

PN ABP-184
82503



DECENTRALIZATION: FINANCE & MANAGEMENT PROJECT

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PN-ARP-180

INSTITUTIONAL ANALYSIS OF COMMUNITY CO-FINANCED AND CO-MANAGED PRIMARY HEALTH CARE PROGRAM IMPLEMENTED BY THE MATERNAL CHILD HEALTH/CHILD SURVIVAL PROJECT (SESA) IN CAMEROON

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March 1993

PREFACE

This document was prepared by Sheldon Gellar and Flavien Tiokou Ndonko provided by the Decentralization: Management and Finance Project (DFM) and Mr. Benoit Etoa, head of the Community Health and Traditional Medicine Service of the Ministère de Santé Publique and funded by the USAID Mission in Cameroon as part of the Cameroon Maternal Child Health/Child Survival Project. Field work for this project was carried out in February and March of 1993.

DFM is sponsored by the Office of Rural and Institutional Development of the Bureau for Science and Technology (S&T/RD) of the U.S. Agency for International Development (Contract No. DHR-5446-Z-00-7033-00). DFM is managed by Associates in Rural Development, Inc. of Burlington, Vermont in association with the Metropolitan Studies program of the Maxwell School of Citizenship and Public Affairs at Syracuse University and The Workshop in Political Theory and Policy Analysis at Indiana University.

The DFM Project is designed to assist developing country governments and USAID field missions in addressing the persistent problem of rapid infrastructure and service deterioration, particularly of rural roads and irrigation works. The project's primary focus is on the analysis of institutions that perform key funding, management, and maintenance functions in order to suggest ways in which these institutions can improve performance and establish policies which encourage infrastructure sustainability.

ACKNOWLEDGEMENTS

The team would like to express its thanks to the USAID/Cameroon staff and to the Ministry of Public Health (MSP) for its cooperation in helping us to prepare this report. A list of those contacted during the course of the institutional analysis of primary health care activities in South and Adamaoua Provinces can be found in Appendix B.

The team owes a special debt to Mr. Benoit Etoa, head of the Community Health and Traditional Medicine Service of the MSP, who served as the public health specialist on our team and representative of his ministry. Mr. Etoa accompanied us on most of our field trips and provided many valuable insights and observations based on his long experience and understanding of Cameroon's primary health care system. The team would also like to express its appreciation to Dr. Cheka Cosmas, author of the community participation statutes, who spent many hours explaining the logic of the rules orienting the operation of the health committees. We would also like to thank Nouhou Alim of the Adamoua Province Health Delegation staff and Pierre Signe of the South Province Health Delegation staff for guiding the team in visits to primary health care centers and hospitals in their respective regions. Finally we would like to thank Dr. Claude Bodart, SESA project national coordinator, Joan Shubert, SESA IEC specialist, Maria Madison, Adamoua Province SESA coordinator, Dorothy Madison-Seck, Sud Province SESA coordinator, and Bess McDavid and Richard Greene of USAID for their logistical support and frank discussions.

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ACRONYMS

ARD	Associates in Rural Development, Inc.
CAPP	Centre d'Approvisionnement Provincial Pharmaceutique/ Provincial Drug Supply Center
COGE	Comité de Gestion/ Management Committee
COGEDI	Comité de Gestion de District/ District Management Committee
COSADI	Comité de Santé de District/ District Health Committee
COSA	Comité de Santé/ Health Committee
CPN	Consultation Périnatale/ Prenatal Consultation
CS	Centre de Santé/ Health Center
DFM	Decentralization: Finance and Management Project
DMH	Direction de la Médecine Hospitalière
DMPR	Direction de la Médecine Préventive et Rurale
DS	District Sanitaire/ Health District
FCFA	Francophone African Currency Unit/ Franc de la Communauté Financière Africaine
FSPS	Fonds Spécial pour la Promotion de la Santé/ Provincial Special Health Fund
GA	General Assembly/ Assemblée Générale
GDP	Gross domestic product
GM	General Manager/ Responsable Exécutif
GOC	Government of Cameroon
GTZ	German Technical Cooperation
HMIS	Health Management Information System

IEC	Information, Education, and Communication
JSI	John Snow, Inc.
MC	Médecin-Chef/Head Doctor
ME	Médecines Essentielles/Essential Medicines
MOPH	Ministry of Public Health/Ministère de la Santé Publique
NWPSFH	North West Provincial Special Fund for Health
ONAPHARM	Office Nationale de la Pharmacie
NGO	Non-Governmental Organization
PCV	Peace Corps Volunteer
PHC	Primary Health Care/ Soins de Santé Primaire
PHD	Provincial Health Delegate
PMI	Maternal and Child Health
RPHC	Reorientation of Primary Health Care
SESA	Soins d'Enfant Sud et Adamaoua
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

In June 1992, the USAID/Cameroon mission requested assistance through the Decentralization: Finance and Management Project (DFM) to conduct an institutional analysis of the community co-financed and co-managed primary health care program in Cameroon. The program is implemented under the USAID-funded Soins d'Enfant Sud et Adamaoua (SESA) Project.

The original terms of reference underscored two main objectives :

1. to analyze the structural and institutional problems related to the functioning of community health committees in Adamaoua and South Provinces, the sites of the SESA project; and
2. to propose options to USAID and the Ministry of Public Health (MOPH) to improve implementation of the primary health care system.

The project team consisted of three members, an institutional analyst, an anthropologist, and an official from the MOPH. The team spent much of its time in the field, interviewing community residents, members of health committees, and MOPH officials in North West, Adamaoua, and South Provinces.

The team looked at the 1989 reorganization of the MOPH, the reorientation of national primary health care (PHC) policy, and SESA's efforts to put in place community participation structures in the co-financed and co-managed PHC system.

The team also examined the functioning of the existing health committees and the new statutes which will give the provincial, district, and health area level legal status and the right to enter into contractual obligations, following their incorporation under the December 1990 Law of Association. The team noted that the statutes placed limits on the powers of community representatives. These limits permitted MOPH members to veto community decisions deemed contrary to national health policy, and gave the MOPH a predominant voice in the management committees, particularly at the higher echelons of the system. The new statutes contain many provisions to insure transparency in financial and management transactions. The complexity of the new statutes will require that they be translated into local languages and terms that the local communities can easily understand.

The team also looked at six major issues related to the effective implementation of MOPH policy in the SESA project zones:

- health district reorganization and its impact on existing PHC structures;

- relationships between referral hospitals and PHC delivery system;
- supervision issues;
- incentives and sanctions to promote better job performance; and
- relationships with the confessional health care system.

The reoriented PHC strategy is a sound one and has the support of the major donors. Donor collaboration makes it possible for the MOPH to establish a coherent and sustainable national PHC system throughout the country. SESA I and the MOPH have laid the groundwork for the new system in Adamaoua and South Provinces since 1989. The system is still in transition and the new structures not all fully in place. Lax supervision, lack of clarity of authority lines, resistance of some RPHC officials to increased community role in decision-making, tensions between doctors and nurses, and low morale due to poor working conditions and lack of monetary and moral incentives could hold back implementation of MOPH PHC reforms.

For the system to move forward, the new district boundaries will have to be confirmed, the composition and duties of the district health teams defined, and the MOPH organigram revised and job descriptions expanded to more clearly define PHC personnel tasks as quickly as possible. Creative incentive systems will also need to be elaborated to build staff morale and motivate PHC personnel to work harder to carry out their assignments.

While SESA I and the MOPH have set up co-management community participation structures at the health area and subdivisional level, these still have no legal status giving them the authority to enter into contractual obligations. Alternative sources of PHC, low incomes, high transaction costs related to logistical factors such as low population densities and poor roads, lack of incentives for community representatives in the PHC system, the subordinate role of women in community affairs, and unclear election rules and processes are all factors which have hindered greater community participation in the SESA/MOPH PHC program. Now that the new statutes are ready, SESA and the MOPH should move forward as quickly as possible to incorporate the COSAs, COSADIs, and FSPS as legal entities under the Law of Association. However, given the complexity of the new statutes, care will have to be taken to make sure that the local populations and community representatives fully understand the rules of the game and their mutual rights and obligations before these new structures become fully operational. If fully understood and implemented, the new statutes, which give community representatives considerable decision-making powers and ensure transparency in financial transactions, should provide the community with a greater sense of ownership over the PHC program and more confidence in the PHC system.

Cameroon's highly centralized financial system which makes disbursement of funds a slow and cumbersome process and a civil service code which makes it difficult to sanction

poor performance and illegal activities of civil servants constitute constraints on current efforts to improve the PHC system. While taking these constraints into account, the SESA project does not have the means to correct the problem at this level. On the other hand, the 1989 reorganization of the MOPH and the December 1990 Law of Association have created important institutional instruments which can and are being used to improve the national PHC system in general and that in the SESA project zone in particular.

The following recommendations are designed to overcome some of the obstacles cited above and to improve institutional arrangements at the operational level where MOPH personnel meet the public. Some have already been suggested in the SESA II project paper and by MOPH officials. Others are new. From its analysis of the issues, the team offered a series of recommendations which can be summarized as follows:

- Launch an educational campaign to explain the new statutes;
- Identify and mobilize existing community structures;
- Improve the current election rules, electoral processes, and enforcement of rules;
- Provide modest compensation for community members and officers of health committees commensurate with their duties;
- Explore various measures to increase the participation of women in community health structures and activities;
- Set up a creative financial and non-financial incentive system to motivate PHC personnel;
- Take measures to decrease inequities in the system and to reduce tensions between doctors and nurses;
- Reorganize PHC structures to fit the new health district boundaries and eliminate unnecessary layers;
- Provide clearer job descriptions and reinforce sanctions for poor job performance;
- Use the North West Province as a model for consideration in utilizing Provincial Health Fund surpluses;
- Establish a good working relationship with a church hospital which can serve as a district referral hospital and create a model health district which will test the effectiveness of collaboration between church missions and the MOPH; and

- Establish a pilot decentralized health district in which the head of the district health service will have direct access to funds and be able to transfer MOPH personnel in the district.

The team concluded that the Cameroon SESA/MOPH experiment is an exciting one, which if successful, could serve as a model for improving PHC delivery systems in other African countries.

I. Introduction

In June 1992, the USAID/Cameroon mission requested assistance from the Decentralization: Finance and Management (DFM) project to conduct an institutional analysis of the community co-financed and co-managed primary health care program in Cameroon, which is implemented under the USAID-funded SESA project. The request was primarily a response to the issues raised by an interim evaluation of the SESA project that took place in late 1991 (Godfrey et al: December 1991).

The study terms of reference underscored two main objectives:

- to analyze the structural and institutional problems related to the functioning of community health committees in South and Adamoua provinces, the two main sites of the SESA project; and
- to propose options to USAID and the Ministry of Public Health (MOPH) which would offer opportunities to better implement the community co-financed and co-managed primary health care system at all levels within the system from the province down to the local health center.

The terms of reference also identified several important tasks for the team:

- to look at the German Technical Cooperation (GTZ) operations in the North West Province to compare their experience in co-financing and co-managing a primary health care delivery system with those of the SESA project which had to operate under somewhat different and perhaps more difficult conditions.
- to study the legal status of the community health committees, their rights and obligations in managing funds, their ability to enter into contractual relationships, and their relations with the MOPH.
- to study organizational issues related to the roles, functions, prerogatives, and responsibilities of the various health officials at all levels (provincial, divisional, sub-divisional, and health center) of the primary health care system, particularly in the domain of information gathering, supervision, and incentives for improved job performance.
- study the legal basis of the planned provincial health funds and propose institutional arrangements for allocating provincial funds.
- propose ways to enhance community involvement in the management of MOPH budget credits affecting their area and institutional arrangements to provide better linkages between the health center, health district, and provincial health committees.

The team consisted of three members: an expatriate political scientist and institutional analyst, a Cameroonian anthropologist familiar with public health issues in the country, and the head of the community health and traditional medicine service whom the MOPH had seconded to the team to serve as the primary health care specialist.

The institutional analyst served as the team leader and principal author of the report. The anthropologist focused on local community structures, traditional health care systems, and community attitudes towards the new primary health care system. The primary health care specialist with his long experience in the MOPH provided the team with an extensive overview of the primary health care system, a detailed description of grass roots primary health care activities and problems, and insights into bureaucratic incentives and disincentives within the MOPH.

