fact have not been rendered – for example, give results of analysis that have not been done – ask payments for services that are officially free of charge (mosquito nets, HIV screening) or subsidized (laboratory tests for PLHIV) or the issuing of fake medical certificates. *In 2006, these multiple forms of corruption brought Transparency International to classify the health sector at the 9th rank among the 20 sectors most affected by corruption in Cameroon.* However, it is not easy to assess its scope, for the amounts concerned vary from 1000 to 200 000 CFAF. Its impact is particularly negative on the access to health care, because of its random and repetitive characteristics and the fact that it affects the most vulnerable. It discourages or delays the recourse to health care or even directs it in a not very rational way.

19. The survey on the accessibility and the determinants of the recourse to health care and drugs (RSM 2004) reveals that 10% of the consultations are paid directly to the personnel and not to the cashier and that the average cost of these bills is 45% higher than the advertised prices. The non-official private practice or the double practice cause a lost of revenues for the health institution but constitutes a source of revenues for the personnel; besides, it promotes absenteeism in public health institutions and contributes to "deflect" public hospital patients towards formal or informal private institutions. The different forms of direct payments siphon off an important share of households health expenditures. The RSM 2004 survey observes that "money is the major problem encountered" and that the "lack of money" is the main reason for self-medication and foregoing treatment.

20. At **the level of the district health service,** the bankruptcy of governance is axed around three major groups of actors – decision-makers, providers, beneficiaries – according to the level of responsibility, the role and interactions among the structures and their system of operation. The final report of the 2007 Systemic Quality Improvement Contest reveals that on the 178 health districts visited, less than 20% refer to governance best practices, especially concerning the incentives for governance and ethics, the community involvement (5%), the monitoring-evaluation (13%) and the risk-sharing (5%).
Non-declared conflicts of interests and tortious agreements deteriorate the quality of the discussions between the local health administration, the caregivers, and the representatives of the communities and of the administrations who are members of health committees and management committees at the provincial, district and health area level. Procurement procedures financed by the central administration and locally generated resources are not always transparent. A survey realized by GTZ in the 1990's hinted that the rate of "grazing" of the central budget allocated to a district can reach 40% of the initial budget allocated to a district.

Why do governance programmes fail in the health sector?

21. Corruption is developing particularly in the domain of health for some well-known reasons and which also apply to the Cameroon context: i) the importance of public financing – 7.9% of public expenditures – ii) the complexity of financing stems from the multiple sources and donors; iii) the importance of the relationship between public and private sectors; iv) the purchase of equipments and products, especially from private suppliers; v) the importance and complexity of the regulations on drugs and medical practices; vi) the preponderant share of direct payments by the households (93.7% of health expenditures); vii) the information asymmetrics between the patient and the care providers which does not allows the patient to check the service; viii) obligation of means but not of performance.

22. The implementation of initiatives to promote good governance in Cameroon, as in many other African countries, has not yet yielded the expected outcomes because of many shortcomings described by Bossert and Thomas (2008), especially qualitative and quantitative shortage of human resources, the difficulty for the community representative to be instrumental in decision-making processes within health committees and management boards as well as unclearly defined roles of local political actors, private partners and beneficiaries. For Derick and Brinkerhoff (2007), the absence of transparency and accountability, the weight and heavy load of centralized administration can impede the governance process either because of the roles and responsibilities of the decision-makers/managers, the care providers and the beneficiaries, or because the structures and procedures which govern their interactions.

23. In Cameroon, if historically it is not easy to specify when and how corruption took this dramatic turn in the health sector, nevertheless, most surveys observe that corruption became rampant during the economic crisis in 1986 – 1994 which caused a drastic reduction of the salaries and other benefits served to caregivers (about 70% in 1993) and a sharp drop in the households' purchasing power. The surveys on the management of the personnel of the health sector in Cameroon (Maia Ambegaokar, 2004) and on the health reform (Balique, 2003) observe that the low salaries of the personnel are generally perceived as one of the causes of the demotivation of health staff and the roots of some corruption practices, absenteeism and poor hospitality in health facilities. The users of health services declare in the survey on the follow-up of public expenditures and the satisfaction of the beneficiaries (NIS, 2006) that i) the wages of health personnel are globally not satisfactory in terms of salary and benefits, ii) concerning the attendance of health institutions, 55.6% of big towns inhabitants prefer private health establishments and 94% of the respondents declare to be satisfied by the quality of consultation in the private sector against 85% in the public sector. If the global satisfaction index in terms of quality is 90%, it is of 88% in public health institutions against 97% in the private health establishments.

24. Corruption and poor governance also stem from the poor representativity of the communities and the civil society in decision-making spheres; the absence of incentives for the members of dialogue structures; the absence of regulatory or institutional criteriae in the choice of actors serving as members of health committees and management committees as well as the the poor involvement of dialogue structures in the planning and management processes of the district health system; the absence of intersectoral and inter-institution coordination. In a more specific manner and according to the national

actors interviewed during the mid term evaluation of the implementation of the sectoral strategy 2001 – 2010, the factors that pave the way for bad governance in the health sector in Cameroon are: i) the delay in the implementation of a regulatory framework for the community involvement, ii) the inadequacy between the regulatory devices and the effective practice in the management procedure of health district, especially the low utilization of regulatory texts and the non-implementation of the manuals of procedures, iii) the poor dissemination of regulatory and legal texts towards all the stakeholders, iv) the absence of mechanisms obliging actors to more transparent procedures in the use resources, v) the poor level of geographic and demographic coverage of the health risk sharing mechanisms, vi) poor involvement of decentralized territorial collectivities in the financing and planning of the health sector, vii) inefficient procedures of monitoring- evaluation, including mechanisms of audit and transparency, viii) poor sense af accountability to dialogue structures and ix) shortcomings of regulation and supervision. In spite of the existence of a legal and regulatory framework to make governance more efficient in health districts since the Declaration of the Policy for the Reorientation of Primary Health Care, the practices observed are not in conformity with the texts because of the poor involvement of some stakeholders including the civil society and the local communities, some documents are outdated considering the present environment whose objective is to promote good governance and decentralization.

25. Other shortcomings of the sector hinder both the governance and the development of the health district. The mid-term evaluation of the Health sector strategy 2001 – 2010 observes that: i) the poor performance of health information system, ii) the absence of an operational health map for an appropriate development of health services and care supply, iii) the absence of a collaboration framework between the actors of the sector, iv) the strong centralization of the management of public resources of this sector, v) the poor utilization of public structures of care, vi) the insufficient organization of the primary health care in urban area, vii) the poor development of the reference/counter reference system and viii) the predominance of direct payments during sickness. As in many other African countries, the health sector in Cameroon is confronted to weaknesses which are, on the providers' side i) confusion in the roles of the different providers in the management process, ii) designation of the community representatives by the administration, iii) absence of financial independence of dialogue structures in front of the health administration, iv) opacity of the texts with regards to the roles of stakeholders and v) poor intersectoral coordination; on the beneficiaries side, i) absence of transparent mechanisms for designing members of health management boards, ii) poor representativity of the community in decision-making, monitoring-evaluation, planning of activities, iii) difficulty in setting up transparency and traceability norms in the production and the management of health districts as well as poor incentives prevent the optimal implementation of the health districts' development initiatives.

26. Besides the collaboration framework between the Ministry of Public Health and the other actors, there is none to foster collaboration among other actors within the sector. The position of the Ministry and the local health administration is ambiguous, for they play both roles of health providers and regulators, thus weakening the functions of inspection, supervision, monitoring and evaluation at the district level. Shortage of human resources remains a major concern and even a threat to the good implementation of the health sector strategy despite recent efforts to increase the working force. The consensual diagnostic made to update the health sector strategy for the 2015 Agenda and transition towards a SWAP observes that: i) the community involvement in the management process is hindered by the absence of a legal framework for community participation in district management boards and health committees, ii) the representativity of the communities within boards and committees is still low, iii) the opacity in the choice of community representatives in decision-making instances as well as iv) the persistence of direct payments which give way to mercantile behaviours within health institutions.

Policy Options to enhance stakeholders' involvement for better governance and speeding up the development of health districts in Cameroon

Option I: strengthening the social control mechanisms

27. The objective is to widely provide local development actors (politicians, municipal counsellors, community groups and NGOs, traditional rulers) with access to relevant information relative to the populations' health conditions, health determinants, resources in order to allow them to fully participate in the processes of priority setting, planning, budgeting, monitoring and evaluation of health activities at the district levels through deliberative forums, consultative processes where civil society, community representatives have a word to say. An opportunity should also be given to consumers and/or members of committees to question the local health administration.

Implementation strategies: training, sensitizing the persons concerned on the stakes, the challenges and the beneficial effects of good governance and the development of health districts, its advantages as well as the deleterious consequences of bad governance; setting up consultative groups on ethics, equity and monitoring-evaluation of health activities; building the capacity of the community leaders to get involved in promoting health; strengthening the capacities of services providers to interact with the communities in a more transparent and responsible way; strengthening the National Health Information System in the sharing of information with the civil society.

Option 2: Promoting health risk sharing mechanisms

28. The reduction of direct payments during sickness yield the potential to reducing corruption opportunities as a third party purchaser introduces a witness that can regulate the relationship between the caregiver and the care receiver by correcting the asymmetry of information within the sector.

Implementation strategies: information, education and communication on the advantages health risk sharing mechanisms as a means of fighting poverty and an instrument of economic recovery; involvement of the municipalities in the promotion of Mutual Health Insurances and Federations of Mutual Heath Insurances; subsidies to reduce financial barriers and increase affordability of premiums for the poorest and; promoting a national social health insurance scheme.

Implementation Issues

29. Implementing the selected options means taking into account some local realities and relevant evidence related to bringing about change in the health system. With the enforcement of the laws on decentralization, it is urgent to **revise, update and disseminate the regulatory framework governing community participation especially dialogue strutures at the health district level.** There is a need to redefine the membership of the different boards and committees, the roles and responsibilities of members and specifically the municipalities. Among the barriers, one should cite bureaucratic and administrative delays, resistance to change of some actors benefiting from the present situation, the poor intersectoral collaboration and overlapping of authority/competence among the administrations. To overcome these barriers, sensitization through **information, education and communication initiatives** geared towards all the stakeholders through the media, training workshops, and booklets can contribute to foster the involvement of stakeholders on the matters concerning health development and its governance. **Strengthening of social control** requires creating an environment that enable the collaboration among providers, decision-makers and beneficiaries in accordance with updated operation guidelines on dialogue structures. The updating of the governance framework should among other things, provide for an assessment of the beneficiaries satisfaction, the conditions of designation of the representatives of the stakeholders including the civil society, insure their representativity, financial freedom/autonomy towards the district health administration. **Procedures of decision-making and management of resources** of the health districts should be updated for more transparency, more involvement of the communities in the planning and the monitoring-evaluation of health development initiatives. As long as the health committees and the management committees do not have a say in the choice of evaluation, sanctions and incentives mechanisms for the personnel, they will remain inoperative concerning the promotion of good governance.

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