The team reviewed a wide range of documents relating to the SESA project and primary health care experiences in Cameroon and other African countries; the organization of the MOPH and its policies; and the organization of the drug distribution system in Cameroon. The team also studied pertinent legal documents such as the civil service code, law of association, penal code, and provisional statutes of the Provincial Special Funds, district health committees, and local health committees in Adamaoua and South provinces. (See the bibliography in Annex A for a list of the documents consulted).

In Yaounde, the team interviewed USAID, SESA, and other donor officials involved in primary health care projects, officials from the MOPH, and the author of the proposed health committee statutes in the SESA project area. The team also made field trips to North West, Adamaoua, and South provinces where they visited hospitals and primary health care facilities and met with SESA project coordinators, MOPH doctors, nurses, and other health officials, representatives of the confessional sector involved in health care programs, and officials from the territorial administration. They also interviewed village chiefs, local notables, community health committee officers and members, patients, traditional healers, and drug clerks. When possible, some time was spent observing the sale of drugs in local markets.

II. Institutional Analysis Framework

Institutional analysis works with four sets of variables or attributes: (1) the physical world; (2) institutional arrangements; (3) patterns of interaction; and (4) outcomes.

Physical world attributes can directly affect outcomes regardless of institutional arrangements. Physical factors such as climate, population density, transportation and communications infrastructure, and water supply sources, for example, are all important factors affecting health and access to primary health facilities. Poor roads, low population densities, and long distances between population and health centers are factors which raise the cost of providing health care to individuals and communities in Adamaoua and South Provinces. Specific time-and-place information such as seasonal variations related to climate also affect the movement of populations (e.g., transhumance of herders in Adamaoua province) and the incidence of certain diseases. Thus, people are more likely to suffer from malaria during the rainy season because access to health centers becomes more difficult during periods of heavy rainfall in areas with poor roads.

Technical knowledge of the causes and cures of diseases also constitute an important aspect of the physical world. Certain diseases have specific physical causes-- e.g. unhealthy drinking water, mosquitoes carrying malaria-producing parasites, etc. In a similar manner, specific drugs can be given to prevent or to cure specific diseases. Technical knowledge thus becomes a crucial part of any successful primary health care strategy.

The concept of institutional arrangements is the main focal point of institutional analysis. While physical world attributes like climate constitute hard constraints which can't easily be changed, institutions are more malleable. Institutional analysis assumes that undesirable outcomes are usually the result of a mismatch between key characteristics of the physical world and a structure of institutional arrangements that provides few incentives for the actors involved to achieve the desired goals.

Institutions are sets of rules which order human behavior. Institutional arrangements can be defined as the set of rules used in any process to determine who is involved, what actions are available to participants, the kind of information available, how decisions will be made, and how costs and benefits are distributed (E. Ostrom et al: 1990). Cameroon's civil service code and laws and decrees defining the organization and functions of the MOPH are institutional arrangements which directly affect the behavior of public health officials. For example, in Cameroon public health policy rules offered free medical care and drugs to the general public. The public health system in many rural areas declined when the government could no longer provide free drugs. The new co-financing system reflects a change in the rules which was designed to revive the primary health care (PHC) delivery system.

Patterns of interaction constitute the third element in the institutional analysis framework. Patterns of interaction refer to the kinds of behavior that result when participants in a particular activity or organization pursue their preferences. Different institutional

arrangements create different incentives and disincentives for certain types of behavior. In this analysis, we shall be primarily concerned with the interactions of public health officials and individuals from the communities involved in the SESA project area participating in the co-financing and co-management primary health care system. Special emphasis will be placed on identifying or proposing institutional arrangements which can provide incentives for better job performance by health officials and greater and more effective community participation in the primary health care system.

Outcomes, the fourth element in the institutional analysis framework, refers to the consequences of people acting within the context of physical world constraints and particular sets of institutional arrangements. For example, low population densities, poor roads, and long distances between communities and local health centers raise transaction costs and make community access to public primary health care services more difficult which in turn can result in higher infant mortality rates. Institutional arrangements related to the civil service code make it difficult for public health authorities to fire or sanction poor performance by public health workers, which in turn can lead to a deterioration in the quality of services provided, which in turn can discourage the local populations from using public health facilities.

Institutional analysis thus works its way through the relationships among the four elements of the framework in order to understand the constraints imposed by the physical world; to evaluate existing institutional arrangements; to anticipate the kinds of strategic calculations taken by the various participants involved and the patterns of behavior flowing from incentive structures created by existing institutional arrangements; and, finally, to forecast the outcomes. Having worked through these relationships, one is then in a better position to design alternative institutional arrangements which will provide the incentives needed to result in better outcomes -- e.g. a more efficient primary health care delivery system and better health for the people participating in the system.

Institutional analysis operates at several levels. Broader systemic institutional arrangements -- e.g. the rules underlying the Cameroon political system, the public finance regime, the civil service code, and the law of association -- affect the institutional arrangements at the intermediate level directly related to Cameroon's public health system and implementation of primary health care policy. Thus, the 1989 laws and decrees reorganizing the MOPH were elaborated according to rules of law-making laid down in the Cameroonian constitution. National finance laws establish sets of rules which determine the allocation of resources and expenditure processes within the MOPH while the national civil service code places limits on the authority of the MOPH to manage its health personnel. The December 1990 Law of Association provides the legal framework for establishing the North West Provincial Special Fund for Health and makes possible the transformation of the health committees in the SESA project zone into legal entities with the capacity to enter into contractual relationships and to exercise control over the expenditure of primary health care funds.

The institutional arrangements underlying the organization of the MOPH provide a framework for the various institutional arrangements --e.g. specific rules relating to the organization of the primary health care delivery system, relations between officials at different levels of the system, fee structures for drug and health services, etc. -- at the operational level where public health officials serve their clientele. In a similar manner, the proposed statutes for the Provincial Special Fund, District, and Health Center Committees provide the framework for institutional arrangements at the operational level where community representatives participate in the co-management of the primary health care system.

Institutional analysis also looks at problems related to the provision and production of public goods and services such as primary health care services. Provision activities concern decision making regarding the quantity and quality of services to be provided -- e.g. which drugs, how many different health services, qualifications of the health care provider at each level, etc. Provision also entails decisions about how and for whom these services are to be made available -- e.g., the mechanisms of the drug delivery system, fee structures, the populations to be covered by a health center or a specific program, etc.

Production refers to the combining of inputs to produce outputs. Inputs would include such items as drug production and distribution, health diagnoses, vaccinations, health education, curative services, prenatal care, family planning services, post-natal care, etc. The outputs in this case would be better health for the local populations affected by the health care system as measured by lower infant mortality rates, longer life expectancy, reduction in the incidence of endemic diseases, fewer deaths in childbirth, etc.

In Cameroon, primary health services are produced by individuals, traditional healers, private doctors, pharmacists, and dentists, drug suppliers, church missions, expatriate NGOs, and the MOPH. The state, represented by the MOPH has no monopoly over the production of goods and services in the health sector. One of the most interesting features of Cameroon's primary health care policy is the willingness of the MOPH to seek institutional arrangements in which the state, local communities, and the private sector (church hospitals and health centers, traditional healers, private drug suppliers, etc.) will collaborate to co-produce primary care health services. One of the major challenges for the MOPH primary health care system in general and the SESA project in particular is to find the optimal mix of institutional arrangements to insure fruitful collaboration in the co-production and co-management of primary health care services by the various actors involved in the system.

Resource mobilization is an important component in the provision and production of public services like primary health care. Institutional analysis looks at the different instruments for resource mobilization -- e.g. donor projects, NGO resources, the national budget, user fees, human investments, voluntary contributions, local taxes, etc. -- and the institutional arrangements needed to insure adequate revenues, equity, efficiency, and political and administrative feasibility in providing the desired service. Although donors have primed the pump in restarting the primary health care system by providing free drugs, the system must now rely heavily on community co-financing -- i.e. user fees for drugs and health

services -- to keep the system solvent. Hopefully, the resolution of Cameroon's public finance and liquidity crisis will eventually permit the state to mobilize more resources through the national budget to finance more of the recurrent costs of primary health care activities. Until then, the main financial burden will continue to fall on consumers.

III. Cameroon's Primary Health Care System

A. Historical Evolution

During the first two decades of independence, Cameroon's public health system was geared primarily to curative medicine. Although a 1963 ministerial decree authorized state health facilities to charge fees for services, these fees were generally levied for hospital services. In the rural areas where government health centers were established, health services and prescribed drugs distributed by the health centers tended to be free. Drug distribution was highly centralized through ONAPHARM, a parastatal mandated by law to provide drugs for public health facilities. The old drug distribution system had several major drawbacks: (1) the tendency to over-prescribe drugs coupled with the absence of a cost recovery system to replenish supplies led to the rapid depletion of drug supplies in many rural areas and frequent shortages; (2) drugs sent down by ONAPHARM were often expensive and did not necessarily match local needs; (3) supervision was lax, often resulting in the disappearance of drugs for the private use of public health personnel and sale in parallel markets. Despite its drawbacks, the old system still drew significant number of people to the rural health centers because services and drugs were free.

Primary health care as a special activity within the MOPH began in 1977 following a presidential decree reorganizing that ministry. It received greater attention within the ministry and the nation following Cameroon's formal adherence to the Alma Ata charter in 1982. During the next few years, the MOPH led a campaign to stress the importance of primary health care throughout the country with the hope of achieving the goals stated in the World Health Organization's proposal to achieve "Health for All" by the year 2000. In 1987 the MOPH organized a national conference in Yaounde to coordinate the activities of all the different actors involved in providing primary health care services. Unfortunately, the growing emphasis on primary health care services took place at the same time that Cameroon was going through a long and difficult economic crisis.

The economic crisis which began in the mid-1980s had an adverse effect on Cameroon's public health system. Declining world market prices for Cameroon's major exports -- oil, coffee, and cocoa -- led to a sharp decline in GDP and state revenues. The rapid expansion of the size of the state bureaucracy coupled with heavy state borrowing and wasteful spending during the 1970s and early 1980s contributed to a major crisis in public finances which has continued into the 1990s.

Prior to the economic crisis, more than 30 percent of the health budget was allocated to rural health services. In 1988, the budget for rural health care was cut by 50 percent and many health facilities lost most of their operating budgets. Moreover, the size of the MOPH budget declined from 26.75 billion FCFA in 1986/87 to 23.976 billion FCFA in 1988-89. This situation was aggravated by the fact that much of the budgeted funds for non-personnel expenditures were not actually spent. During the late 1980s and early 1990s, ONAPHARM experienced increasing difficulty in obtaining drugs for distribution to the rural areas. For

example, in 1989/90 only 400 million FCFA of the 2.1 billion FCFA allocated for drugs were expended (USAID Cameroon; October 1992). The lack of drugs coupled with the shortage of operating funds led to deteriorating primary health care services in the rural areas. While the number of health personnel remained more or less intact, the means at their disposition to carry out their responsibilities were lacking. The result was a sharp decline in the number of people going to rural centers.

The deterioration of public health services in general and primary health care services in particular led to reforms in the health sector during the late 1980s and early 1990s and a major reorganization of the MOPH in 1989.

B. Reforms in the Primary Health Care System

1. Reorganization of the MOPH

In January 1989, a presidential decree (89/011) reorganized the MOPH and defined the tasks of the different directorates and field services in the ministry. The decree established six main directorates at the central administration level: (1) Hospital Services; (2) Preventive and Rural Medicine; (3) Pharmacy; (4) Family and Mental Health; (5) Planning, Studies, and Health Statistics; and (6) General Affairs. The reorganization did not establish any single directorate or service to oversee the primary health care system. Each directorate is involved in some aspect of the primary health care delivery system. Thus, the pharmacy directorate is involved in drug distribution; the preventive and rural medicine directorate is involved in community health services, fighting endemic diseases, and promoting public hygiene and sanitation; the hospital services directorate is involved in supervising public and private health facilities and laboratory analyses; the family and mental health directorate in maternal and child health (PMI) and nutrition education; the planning, studies and health statistics directorate is involved in information management systems related to primary health care; and the general affairs directorate is involved in managing personnel and motor pools. In practice, the present director of preventive and rural medicine (with the backing of the minister) has assumed the task of overseeing the rural primary health care system. The absence of a clear-cut hierarchical authority structure over the primary health care system has led to some confusion and conflict over the role and authority of the field extensions of the different directorates.

The so-called external or field services of the MOPH established by the 1989 reorganization coincide with the administrative organization of the country. There are thus Provincial Delegations, divisional (département) services, and sub-divisional services (arrondissement). The Provincial Health Delegates (PHD) represent the minister in their respective provinces and are in charge of overseeing all provincial level public health services. All the provincial-level medical officers report directly to the PHD. Again, there is potential for jurisdictional conflicts since the field representatives of the different directorates often feel that they are responsible primarily to their directorate head at the central administration level.

The divisional health service is headed by a chief medical officer (chef-médecin) who is responsible for organizing, managing, supervising, programming and coordinating all of the health services in his division. Each division (département) has a hospital, a center for preventive and rural medicine and a maternal and child care (PMI) center which is often an extension of the divisional hospital. As chief medical officer for the division, the divisional chief of public health is responsible for supervising all curative and preventive health activities in the division.

The subdivisinal (arrondissement) health service consists of the subdivisinal hospital which is often little more than a somewhat larger health center, compared with the various health area centers and village health posts in the subdivision. The head of the sub-divisional health service ensures the functioning of the sub-divisional hospital and the organization, supervision, and control of the various public health facilities in the sub-division; monitors the activities of private health facilities; and assumes the responsibility for preventive and rural medicine activities, as well as the battle against transmissible diseases.

As one descends from the province to the health area centers, the health service structures become increasingly less specialized and more polyvalent.

2. Reorientation of the Primary Health Care System

On May 31, 1989, the MOPH announced a new policy to reorient Cameroon's primary health care system. The new policy called for greater community involvement in financing and managing primary health care services and dialogue structures to facilitate better communications between public health officials and local communities.

To encourage greater community participation, the MOPH wanted to establish community health committees at the health center and subdivisinal levels to complement the existing village health committees. The community health center and subdivisinal/district health committees would form management sub-committees made up of community representatives and public health personnel who comprised a board of directors to manage the health facilities and activities at their level. The MOPH laid down rules relating to the composition of the health committees, their functions, powers, and scope of activities, decision making processes, and relationships to other bodies like the sub-divisional development committees.

One of the major innovations of the reorientation program was the establishment of the principle of community co-financing of primary health care activities largely through payment for certain medical services and the purchase of medicines used to prevent or treat illnesses. Cost recovery through user fees and drug charges thus became the main motor for revitalizing the moribund primary health care system in the rural areas. On the other hand, the state would continue to be responsible for training, the salaries of health personnel, the construction, equipment, and rehabilitation of health facilities, and the initial provision of drugs to be sold within the new primary health care delivery system. Donors and NGOs

would also be asked to participate in financing the new system and to coordinate their efforts to ensure a coherent national primary health care delivery system.

The 1989 reorientation identified the district as the key operational structure in the new system. At that time, the MOPH tended to regard the health district as encompassing the sub-divisional administrative jurisdiction. The district hospital would serve as the referral hospital for all of the health centers in the district and contain more advanced and specialized medical services while the health centers covering the health areas (aires de santé) would serve as the main grassroots primary health care provider. At the top of the system, the provincial hospital would serve as the referral hospital for all of the district and divisional hospitals.

In March 1992, the MOPH published an official version of its national policy in reorienting Cameroon's primary health care system to provide "Health for All" by the year 2000. The new version reiterated the need to reinforce the district health services as the pivotal point of the system which still coincided with the sub-divisional level. It also spelled out more clearly the role of the health centers in providing global, continual, and integrated health services in the following eight areas:

- Maternal and child Care (Santé de la Mère et de l'Enfant)
- Preschool child care consultations (Consultations préscolaires) concerning nursing, vaccinations, and treatment of diarrhea.
- Prenatal consultations (Consultations Prénatales/CPN)
- Family planning consultations (Planification Familiale)
- Curative consultations (Consultation Curative)
- Treatment of chronic diseases such as leprosy, tuberculosis, diabetes, etc. (Consultations des Chroniques)
- Referrals and follow-up (Référence/contre Référence)
- Health promotion and education (Promotion de la Santé) through Information, Education, and Communications (IEC) activities, provision of potable water, and public health and sanitation programs.

The March 25, 1992 policy declaration also included refinements of the original 1989 reorientation policy and several innovations. First, the role of the Provincial Health Delegation was upgraded, especially in the areas of supervision and drug distribution. Second, the policy called for the establishment of provincial level health committees and management committees to oversee the Provincial Special Fund for Health (Fonds Special)

pour la Promotion de la Santé) to complement the health center (COSA) and district level (COSADI) health and management committees. Third, the health committees were to formulate an action plan at the health center, district, and provincial levels. Fourth, the establishment of a health management information system (HMIS) was to become part of the primary health care strategy. Fifth, greater emphasis was placed on the importance of supervisory activities in ensuring the success of the primary health care program. Finally a policy of providing inexpensive essential generic drugs was more clearly articulated and made the cornerstone of the co-financing system designed to cover the recurrent costs of the drug distribution program plus generate a surplus to be used for other public health activities.

Many of the innovations in national policy were based on the work of three important primary health care (PHC) programs: the GTZ-supported PHC project in the North-West Province, the SESA project in Adamaoua and South Provinces, and the Belgian-supported CIM project in Diamare division of the Far North province. The GTZ PHC project provided the models for provincial-based drug logistics systems, provincial cost recovery systems, and provincial community dialogue structures. The SESA project developed the models for integration of preventive and curative services, the link between primary and reference care, decentralized supervision, provincial-based health management information systems, and the delineation of health center areas. In addition, SESA first developed the notion of district-based health management systems. The Belgian PHC project did innovative work in the areas of cost recovery and the standardization of diagnosis and treatment.

While the donor community has enthusiastically endorsed the new PHC reorientation strategy, the confessional primary health sector has been more reluctant to integrate their own health facilities and programs into the new PHC system. The possibilities and constraints of effective collaboration between the church health sector and that of the MOPH will be discussed in more detail in section V of the report.

3. SESA I Project Responses to Primary Health Care Reform

The USAID funded SESA project began in 1987 before the reorientation of the Cameroon PHC system. At that time, the SESA project was narrowly focused on improving health services for women and children in Adamaoua and South Provinces. The project sought to aid the MOPH in delivering five key vertical services to the project zone-- immunizations, diarrheal disease control, nutrition promotion/growth monitoring, child spacing, and malaria treatment. SESA also set up a revolving essential drug fund to assure regular drug supplies and management, logistics, and supervision systems to support the delivery of services. By the end of 1989, SESA had adapted its strategy to conform with the MOPH's reoriented PHC policy by moving away from vertical interventions and towards more integrated PHC activities.

The SESA project helped the MOPH to further develop and operationalize the major public health aspects of the Reorientation of Primary Health Care (RPHC), e.g., supervision,

decentralized planning, health management information, and health referral systems. On the operational side, SESA focused its energies towards establishing the following:

- community participation structures -- e.g., local health and management committees;
- a cost-recovery and drug distribution system;
- plans for operationalizing the district health system outlined by the MOPH; and
- health management information and IEC systems within the provincial health services.

SESA developed a set of 12 modules for the RPHC which serve as the definitive training texts for establishing community co-financed and co-managed health care in Cameroon.

The December 1991 interim evaluation of SESA I noted that the project had moved forward in identifying health area limits, developing training manuals for PHC personnel, organizing and training community health committees and health management committees, and establishing a drug supply and cost recovery system. However, the evaluation also found some of the following weaknesses in the project:

- poor functioning of the community health committees;
- poor management of the revolving fund pharmacies;
- the lack of understanding of the new system and its administrative procedures on the part on health personnel and community members;
- confusion concerning the respective roles of MOPH and community managers regarding the oversight of funds;
- lack of compliance with the rules on the part of health personnel--e.g. incomplete reports, non-use of report data, distributing drugs on credit, waiving consultation fees, etc.; and
- utilization rates below those needed to support the recurrent costs (not including the salaries of MOPH personnel) of the health centers.

The SESA II project design team reported that important progress has been achieved in addressing many of these problems. Many of the recommendations in the interim evaluation concerned ways of improving the management system and providing more effective training of health personnel.

Since the evaluation, SESA has developed the following:

- a computerized provincial health management information system, which includes monthly health center activities reports, information feedback letters, and posters at each health center which track eight key health indicators;
- a new drug delivery and cost recovery system which links the delivery of drugs with the financial reconciliation of accounting documents;
- an improved supervision system with additional supervision guidelines/checklists for provincial and district supervisors, and new guidelines for supervision from the central to the provincial levels; and
- the design of mechanisms (including training materials) to integrate family planning and diarrheal disease control into the RHPC.

The evaluation recommendation most relevant to institutional analysis called for a study of the legal status of the community health committees in managing health funds. To date, the existing health committees in Adamoua and South Provinces have no official legal status. However, provisional statutes for the Provincial, District, and Health Area level Health Committees have been drawn up by a legal health specialist and recently approved by the MOPH. One of the project's most difficult tasks will be explaining the new rules of the game to the existing health committees and MOPH PHC personnel.

Section V of the report will provide an institutional analysis of the performance of PHC personnel, the community health committees, and the PHC delivery system as a whole and identify the main obstacles towards implementing MOPH and SESA project objectives in Adamaoua and South Provinces.

4. The GTZ/MOPH PHC Experience in North West Province

In response to a recommendation by the project's external evaluation team, SESA redesigned its logistics and financial management system based on the model established by GTZ in the North West Province. The GTZ has been working in the North West Province since 1986. It helped organize an effective drug supply and cost recovery system at the provincial level which has been able to deliver drugs to over 70 health centers and to generate sizeable surpluses. The system has been replicated in the South West and Littoral Provinces where the GTZ is also active.

The two most salient features of the GTZ experience in the North West Province have been the establishment of a Provincial Drug Supply Center (Centre d'Approvisionnement Provinciale Pharmaceutique or CAPP) and the creation of the North West Provincial Special Fund for Health (NWPSFH) which has enjoyed the status of a legal entity recognized by the

Government of Cameroon (GOC) under the Law of Association of December 19, 1990 since June 5, 1991.

The North West CAPP has run the essential drug program in the Province since the late 1980s. The CAPP was run by the head of the MOPH Provincial Pharmacy service from 1987 until September 1992 when she obtained a leave of absence to study abroad. When the NWPSFH was established, the same person also assumed the role of General Manager of the Special Fund. This function is now held by a former MOPH administrator. Between January 1989 and June 30, 1991, the essential drug program generated a surplus of 89.2 million FCA after covering its basic operating costs. This surplus can be used to constitute an emergency reserve, provide supplemental funding for local community health centers, purchase laboratory supplies and equipment, and provide bonuses for PHC personnel meeting high job performance standards.

Health center utilization rates are relatively high, but have fallen in the North West as in the other provinces during the past two years. The availability of regular drug supplies means that the people coming to the health centers can get the drugs they need. Utilization rates in the Province and the capacity to generate a surplus are also positively affected by the following factors:

- high population densities and urbanization rates which reduce transaction costs entailed in traveling to the nearest health center;
- relatively high cash incomes compared to the rest of rural Cameroon which means more money to purchase drugs and pay for services;
- a tradition of paying for medical services dating back to British colonial rule when consumers paid for public health services; and
- a relatively highly educated population aware of the value of modern medical facilities.

Community participation structures have also been relatively effective in the North West Province which has a strong community development tradition and well-organized social structures. A recent GTZ study (van Geldernalsen: August 13, 1991) noted that community initiatives in the North West Province to participate and manage PHC programs have been higher when the following conditions were present:

- knowledge of the possibility of getting into the program;
- lack of acceptable health care alternatives;
- dynamic community leaders with contacts outside the village; and

- strong existing community structures (churches, village development committees, etc.).

The study also noted that the handling and management of money proved problematic and eventually unsustainable when supervision and control were diminished. Embezzlement was more likely to take place when large sums of money were involved. The unpaid community health center management committee members also found themselves under heavy pressure to provide loans to needy relatives and other community members when not regularly checked. One way of dealing with this issue in the Province was to establish a rule that the pharmacy clerk had to immediately deposit anything over 50,000 FCFA in cash in a local banking or postal savings account. The Special Fund also hired a lawyer on a part-time basis to follow up the cases where accounts were not settled and future payment doubtful.

Effective community participation and management were undermined when the following factors were present:

- an overall poor population;
- irregular and lax supervision;
- a divided community and strife within and among villages;
- the absence of educated community members; and
- the presence of hawkers with cheap drugs from Nigeria.

The articles of association creating the NWPSFH serve as the model for Provincial community participation and management structures in the other provinces. They are less detailed than the articles of association proposed for Adamaoua and South Provinces. Rules of representation were designed to give community representatives a decisive majority in the general assembly, but gave more power to MOPH representatives on the management committee. Thus, the Provincial Health Delegate (PHD) had to be president of the management committee, while the general manager (who had to be a MOPH official) was also the secretary.

The general assembly of the NWPSFH included three different categories of members:

- Five *ex officio* members, including a representative of the Governor, a representative of the MOPH, the Provincial Health Delegate, the chief of the Provincial Preventive and Rural Health Service, and a representative of the GTZ, the main PHC donor in the region.
- 38 active members, including two representatives of each subdivisional and district Community Health Committee; a councillor from the Bamenda city

council; two members of parliament, one from the ruling party and the other from the major opposition party in the parliament in the region; one representative of each of the three major religious health services operating in the North West; one representative of the NGOs in the region; and the General Manager.

- Up to six honorary members with no voting rights including a representative from the following national professional associations practicing in the region-- medical doctors, pharmacists, dentists, and health technicians. Other experts could also be chosen by the management committee.

Unlike the proposed statutes for the Special Fund in South Province, the articles of association for the North West Fund have little to say about the powers of the General Assembly which is required to meet only once a year. In the North West Province, the Management Committee exercises most of the powers of the Fund and is responsible for overseeing the objectives of the Fund within the resources available to it. Thus it is empowered to:

- Elaborate job descriptions and make proposals for the appointment of necessary staff and propose remuneration policies for staff and parties involved in the Fund to the General Assembly.
- Set up organizational arrangements and agree on bookkeeping, finances, accounts, control and audit procedures.
- Propose the use of net proceeds realized by the Foundation to the General Assembly on the basis of proposed Action Plans of the sub-divisional health committees.
- Promote and improve the supply of essential drugs and other materials and services and propose local sales policies, including price setting procedures as defined by the MOPH to the General Assembly.
- Continuously control the activities of the provincial drug supply system and other funds and interests of the Fund.

The General Manager is responsible for the day-to-day running of the Fund. At the current time, the main preoccupation of the General Manager seems to be overseeing the operations of the Provincial drug supply system and keeping the accounts of all money received and spent by the Fund and the assets and liabilities of the fund.

The articles of association provide for a great deal of transparency in financial transactions. The books of the account are open to members of the management committee and independent external auditors audit the books periodically.

The North West Province is planning to implement an incentive system to reward its personnel for good job performance. For example, key personnel will receive a monthly bonus which will depend on meeting certain job performance criteria -- e.g., completion of monthly reports, keeping accurate accounts, etc. Deviations from a prescribed standard of excellence result in a corresponding reduction in the size of the bonus. Other incentive payments are to be based on the volume of transactions and activities. Thus, the pharmacy clerk in the North West receives 10 FCFA for each receipt reported. The more business he/she has, the higher the bonus. The fund plans to allocate fund surpluses to the local community health centers by using a formula which combines a flat rate for each center plus a fixed percentage of the volume of receipts generated by the center.

The North West Province GTZ/MOPH PHC experience seems to have worked best in providing drug supplies to the health centers in the system and revitalizing these grass roots level institutions. However, official reports and respondents in interviews have noted some laxity in supervision which has resulted in frequent non-compliance of the rules by public health personnel. While the NWPSFH marks a major advance in community co-participation and co-management, more needs to be done to increase community participation and control. To date, the NWPSFH has been dominated by representatives of the MOPH with relatively little input from local representatives.

IV. Analysis of SESA/MOPH Primary Health Care System in Adamaoua and South Provinces

A. Legal Status and Analysis of Community Health Committee Structures

The diverse community health committees at the health area, health district, and provincial levels constitute one of the main cornerstones of the reoriented PHC system in the Cameroon. During the early 1990s, SESA I helped organize community health and co-management committees and train committee members in Adamaoua and South Provinces. To date, these community structures have no legal personality. In fact, in some of the project areas, the local territorial administrative officials have not yet given their stamp of approval to the health committees. However, the MOPH has recently given its approval to statutes drawn up by a Cameroonian lawyer which will transform the existing health center and district health committees in South and Adamaoua Provinces into legal entities under the December 19, 1990 Law of Association. Statutes have also been drawn up to create a Fonds Special pour la Promotion de la Santé (FSPS) in both provinces. By the end of 1993, the legal basis for the community co-financing and co-management health structures should be in place in the SESA project zone.

1. Legal Powers Granted Under the Association Law

The 1990 Law of Association gives considerable autonomy to organizations set up under this system, especially to indigenous Cameroonian associations which can receive recognition simply by declaring their formation and furnishing two copies of their constitution. The declaration needs to be brought to the senior Divisional (Department) territorial administration officer (préfét) and contain the name, object, and headquarters of the association as well as the names, occupations, and addresses of those responsible for running the association. The associations are more or less automatically recognized unless considered to be a danger to public order. The recognition process is swift; if the territorial administration takes no negative action against the association within two months after the declaration, the association automatically acquires legal status.

Legal status gives the association the right to freely administer its affairs without interference by the territorial administration as long as it complies with its constitution and the laws in force. Once incorporated and recognized, the association has the following legal rights which permit it to:

- institute legal proceedings -- e.g., enter into contractual relations with other parties (e.g., hiring and firing employees), initiate litigation to protect its interests (e.g., taking parties to court who have violated their contractual obligations);
- manage and use funds derived from contributions; and

- purchase and own premises for its offices and meetings of its members and immovable property necessary for pursuing its aims.

2. Limits on Community Control by MOPH

One of the most striking features of the area, district, and provincial level co-management health associations is the presence of state health officials as members and officers of both the health committee and management committee at all levels. This means that these institutions are not truly private associations but quasi-public institutions subject to the considerable influence of MOPH health officials. This is particularly true at the provincial level where MOPH representatives play a dominant role in the management committee.

The presence of health officials accountable to both the general assemblies of the health committees and the MOPH can create conflicts of interest and be a potential source of tension between community representatives and state health officials.

The proposed statutes for the COSAs, COSADIs, and FSPS give *ex officio* health official members the power to block any decision taken by the majority which they feel violates or contradicts Cameroon's national health policy. The chief MOPH official at the next higher level has to arbitrate. If he takes no negative action within two months, the original decision is applied. Thus, the district-level head doctor (medecin-chef, - MC) arbitrates blocked decisions taken at the COSA level, while the PHD, as president of the FSPS, arbitrates blocked decisions taken at the COSADI level. Finally, the Minister of Public Health arbitrates blocked decisions at the FSPS. The MOPH feels that arbitration of disputes by Ministry officials is necessary at this early stage of the PHC program. Once the non-health official members of these various bodies become conversant with health policy issues, future modifications of the statutes in this regard may be envisioned.

Community members of the health committee do not have the right to discuss technical topics related to national health policy defined as the reserved domain (domain réservé) by the health official *ex officio* members. However, these topics can be discussed for an exchange of views within the management committee when the health officials are willing to do so.

The recent recentralization of the drug distribution system which was designed to reduce the loss of health center receipts through theft and embezzlement has created some tensions between the community representatives in the co-financing and co-management system and the SESA/MOPH project. The tighter supervision and collection of health center funds generated by drug sales and consultation fees by provincial health supervisors have left some community representatives with the feeling that they have lost real control over local health center resources.

3. The Organization of the COSAs

The COSAs which represent the population at the health center level constitute the basic unit of community participation structures in the PHC system. At the end of 1992, the SESA/MOPH project encompassed 15 health areas (aires de santé) in Adamaoua Province with an estimated population of 73,996 and 17 health centers in South Province with an estimated population of 116,388. It should be noted that the project has also organized COSAs in health areas which have not yet been fully incorporated into the co-financing and co-management system. None of the COSAs have a formal legal basis.

a. Objectives

The objectives of the COSAs are clearly stated in Article 4 of the statutes:

- Work with the PHC team at the health center to identify priority areas for health intervention activities, to elaborate a health action plan for the health area (aire de santé), and to support the health team in implementing the action plan.
- Monitor and evaluate health activities and the implementation of PHC programs in the area.
- Participate in the management of budgetary and other financial resources made available for PHC activities.
- Raise community awareness of the causes of the most frequent diseases and methods for preventing them and influence the health practices of the health area.
- Mobilize the community to participate more actively in the various health programs and to efficiently utilize the available health services.

b. Composition of Members, Duties, and Advantages

The COSAs have three categories of members: *ex officio* (membres de droit), active (actif), and honorary (honoraire). The *ex officio* members consist of the health center chief, a nurse or auxiliary health worker chosen by the staff, and a representative of churches and NGOs operating in the health area. The active members are community representatives, two from each village in the health area. The statutes call for taking into consideration differences in ethnic, religious, and cultural factors in selecting COSA members in order to insure that most elements in the community are represented. There are no requirements for community members to be literate. The honorary members have no voting rights and are named by the COSA.

The duties of the COSA members are to carry out the objectives stated earlier. These include ensuring a dialogue between health center personnel and the community; asking the community to directly participate in covering the costs of the PHC system through dues, payment for health services, etc.; mobilizing the community to use the health center more efficiently and diffuse information which could improve health and public hygiene; and initiate local health and socio-economic development projects.

Active and *ex officio* members are entitled to participate in the general assembly and can be elected to the COSA management committee (COGE) and represent the COSA at the COSADI and FSPS levels. They receive no salary or other payments for their participation.

c. Structure and Powers of COGE and General Assembly

The General Assembly is the supreme deliberating and decision making body of the COSA. Its decisions are binding on all members. The General Assembly must meet at least once a year and has the following powers:

- deliberate and adopt the COSA health policy.
- examine and adopt the action plan for the coming year.
- adopt the COSA budget.
- examine, approve, and rectify the COSA accounts kept by the management committee.
- decide the use and redistribution of COSA surpluses proposed by the COGE.
- set the authorized debt and investment ceiling of the COSA.

The Bureau of the General Assembly consists of a president, vice president, secretary, and 2 auditors (Commissaires aux comptes). The president, who is a community representative, presides over the General Assembly meetings and arbitrates problems within the COSA. The head of the health center serves as the secretary and keeps records of the meetings while the two auditors verify the accounts of the health center pharmacy clerk and the COGE treasurer. The president also usually serves as the president of the COGE.

Much of the work of the COSA is done by the management committee which consists of 7 members. Three come from the ranks of the *ex officio* members; the other 4 from the active members. The bureau consists of four key offices: the president, held by a community representative; the treasurer, also held by a community representative; the secretary held by head of the health center, and a technical resource person involved in health education named by the head of the district health service. The president and treasurer co-sign checks on the COSA's bank or postal savings account.

The COGE has considerable management powers which include the power to:

- enter into contractual obligations for the COSA with other parties.
- verify, control, and evaluate the execution of the Action Plan for the health area in collaboration with the District Health Officer (médecin-chef).
- recruit and remunerate the health center pharmacy clerk (commis).
- oversee the functioning of the drug supply system for villages in the health area.
- make propositions for approval by the General Assembly concerning remuneration policies, incentive systems, human, material, and financial resource use within the COSA health area, and annual budget and action plans.
- prepare the meetings and regular financial and management reports to the General Assembly.
- represent and defend the interests of the health area at the district level and inform the General Assembly of its activities at the COSADI level.

d. Rules to Insure Transparency

The proposed COSA statutes contain several rules to ensure transparency and to provide checks on abuses in the PHC system.

First, all COSA members have access to reports produced by the COGE concerning COSA operations and the right to consult COSA's statutes, internal regulations, accounts registers, and the minutes (procès-verbaux) of the General Assembly. The full use of this privilege may be somewhat hamstrung by the fact that not all COSA members are literate in French, since literacy is not required as a qualification for membership at this level.

Second, the two auditors in the General Assembly bureau check the monthly accounts of both the health center pharmacy clerk and the COGE Treasurer. One of the auditors is named by the district financial and administrative affairs health officer while the second is a representative of the community. The audits supplement the periodic checks by the provincial level supervisor or the drug supply program and the more frequent monitoring of the pharmacy clerk's daily transactions by the head of the health center. Increasing the number of people involved in examining the books reduces the opportunities for complicity between health and community personnel (e.g. pharmacy clerk and treasurer) involved in monetary transactions. Greater transparency also builds community confidence in the PHC system as the community becomes more aware of how funds are collected, deposited, and used.

Third, the General Assembly has the power and obligation to examine, approve, and rectify the official accounts prepared by the treasurer who must present a financial balance sheet and keep accurate records.

Fourth, the treasurer collaborates with the head of the district hospital in controlling COSA receipts, resources, and expenditures made by the head of the area health center and the pharmacy clerk. He/she also oversees the judicious use of funds and the accuracy of various accounts kept by the pharmacy clerk and health center head. In turn, the president as the second co-signer of COSA checks keeps an eye over expenditures by the treasurer who is responsible for keeping the caisse d'avance and paying the pharmacy clerk.

The new transparency rules are much more complex and comprehensive than the actual operational rules governing the day to day transactions of the existing COSAs. The legal status of the COSAs will give them greater power to exercise sanctions over those embezzling funds or failing to account for missing funds. For example, the statutes explicitly express that the treasurer is legally liable for financial losses resulting from his negligence or malfeasance. As a legal entity, COSA has the authority to initiate court proceedings and to prosecute those suspected of stealing money and materials and embezzling funds.

e. **Obstacles to Effective Community Participation and Co-Management of PHC Structures at the COSA Level**

The proposed COSA statutes provide an excellent framework for enhancing community co-management of the PHC system at the health area level and increasing transparency. However, several political, economic, social, and cultural obstacles will have to be overcome to make the system work efficiently:

1. The complexity of the COSA statutes will make it difficult for community representatives and local PHC officials to master all of the rules and the consequences of violating the rules. The fact that some COSA community representatives are illiterate may reduce their effectiveness and ability to explain the new PHC system and the role of the community within the system to their constituents.

2. Logistical problems may hinder the application of rules of democratic representation and checks and balances to ensure transparency and internal controls over monetary transactions. The poor roads and relatively long distances of many villages in the health area from the health center in both Adamaoua and South Provinces discourage the participation of community representatives from the periphery, especially when they receive no compensation for travel to attend meetings. The heavy duties of the president and treasurer of COGE who both have to physically sign checks and be available to monitor health center activities mean that choosing a president and/or treasurer from the periphery villages will likely delay many COSA transactions. This was the case in the Dir health area in Adamaoua province where the treasurer lived a considerable distance from the health center and was not easily available to co-sign checks. On the other hand, choosing COGE

officers who live close to the health center risks alienating the support and participation of those in the periphery who may not feel fully represented and perceive the health center as being primarily for those in the central area.

3. The community's perception of the role of COSA members as primarily one of political rather than technical representation has undermined the effectiveness of the existing COSAs. In several areas, the community has designated traditional political leaders and authorities as COSA representatives who often have no interest in and little understanding of health issues. It would be more effective to conceptualize and present the elected COSA members as technical representatives designated by the community to specialize in health issues.

4. The feeling that COSA members should receive some compensation for participating in the system has already led to reduced participation of COSA members in some areas. At the beginning of the project, community members seemed to be more willing to accept the principle that COSA members and officers would not be paid because they wanted to have the community pharmacy opened and be part of the drug distribution system. However, with the passage of time, COSA members are now more reluctant to spend their time, energy, and often their own money to attend meetings, hence the growing demand for some financial compensation. Since the concept of co-management and creating COSAs originated with the MOPH rather than the local communities, some COSA members see themselves as aiding the cause of the MOPH rather than that of their communities and hence expect to receive some compensation as quasi-civil servants (fonctionnaires).

5. Many local communities see the new PHC co-management system in Adamaoua and South Provinces as primarily an American project rather than a new system. This diminishes their sense of ownership and raises expectations about receiving more benefits, including free distribution of drugs. In the South, some people interviewed thought that the SESA I project had failed and that a new "project" was going to come into the area to implement the new system. Moreover, many MOPH personnel in the field often perceive the new PHC system as a donor-initiated project. This attitude is reinforced by the fact that health centers not yet incorporated into the first or second wave of the SESA/MOPH project are not part of the drug distribution system and lack the same degree of logistical support and supervision as those already touched by the project.

6. The absence or limited involvement of women in the COSAs deprives the SESA/MPS PHC program of important input from the main targeted beneficiaries of the project. Traditional socio-cultural factors explain the limited representation of women in the COSAs, especially in Adamaoua province where traditional Islamic practices preclude women holding leadership roles. Christian women in Adamaoua and South provinces tend to be more active in public life but still play limited leadership roles, especially in mixed groups. More needs to be done to involve women in health activities. Existing women's associations such as tontines might be mobilized and oriented towards health activities. The paucity of female health personnel in many rural areas also may discourage greater utilization of rural health

centers by women since some husbands are reluctant to send their wives to be examined by men. Current civil service rules encouraging married female state employees to be posted with their husbands has led to a heavy concentration of female health personnel in urban areas.

7. The lack of understanding of some health care personnel of their new roles and relationships with local community representatives in the co-management system may also affect the effective functioning of the new system. For example, some of the newly appointed health center chiefs interviewed in the field did not undergo any special training before being assigned to co-financed and co-managed health centers and thus were not fully aware of their new roles. The new COSA statutes are fairly complex and will have to be carefully explained to health center personnel as well as to the local communities.

8. The reluctance of some state health personnel to accept the new PHC system because it obliges them to share decision making powers with local communities and makes health center financial transactions more transparent and accountable, thus reducing the opportunities for fraud and diversion of health center resources for personal use may lead to some resistance in implementing the new system.

f. Economic Factors and Quality of Services as Factors Affecting Health Center Utilization

In addition to economic factors, the quality of public and alternative health care facilities also affect the utilization rates of government health centers (Litvack: 1992).

The economic crisis has reduced the ability of individuals and local communities in the project zone to pay for health services. Declining incomes mean that a relatively larger percentage of the household budget must be allocated to maintain similar levels of health care. While the South Province has higher per capita incomes than Adamaoua Province, purchasing power has been hard hit by the sharp decline in cocoa prices, the region's principal cash crop. It is yet to be seen whether a rise in cocoa producer prices or more prompt payment for cocoa crops will be accompanied by a greater willingness to pay for health services. In Adamaoua Province, cash incomes are much lower than in South Province because of the absence of major cash crops. Medical payments there represent a relatively higher percentage of household expenditures than in South Province. Current economic conditions are thus less favorable in South and Adamaoua Provinces than, for example, in the North West Province where the sale of fruits and vegetables to Yaounde has partially compensated losses of farmer income due to falling coffee and cocoa prices.

The assumption that people are not willing to pay for public health services and medicines because they once were free does not seem to hold water, despite grumbling from the local populations about having to pay. In the first place, where the co-financing and co-management PHC has been installed, health center utilization has gone up. Jennie Litvack's study shows that even the poorest elements have increased their use of health care facilities in

co-financing health centers. Second, it is clear that people have been willing to pay cash when frequenting church mission hospitals and rural health facilities even when user fees have been higher than those charged in state-run health centers. Third, consultation fees (prise en charge) associated with the purchase of a health book (cahier) are nothing new to the rural populations who have paid fees in cash or in kind to traditional healers (guérisseurs traditionnels) before the latter would treat them.

While low incomes reduce the ability of clients to pay for health services, the longstanding liquidity crisis in Cameroon's public finances has contributed to a deterioration in the quality of health services as budgeted funds for the operating costs of rural health area centers have not been able to be fully used. For example, most of the health centers visited by the team Adamaoua Province had 450,000 FCFA budgeted per semester for recurrent costs. In most instances, none or only a tiny fraction of the budgeted funds were actually spent. The inability of local health centers to actually use the funds budgeted for recurrent costs means that many health centers lack basic materials -- e.g., gauze, bandages, scissors, surgical gloves, chemicals to do laboratory tests, etc.-- which may lead individuals to bypass the rural health center and go directly to an urban hospital or to use a church mission health facility.

Factors such as absenteeism on the part of rural health personnel, indifferent attitudes of health staff to their clients, and the poor state of the health center's physical facilities have adversely affected the quality of services in some health areas. For example, in Adamaoua Province, rural health officials must often spend several days a month away from their posts because of their need to travel to Ngaoundere to receive their salaries. In some places, community members have complained about the limited availability of health center personnel who are theoretically supposed to be on call 24 hours a day. Morale of health personnel is also low because of recent salary reductions. Poor maintenance or breakdowns in the water supply system in some areas resulted in water shortages and the lack of potable water and proper toilet facilities in some health facilities.

The presence of alternative PHC sources in rural areas can also adversely affect utilization rates. Alternative sources include self-medication, traditional healers, church mission health facilities, itinerant market peddlers of drugs, and private clinics and pharmacies. The decision of which source to use depends on a combination of several factors:

- socio-cultural attitudes towards certain diseases and their treatment.
- direct cost factors such as consultation fees and the price of drugs.
- transaction costs entailed in getting to the health service--e.g., travel time, transportation costs, waiting time, etc.
- the degree of client confidence in the particular health care provider.

For example, many people resort to home remedies for certain kinds of ailments or prefer to go the traditional healer to treat certain medical problems like simple fractures, poisoning, or liver problems or to traditional midwives for child delivery. Those who have fever or malaria symptoms may prefer to buy aspirin or quinine in the market from an itinerant peddler rather than pay the costs of a consultation fee at the local health center and perhaps higher prices for drugs. The unavailability of drugs at a government health center or the belief that a certain brand name drug is far superior to the generic drug offered by the health center to treat the ailment may lead some clients to buy their drugs in a private pharmacy in town. The lower prices charged by the traditional healer plus the fact that he/she often accepts fees in kind or payment in several installments offers someone short of cash with an alternative to the health center which demands immediate payment for services and drugs and gives no credit. On the other hand, clients may be willing to pay more for services at a church mission hospital because they believe that the quality of service is higher or feel more comfortable with people from their own church denomination.

In short, the government-run health center has no monopoly over the production of PHC services and must compete with other providers in attracting customers. Government health centers can attract more clients and increase utilization rates by providing low cost and high quality PHC services. It would be a serious mistake for the government to try and eliminate alternative sources of PHC services. Heavier policing of itinerant market drug peddlers, for example, would entail high surveillance costs, provide more opportunities and temptations for officials to accept bribes in exchange for not checking market drug sales, and reduce the amount of low cost drugs available to the local populations. On the other hand, there is a strong need to encourage collaboration and coordination among the diverse PHC providers in order to improve services and to make more health care accessible to larger segments of the population. The proposed legislation to officially recognize traditional healers as part of the PHC system while setting standards is a positive step in the right direction as are efforts to work out a system of collaboration between the public and confessional health sector acceptable to both parties.

4. The Organization of the COSADIs

The health district is slated to be the functional management unit of the new PHC system and will cover an estimated population of 50,000 to 100,000 people. At the July 1992 Bertoua National Workshop sponsored by the MOPH, South and Adamaoua Provinces were tentatively divided into six districts. As of March 1993, the MOPH had not yet completed its plans to formally organize health districts and put together a health district team within the new district boundaries.

Until now, the district health committees (COSADIs) have been organized at the level of the subdivision (arrondissement). Once, the new district system is put in place, the size and composition of the COSADIs will expand to take into account the new district boundaries. The COSADIs are to be part of the provincial health system headed by the

Fonds Special Pour la Promotion de la Santé (FSPS). Its competence extends to the area that will be covered by the new health districts.

a. Objectives

The objectives of the COSADIs are essentially as those listed for the COSAs as listed earlier in the paper. The main difference is that the COSADI's partner is the district health team rather than the area health center. COSADI's domain of surveillance will also include the district reference hospital.

b. Composition of Members, Duties and Advantages

Like the COSAs, the COSADI has three categories of members: *ex officio*, active, and honorary. The *ex officio* members are:

- the head of the district health service,
- the head (médecin-chef) of the district hospital,
- the head of each health area center in the district, and
- a representative of each church mission or NGO involved in PHC activities in the district.

Each COSA has two representatives on the COSADI, one of whom is the president of the management committee and the other designated by the COSA. Honorary members are recognized and approved by a majority of the General Assembly after being nominated by the district management committee. Honorary members, unlike the *ex officio* and active members have no voting rights.

The members of the COSADI have basically the same advantages accruing to COSA members at the health center level. However, unlike COSA members, all *ex officio* and active COSADI members have the right to be reimbursed for transportation costs and per diem relating to their participation in General Assembly or Management Committee meetings. Each institution represented in the COSADI (MOPH, church missions, NGOs) is responsible for paying for transportation and per diem for its representatives at COSADI and COGEDI meetings. The COGEDI may pay for this if the institution cannot.

c. Powers of the General Assembly and COGEDI

The powers and rules of procedure of the General Assembly of the COSADI at the district level are basically the same as those elaborated for the COSA at the health area level. The General Assembly thus is the supreme decision making body of the COSADI and must

approve budgets, action plans, remuneration policies, and other major health policy decisions formulated by the COGEDI management committee.

The bureau of the General Assembly consists of a president, vice-president, secretary, and two auditors (Commissaires aux Comptes) who verify the monthly accounts of the health area pharmacy clerks and the accounts of the COGEDI treasurer.

The COGEDI, whose members come from the General Assembly, has nine members, four *ex officio* and five active. The *ex officio* members are:

- the head of the district health service,
- the head of the financial and administrative affairs service of the district hospital,
- a nurse (infirmier) elected by his/her peers from the area health centers, and
- the médecin-chef of the district hospital.

One of the interesting features of the COGEDI is that there is no room for a representative of the church mission sector to be an *ex officio* member. This may create some problems of representativity, particularly in districts where a church mission hospital has been designated as the district's reference hospital. The church mission may object to not having one of its own representatives on the COGEDI.

The five active members are chosen by community representatives in the General Assembly of COSADI. Unlike community members of the COSA management committees, community members on the COGEDI must be literate and able to regularly attend meetings. To insure that all of the health areas in the district have representation at some point on the COGEDI, when vacancies occur, the election rules give priority to choosing new members from health areas which had no previous representation.

The bureau of COGEDI consists of four members: a president chosen by the community representatives; a secretary who is the head of the district health service; a treasurer who also comes from the community; and the head of the district hospital. The president represents the COSADI in civil matters and in dealing with state authorities, convokes the general assembly, prepares the agenda for meetings, and is the final arbiter in settling disputes within health area management committees. The secretary prepares the minutes, keeps all documentation concerning the COSADI and sees to it that COSADI decisions conform with national health policies. The treasurer has very heavy responsibilities. He/she is liable for damages done to the COSADI through negligence in managing its funds or through embezzlement. The treasurer has many of the same powers exercised by the COSA management committee treasurer at the health area level. He also checks the books of

the district hospital's pharmacy clerk and controls the funds generated by the sale of drugs by the district hospital pharmacy.

The COGEDI is the executive arm of the COSADI and formulates much of COSADI's policies -- e.g., personnel remuneration, location of new health facilities in the district, budgets, district action plans, drug prices and margins, the use of human and financial resources within the health district, etc. The COGEDI also has the power to take measures to deal with needy people (indigents) in the district who cannot afford to pay for medical care. The contractual powers of COGEDI are limited since it can apply only those conventions, contracts, and transactions approved by the FSPS. Contractual relations not approved by the FSPS are not valid.

The resources of COSADI come from various sources. Whereas the financial resources of the COSAs derive mostly from consultation fees and drug sales at the health center level, much of the COSADI's financial resources are generated from the district hospital's revenues as spelled out in the 1992-/93 finance law.

d. Rules to Ensure Transparency and Checks on Abuses

The COSADI statutes contain most of the rules elaborated at the COSA level to ensure transparency and checks on abuses in the district PHC system. Thus COSADI members have access to all the accounts, financial registers, and minutes of General Assembly and COGEDI meetings. COSADI checks must be co-signed by the President, Treasurer, head of the district health service, and a fourth member of COGEDI. Equipment belonging to COSADI can't be employed for personal use and violations of this rule will be sanctioned by penalties prescribed in article 184 of the penal code. The various actors involved in financial transactions are controlled at several levels, above from the FSPS and laterally by the General Assembly auditors. The treasurer keeps track of the hospital's pharmacy clerk and controls the funds generated by the hospital pharmacy.

It remains to be seen whether employees hired by the community like the hospital pharmacy clerk will have the self-confidence to disobey orders coming from hospital officials which violate the rules for selling drugs. In one hospital in South Province, the hospital pharmacy clerk told a member of the team that he had given several drugs to a hospital official without being paid for them because the doctor had insisted that he had the right to requisition drugs.

e. Issues Related to Effective Community Participation in COSADI's Co-Management Structures

The district level may prove to be the most difficult of the three levels-- health area, district, and province -- to organize effective community participation structures and collaboration with health service officials.

In the first place, the district, in most instances, encompasses a larger territory and population than the sub-division. Existing health committees set up by SESA I operate at the sub-divisional level which in earlier models of the PHC system served as the district level. Since the number of districts (6) in Adamaoua and South Provinces are less than the number of subdivisions (arrondissements), the role of the subdivisional health committees will have to be rethought. Once the district has been officially set up, there will be no place for a subdivisional health committee since the district health committee (COSADI) will have representatives directly elected from the COSAs at the health area level.

Second, the main thrust of the SESA I project to date has been to reinforce rural health centers. While expanding the number of health centers involved in the project, SESA II will also be involved in reinforcing district health structures which may involve a somewhat different constituency and set of structures because of the following reasons:

- The district hospital which serves as the reference hospital for the district becomes a main focal point of district health level health activities rather than the rural health center.
- The district hospital is located in an urban area and is likely to draw more clients from the town in which the district hospital is located than referral clients from the rural health centers in the district.
- The main source of revenues for the COSADI will come from district hospital receipts which will be managed according to rules defined by decrees taken by the Prime Minister regarding divisional and sub-divisional hospitals. Community representation on the hospital management committee as defined by decree differs somewhat from the representation patterns called for in COSADI statutes. For example, the COSADI statutes do not reserve a place for a representative of the commune in which the district hospital will be located.
- The most influential or at least the most active community representatives on COSADI are most likely to be urban dwellers. It will be more difficult for rural representatives to be available to monitor district hospital activities.
- However, in the COSAs, health personnel representatives were nurses, in the COSADIs, medical doctors constitute the majority of MOPH representatives on the COSADI and COGEDI.
- Once the district is formally established, the MC of the district hospital will play a much larger role and be more involved in district PHC programs than in the past when he/she was mainly responsible for hospital curative care.

- The role of the territorial administration will also be affected as districts may encompass health centers from more than one subdivision. Thus a health center in one subdivision may be attached to a district with headquarters in another subdivision, division, or even province. Under the previous system, the district coincided with the subdivision while the COSADI was theoretically considered to be a subcommittee of the subdivision development committee presided by the sous-préfet. The district PHC structure has no formal place for the sous-préfet.
- Although the MOPH is definitely thinking of using certain church mission hospitals as district reference hospitals, the COSADI statutes contain no provisions for different patterns of representation if confessional hospitals agree to collaborate in the global state PHC system and serve as district reference hospitals.

Given SESA's past experience and orientation towards rural health centers, it will require a much greater and probably longer effort to establish effective community co-management participation structures at the district level which incorporates new constituencies, a much larger role for doctors and hospital personnel, and different relationships with the territorial administration. It also requires community representatives on the COGEDI to have a higher technical skill level than those on the COSA management committees.

5. The Organization of the FSPS

The summit of the community co-management participation structures is the Special Provincial Health Fund (Fonds Spécial pour la Promotion de la Santé or FSPS). Like the other co-management structures in the PHC system, the FSPS is to be set up as an autonomous non-profit association aimed at improving the health of the people living in the province.

a. Objectives

The objectives of the FSPS in Adamaoua and South Provinces are essentially the same as the North West Provincial Special Fund for Health which serves as the basic model and include the following:

- to ensure an adequate drug supply to state, secular, church, and municipal health facilities in conformity with national health policies.
- to help the MOPH finance the operation of health services.

- to contribute to the improvement of the quality of health by ploughing back funds generated by the FSPS into health needs according to decision taken by the General Assembly concerning the use of surplus funds.
- to improve all forms of health services in the province.
- to promote health and nutrition education.
- to improve the efficiency of human, financial, and material resources available to the people in the region.
- to adhere, contribute and benefit from the advantages and interventions of the National Special Fund for Health.
- to enter into any arrangement or joint venture with any person, society, or organization carrying on activities which the FSPS is authorized to carry on.
- to establish, run, and support other related funds and institutions working toward the improvement of health care in the province.

b. Composition of Members

The FSPS has three categories of members: *ex officio*, active, and honorary. The FSPS has four *ex officio* members:

- a representative of the Governor.
- a representative of the MOPH chosen by the minister.
- The Provincial Health Delegate who also serves as president of the management committee.
- the head of the donor project supporting PHC activities in the province(SESA I and SESA II).

In the Northwest, the head of the provincial preventive and rural medicine service was a fifth *ex officio* member. In the South and Adamaoua Provinces, the PHD can be assisted by one of the heads of the provincial services who has no vote.

The number of active members in the FSPS is smaller than the number of community representatives in the NWPSFH which sends two representatives from each subdivision health committee as compared with only one representative from each of the six COSADIs. The mayor of the town in which the provincial headquarters is located is that COSADI's representative or someone else designated by him/her. Other active members include:

- a representative from each of the church missions working in health activities in the province.
- a representative of the NGOs working in health activities in the province--e.g. Save the Children in the Extreme North Province.
- a deputy from the governmental majority party designated by the party's deputies in the province.
- a deputy from the major opposition party in the province designated by the deputies from his party in the province.

The number of active members will be much smaller in the South and Adamaoua Province FSPS than in the North West Province Fund. The result is that the weight of community representatives in the General Assembly is much less vis-a-vis government representatives. The honorary members representing the different health professions are essentially the same as those designated in the NWPSH statutes. One of the peculiar features of the composition of the membership of the FSPS is that the number of active General Assembly members is not less than the number of active members on the management committee which has 2 community representatives from each division.

The advantages of the *ex officio* and active members are essentially the same as those elaborated for the members of COSADI and include per diem and compensation for transportation to attend General Assembly and management meetings.

c. Powers and Functions of the General Assembly and Management Committee

The powers and functions of the General Assembly are spelled out in much greater detail in the FSPS statutes than in those of the North West Fund. The various powers and functions are similar to those spelled out for the COSA and COSADI General Assemblies and include such items as deliberating on and approving FSPS annual budgets, policies, action plans, utilization and distribution of FSPS surpluses; setting debt and investment ceilings; examining, approving and rectifying the accounts presented by the management committee; and validating decisions by the management committee to exclude members or fire FSPS employees. The General Assembly also has the power to accept or reject the candidates for General Manager (Responsible Executif) nominated by the management committee. In extraordinary sessions, the General Assembly can also make decisions concerning the dissolution, fusion, or splitting of existing COSADIs, modification of existing statutes, and the election of new members of the management committee.

The bureau of the General Assembly consists of the representative of the Governor who presides over the General Assembly meetings, a vice-president chosen from the active membership list, and the PHD who serves as the secretary. There are no auditors on the

bureau since auditing functions at the FSPS level will be carried out by independent external auditors.

Members of the management committee serve three year terms. The management committee consists of:

- all four *ex officio* members.
- two COSADI representatives from each administrative division.
- the mayor of the administrative division in which the provincial hospital is located plus a representative of the COSADIs of that division.
- one representative from the church missions on a rotating basis.
- the General Manager of the FSPS (Responsible Executif).

Although community representatives have a majority on the management committee which meets at least once every three months, public health officials control the bureau of the management committee with the PHD serving as the president and person responsible for representing the FSPS in dealing with public authorities and the General Manager who must be hired from the ranks of the MOPH serving as the rapporteur. The vice-president of the bureau is the only representative of the community and has no special function.

The FSPS management committee serves as the executive arm of the General Assembly and carries out its decisions. But it is really the management committee which takes the initiative in defining policy which the General Assembly can approve, modify, or reject. It has similar powers to those enjoyed by the COSADI and COSA management committee in the domain of policy making -- e.g., preparation of budgets, action plans, personnel remuneration policies, drug pricing practices, and criteria for using provincial resources and the FSPS surplus. The FSPS management committee also has considerable supervisory powers and is responsible for controlling and monitoring the drug supply system to the COSADIs, naming an expert accountant to verify the books and records of the FSPS as well as the COSADIs, and COSAs in the province, and ensuring that institutions like the provincial hospital and the COSADIs conform with national health policy in their operations. The management committee also has to approve all COSADI transactions and relationships which may affect provincial planning and health policy.

The General Manager runs the day-to-day affairs of the FSPS under the authority and control of the management committee. His/her nomination must be approved both by the General Assembly and the Minister of Public health. The General Manager receives a salary from the state and represents the FSPS in dealing with third parties. He/she performs similar duties to those of the treasurer at the COSADI level in dealing with the FSPS' financial

records and transactions. He/she also is responsible for preparing reports, supervising FSPS personnel, and other managerial duties.

The proposed statutes of the FSPS provides operational rules for the transition period while the SESA/MOPH structures set up during SESA I are being integrated into the new FSPS structures. For example, the various activities, investments, and property of the SESA project such as the CAPP become those of the FSPS as soon as the FSPS makes its declaration before the Cameroonian administrative authorities. State employees seconded to CAPP from the MOPH will remain state employees and continued to be paid by the state after the FSPS takes control of CAPP. As in the North West Province, the head of CAPP will become the General Manager until the nomination of a new General Manager by the General Assembly. Thus, until the community participation structures become fully operational, the FSPS will remain largely an extension of the SESA/MOPH project and managed primarily by MOPH and SESA project officials.

d. Rules to Ensure Transparency and Checks on Abuses

The rules to insure transparency by providing easy access to FSPS books, records, financial registers, and General Assembly minutes and Management Committee meetings are essentially the same as those at the COSA and COSADI levels. The General Assembly also must provide information to the health committees concerning the exact amount of state budgetary funds allocated for the various health facilities in the province. This kind of data will prove to be useful in informing the public about state budgetary processes and possibly provoke pressure from public opinion to reform existing procedures which thwart the actual expenditure of budgetary resources.

The statutes provide for the use of independent external auditors to verify the accuracy of the various financial records and to make an evaluation of the effectiveness of FSPS administrative and financial management. Rules also exist to prevent nepotism. Other rules make it clear that violation of FSPS statutes and rules may be sanctioned by penalties which include suspension, exclusion from membership, firing, and bringing the offender in criminal cases to justice. The FSPS statutes also hold the General Manager legally responsible for damages done to the FSPS due to negligence or malfeasance.

e. Issues Concerning Community Participation in FSPS Co-Management Structures

The SESA project began as a top-down project which worked closely with the MOPH directorate of Preventive and Rural Medicine and provincial health delegations. During the course of the project a serious effort was made to establish community participation structures and to decentralize decision making authority from the central administration to the provincial level. SESA II seeks to continue this trend and seeks further decentralization of PHC activities at the district level and more effective community participation in co-management structures.

The formal establishment of the FSPS will require that the existing COSADIs elect members to represent them to the FSPS General Assembly. It is not clear whether the existing COSADI community participation structures are truly representative. For example, it is not clear how elections to COSAs and COSADIs are actually organized and supervised. The various statutes say nothing or little about the setting of dates for elections, the nomination procedures, the organization and supervision of the actual elections, the counting of votes, the handling and resolution of electoral disputes, etc. The absence of clear-cut voting procedures can lead to an unrepresentative membership in the health committees. For example, in one health area in the South Province, the elections to the COSA seemed to be organized by an influential, retired sous-préfêt who allegedly chose most of the village delegates to the COSA and a relative as pharmacy clerk. In another case, a prominent local private pharmacist was president of the arrondissement health committee, thus raising questions of conflict of interest. In Adamaoua Province, traditional leaders --e.g. lamidos-- tend to dominate the electoral process.

Community participation in the co-management of the provincial referral hospital is relatively limited. Although recent legislation calls for establishing a management committee for provincial hospitals, community representatives are a distinct minority on this committee which is dominated by health and other state officials.

Because the initiative for organizing the FSPS has been taken primarily by the SESA/MOPH health project in South and Adamaoua Provinces, it may take some time before FSPS community members feel some ownership of the system. Unlike exclusively private associations organized under the Law of Association, the FSPS is a mixed body with a heavy representation of state health officials. Representation issues are further complicated by the need to integrate the provincial confessional health structures which have different operational and representation rules into the FSPS system. Moreover, the churches have an evangelical mission which makes them reluctant to become part of a secular PHC system which may be perceived as asking them to renounce their evangelical activities.

B. MOPH Primary Health Care Structures in South and Adamaoua Provinces: Reorientation and Community Collaboration Issues

The reorientation of national PHC policy since 1989 requires MOPH field structures and personnel to adapt to changes in their mission and spheres of operations and their relationships with the local communities they serve. This section examines six major issues related to the effective implementation of PHC policy in the SESA project zones:

- health district reorganization and its impact on existing PHC structures.
- relationships between referral hospitals and the PHC delivery system.
- hierarchical relationships in supervisory activities.

- incentives and sanctions to promote better job performance of PHC personnel.
- the development of improved IEC structures.
- relationships with the professional health care community.

1. Reorganization of District System Boundaries

Under the reoriented system, the district is to become the key operational unit in the provincial PHC delivery system. Before the July 1992 Bertoua conference, health districts coincided with the subdivisional administrative boundaries. The subdivision did not work well as a district unit because the population sizes were often too small to support a referral hospital and district health office. This was particularly true of regions like Adamaoua and South Provinces which had very low population ratios and subdivisions with populations under 10,000 people. The Bertoua conference proposed a delimitation of health districts consisting of one or more subdivisions which would attempt to coincide with divisional administrative boundaries. Adamaoua Province was divided into six districts: Banyo, Djohong, Meiganga, N'Gaoundere, Tibati, and Tignere while the South Province was also divided into six districts: Ebolowa, Ambam, Sangmelima, Zoetele, Kribi, and Lolodorf.

Thus far, the MOPH has not officially accepted the new district boundaries nor elaborated the composition and job descriptions of the district health team. This delay in creating the district structures affects the establishment of the corresponding district community participation structures which until now have been operating at the subdivisional level.

The establishment of new district boundaries will have far-reaching consequences on district and subdivisional level hospitals. For example, the subdivisional hospital in Djohong which has limited and dilapidated facilities is now slated to become a district referral hospital. This will entail upgrading its facilities if it is to serve as a full-fledged district referral hospital. Such upgrading will require considerable investments, which on a per capita basis will be very expensive, because Djohong serves an area with a population of less than 21,000. On the other hand, the formal role of the subdivisional hospital will be downgraded. Because of political considerations, it will be difficult to eliminate certain subdivisional hospitals with small population catchments despite the fact that they are not economically viable, expensive to maintain, and don't provide the level of health services normally associated with a hospital. Maintaining the subdivisional hospitals also means maintaining a doctor rather than a nurse to head it. This raises personnel costs and also may lead to low morale on the part of doctors who feel that they have to manage a sub-par hospital facility.

The enlargement of the population served by the new health districts will necessitate a revision of the size and duties of the existing subdivisional district teams. One expert (Dujardin: February 28, 1992) suggests that the district health team should consist of five members consisting of two doctors, two nurses, and an administrator. One of the doctors

would head the district PHC service and hopefully have some training in public health; the second doctor would head the district hospital. One nurse would be chosen by the staff of the health center while the other nurse on the team would be chosen by the hospital personnel. The fifth member of the team would assist the district head in managing the program. Supervision of the health centers would be primarily carried out by the nurses but the doctors would also be involved in supervisory activities.

Team members should be recruited and trained collectively in order to create a team rather than an agglomeration of individuals. People trained in the new district health system would be assigned to an operational health district and not have their training lost by being assigned elsewhere. Staff stability will be an important element in insuring better results. Rules committing staff to at least three years service in a health district team should be introduced and rigorously enforced. District team leaders should also be granted authority to discipline district health personnel

The role of the divisional level health services will also have to be rethought. In many instances, the divisional hospital will become the district referral hospital. If this is the case, then there is no need for a subdivisional referral hospital or subdivisional team to conduct supervisory activities at the health center level. In short, the creation of the district may permit the MOPH to eliminate one bureaucratic level, especially for supervisory activities.

PHC care strategies for health districts should take into consideration differences in size, area, and urban/rural population ratios. For example, a health district like Ngaounderé serving a population of 142,000 people with a large urban clientele and an excellent Protestant hospital in its jurisdiction should have a different strategy than that of Banyo with a population of less than 35,000 people and a small urban population. District PHC strategies should also take into consideration differences in the financial resource base. Urban health centers will play a greater role in districts with a large urban population.

2. Tensions between Referral Hospitals and PHC Services, Doctors and Nurses

In the past, the hospitals have been primarily curative institutions serving a predominantly urban constituency. They have been run by doctors trained primarily in curative techniques who had little if any contact with the PHC services in the field, particularly at the health center level, which is run by nurses.

The reorientation of the PHC system calls for a greater role for hospital doctors in the system. First, they are asked to send down information concerning patients referred to them from the rural or urban health centers so that the latter can do follow-up work. Second, the hospitals must make a greater effort to refer patients not needing more specialized and advanced health care to health centers. Third, the hospital doctors are asked to devote part of their time to planning and supervising PHC activities within the district and to making periodic visits to the field. Fourth, the hospital doctor who in the past had been used to

enjoying considerable autonomy from the chief officer at the divisional or subdivisional level must now work more closely with the district PHC head chief and accept him/her as his superior in the hierarchy. The team's field visits noted that the hospital doctors seemed to show little interest in getting more involved in rural PHC services. The current rules reward doctors who spend much of their time consulting patients in the hospitals and few incentives for going out in the field. The current reward system may also discourage doctors from accepting positions as district PHC medical officers which give them greater responsibilities without additional compensation and less opportunities for earning supplementary income through hospital consultations.

The greater role to be played by nurses on the district team in coordinating and supervising rural health center activities could increase tensions between doctors and nurses since the present rules offer no additional compensation or upgrading of their status in exchange for the nurses accepting greater responsibilities in the PHC delivery system. Hospital nurses also resent rules that in the past permitted doctors to receive a share of the hospital consultation fees while nurses received nothing. Changes in the rules concerning the distribution of resources generated by district hospitals which would grant nurses and other hospital personnel a share of the receipts could improve morale and team spirit as would additional compensation for nurses with heavy rural PHC supervisory duties.

3. Hierarchical Relationships in Supervisory Activities

Lax supervision of PHC delivery systems and personnel is one of the major causes of poor performance. The reorientation of the PHC system requires considerable changes in attitudes and roles on the part of PHC personnel and community representatives and employees involved in the co-financing and co-management system. As a result, there is a need for greater supervision at all levels in the system and the need to clarify two important issues:

- Who has the authority to supervise whom in the chain of command?
- What should the role of CAPP personnel be in supervising those involved in the provincial drug supply system?

The main purpose of supervisory activities is to provide guidance to MOPH officials, community health committee officers, and community health employees like the pharmacy clerks so that they may perform their roles in a satisfactory manner. Until recently, each level--provincial, divisional, subdivisional, and health center-- would designate one or more officials to supervise the PHC activities of the next lower echelon in the chain of command. Thus, provincial officials would supervise the divisional services; divisional officials the subdivisional services; subdivisional services the health centers; and health center officials the village health posts. In most instances, supervisory teams consisted of a doctor and a nurse with the nurse making more frequent supervisory visits. When the new district boundaries become operational, it will be possible to eliminate the existing divisional and subdivisional

supervisory functions and make the supervisory system less cumbersome. Thus, provincial officials will supervise the health districts, and health district officials will supervise the health centers.

While the hierarchical chain of command is fairly clear, the role of horizontal supervision by the heads of the provincial, district, and area health services is less clearly indicated. For example, does the PHD have the authority to supervise officials in the provincial hospital or CAPP? If so, does he/she have the requisite skills to do so? The same questions can be raised at the district and health center levels.

Poor supervision of the drug supply system can result in stockouts, overstocking and understocking of certain drugs, and inadequate security measures. At the present time, CAPP sends people from the provincial level to periodically supervise the activities of pharmacy clerks in the drug supply system and collect receipts. Unfortunately, in some instances, provincial CAPP coordinators limit their role to checking the books and collecting receipts without taking the time to discuss problems raised by the pharmacy clerks or to suggest ways in which the pharmacy clerk can improve his/her performance. This limited form of supervision could stem from lack of training on the part of provincial CAPP coordinators, poor motivation, and/or insufficient time allocated for supervisory missions to health centers. In the Adamaoua region where distances are long and roads poor, CAPP supervisors must spend a good deal of their potential supervisory time traveling to and from health centers. With the expansion of the number of health centers participating in SESA II, the supervisory burden will become even greater. One possible solution would be to shift some of the supervisory functions concerning the pharmacy clerks to members of the district team who are closer.

4. Incentives and Sanctions To Promote Better Job Performance

The reorientation of PHC policy actually requires most PHC health personnel to do more than they have in the past. One of the main problems facing the SESA/MOPH project is how to motivate health personnel to do their jobs well and honestly.

Community focus groups have cited poor attitudes on the part of health providers as a major reason for not frequenting the health centers. Several factors contribute to poor attitudes, low morale, and lack of motivation on the part of government health workers:

- having nothing or little useful to do with one's time because of poor planning, few clients, or lack of materials needed to carry out the assigned tasks.
- having little understanding of the job and little or no responsibility in decision making.
- the pervasiveness of corruption which encourages health workers to use public goods for private use.

- the difficulty of applying sanctions -- e.g., jailing, firing, demoting, and reducing salaries -- against those stealing, violating regulations, or doing a poor job because of complex civil service regulations.
- recent reductions in salaries.
- inequities within the health care system such as doctors getting the lion's share of benefits connected to consultations and the assignment of certain people to remote isolated areas while others always seem to manage to stay in the big towns.

In popular parlance, "motivation" usually refers to some financial payment in Cameroon. The social soundness analysis for the SESA II project paper provides a detailed discussion concerning the need to provide more incentives to motivate public health personnel and offers several examples of non-financial incentives to motivate personnel:

- greater participation in decision making directly affecting their work encouraged by a more participatory management style on the part of health officials higher up in the system.
- opportunities for professional growth and advancement through stages and leaves to pursue a higher degree.
- recognition of the importance of their job responsibilities.
- providing needed equipment such as motorbikes for nurses to visit villages or lab materials to carry out tests, decent furniture for offices, etc.
- providing health officials with a more positive public image through interviews in the media concerning their activities and the publication of an in-house journal.

Part of the surplus generated at different health structure levels could be used to offer financial incentives to those doing a fine job in their work. The social soundness analysis suggests the following kinds of financial awards:

- Post differential awards for personnel assigned to remote health areas.
- Outreach awards for health personnel working in outreach vaccination and health education campaigns.
- Language proficiency awards for newcomers mastering the local language.

- Community support awards for COSA members participating in planning activities and mobilizing their communities to participate in health campaigns.
- Individual rewards for managers of hospitals, district health services, health centers, supervisors, nurses, etc.
- Collective rewards to be given to health teams for outstanding performance.
- Funding for small-scale community development projects as rewards to communities with excellent results in stimulating greater utilization of area health centers.

These rewards need not entail large sums of money.

One of the most difficult tasks for making the new PHC system a success will be getting hospital doctors out of their hospitals and into the field. The present system rewards those doctors who stay in the big towns and penalizes those who work in subdivisional hospitals or those who head subdivisional level PHC services. Rule changes within the MOPH might be considered which would require doctors to serve at least one out of every three or four tours in a rural area and provide more rapid promotion and/or an end of term bonus for doctors doing excellent PHC work in remote and difficult areas.

Much more also needs to be done to provide health officials with more authority to sanction offending subordinates. Moreover, community opinion should be considered in dealing with corrupt health personnel and those with poor attitudes. In the North West Province, community pressure has succeeded in removing several health center heads who were perceived as not serving the public very well.

Salaries could be frozen and a new financial incentive system established which would make job performance bonuses an increasingly larger part of the total remuneration package. As performance bonuses become an increasingly larger part of total remuneration, poor performance would be penalized as the real value of fixed salaries would decline as living costs go up.

5. The Development of Improved IEC Structures

SESA evaluations have reported that many health personnel and community representatives do not fully understand the new PHC system or the roles that they are expected to play. Our team's field visits support this contention. IEC functions must be improved and expanded to rectify this situation.

Health personnel at all levels are expected to adopt new roles and expand the scope of their activities within the framework of changing jurisdictional boundaries and job descriptions. These changes need to be carefully explained to PHC personnel.

In a similar manner, community representatives are expected to master fairly complex rules for participating in the various co-management community health committees. The new COSA, COSADI, and FSPS statutes will need to be carefully explained to the community.

Improvement in IEC skills will entail better public relations and greater use of the media (radio, television, newspaper), audio-visual materials, cassettes, and forum groups to inform the public about the details of the PHC program, the role of the community health committees in the new system, the scheduling of diverse health campaigns, the causes of diseases and measures needed to prevent these diseases, etc. District and health center personnel could receive some additional training in IEC techniques and could be made more aware of the importance of IEC activities in generating support for PHC activities and feedback which can be used to improve services and collaboration between the community and PHC staff.

6. Collaboration with the Confessional Health Sector

Church mission health facilities have played an important role in providing medical services and supplementing the state's PHC system. There are three major confessional health providers in Cameroon:

- the diverse Protestant church missions organized at the national level within FEMEC which supports 23 hospitals, 97 health centers, three nurses training schools and a staff of more than 60 doctors and 2500 employees.
- the Catholic Church with 8 hospitals, 126 health centers and maternities and a staff of 26 doctors and 1200 employees.
- AD LUCEM, a non-profit, non-denominational Christian organization with 5 hospitals, 12 health centers, and a central pharmacy and a staff of 550 employees.

The co-financing concept is not new to the church health sector. User fees provide nearly all of the resources needed to keep the church health facilities operating. In the three church hospitals visited by the team, user fees contributed 90-95% of the funds needed to run the hospital, the rest came from church contributions.

In general, confessional health facilities are clean and well-managed and provide good service. They also have higher utilization rates than state health facilities. In many instances, people prefer to use church health facilities over state facilities for various reasons:

- belief that the quality of service is better.
- more courteous attitude on the part of the staff to the public.
- cleaner and better-organized facilities.
- more flexible payment mechanisms.
- religious solidarity on the part of members of the church.

The confessional sector is thus, in some ways, a competitor of the state. Like the state, the confessional sector has also been adversely affected by the economic crisis and has been hard pressed financially to maintain the quality of services. The confessional health sector suffers from some of the following problems:

- high cost of drugs and relatively limited purchasing power of individual churches.
- lack of standardization in equipment and difficulty in getting spare parts.
- the high cost of supervising health centers in the system which are often scattered over large areas and quite distant from the referral hospitals.
- lack of transportation resources.
- lack of funds to train health center personnel.
- decline in the purchasing power of rural communities which makes it more difficult to collect fees and reduces utilization rates.

Collaboration between the confessional and state health sectors would be beneficial to both parties. The state could provide the confessional sector with additional personnel and training facilities, reduce the costs of purchasing drugs by buying in bulk, and reduce supervisory costs through a more rational spatial allocation of supervisory functions. For its part, the confessional sector can contribute highly efficient hospitals to serve as reference hospitals in the new district system.

While the MOPH is eager to integrate the confessional health sector into the reoriented PHC system, the churches have been reluctant to join. In the first place, they did not participate in the design of the new PHC system and were not consulted concerning the delimitation of the new health districts. Hence, they tend to perceive the PHC system as a state system rather than a global system encompassing all of the actors providing medical care. Second, they fear that integration will force them to play down their evangelical mission since their goal is not only to heal the sick but also to bring the Gospel. This feeling

is much stronger on the part of Church officials than on the part of the lay doctors running the mission hospitals and health centers. Third, the confessional sector has concerns that integration will lead to a loss of control over the management of their health facilities and a decline in the quality of their services.

In practical terms, it will take considerable negotiation and dialogue between the MOPH and confessional health sector to elaborate a set of principles and rules which will be satisfactory to both parties. At the present time, the various churches have their own personnel management systems, community participation structures, and supervisory systems which are quite different from those in the MOPH PHC system. Some of the more thorny issues concern the following:

- the authority of district church hospital doctors to sanction state personnel assigned to church hospitals.
- the willingness of MOPH personnel to accept the evaluation and authority of church health officials in the program.
- harmonization of the rules defining community representation in church health facility management structures with those in the state system.
- willingness to come up with a common action plan for state and church health services within a given jurisdiction.
- agreement on the utilization of resources and surpluses generated by the drug supply system and hospital and health center facilities.

The resolution of these issues will not be easy and will require delicate negotiations. It would be best to proceed slowly. One could initiate collaboration in a model district. For example, the director of Enongal Presbyterian Hospital, just outside of Ebolowa city limits, expressed interest in the new PHC system and had an excellent understanding of the advantages of collaboration and the issues which had to be resolved before such collaboration would be acceptable to his church. The director said that he had the confidence of the church authorities and believed that he could convince them to support integration into the district health system if he gave his approval after being assured that the proper safeguards were in place.

V. Conclusions and Recommendations

The reoriented PHC strategy is a sound one and has the support of the major donors. Donor collaboration makes it possible for the MOPH to establish a coherent and sustainable national PHC system throughout the country. SESA I and the MOPH have laid the groundwork for the new system in Adamaoua and South Provinces since 1989. The system is still in transition and the new structures not all fully in place. Lax supervision, lack of clarity of authority lines, resistance of some RPHC officials to increased community role in decision-making, tensions between doctors and nurses, and low morale due to poor working conditions and lack of monetary and moral incentives could hold back implementation of MOPH PHC reforms.

For the system to move forward, the new district boundaries will have to be confirmed, the composition and duties of the district health teams defined, and the MOPH organigram revised and job descriptions expanded to more clearly define PHC personnel tasks as quickly as possible. Creative incentive systems will also need to be elaborated to build staff morale and motivate PHC personnel to work harder to carry out their assignments.

While SESA I and the MOPH have set up co-management community participation structures at the health area and subdivisational level, these still have no legal status giving them the authority to enter into contractual obligations. Alternative sources of PHC, low incomes, high transaction costs related to logistical factors such as low population densities and poor roads, lack of incentives for community representatives in the PHC system, the subordinate role of women in community affairs, and unclear election rules and processes are all factors which have hindered greater community participation in the SESA/MORPH PHC program. Now that the new statutes are ready, SESA and the MOPH should move forward as quickly as possible to incorporate the COSAs, COSADIs, and USPS as legal entities under the Law of Association. However, given the complexity of the new statutes, care will have to be taken to make sure that the local populations and community representatives fully understand the rules of the game and their mutual rights and obligations before these new structures become fully operational. If fully understood and implemented, the new statutes, which give community representatives considerable decision-making powers and ensure transparency in financial transactions, should provide the community with a greater sense of ownership over the PHC program and more confidence in the PHC system.

Cameroon's highly centralized financial system, which makes disbursement of funds a slow and cumbersome process, and a civil service code which makes it difficult to sanction poor performance and illegal activities of civil servants constitute constraints on current efforts to improve the PHC system. While taking these constraints into account, the SESA project does not have the means to correct the problem at this level. On the other hand, the 1989 reorganization of the MOPH and the December 1990 Law of Association have created important institutional instruments which can and are being used to improve the national PHC system in general and that in the SESA project zone in particular.

The following recommendations are designed to overcome some of the obstacles cited above and to improve institutional arrangements at the operational level where MOPH personnel meet the public. Some have already been suggested in the SESA II project paper and by MOPH officials. Others are new.

A. Recommendations Concerning Community Participation Co-Management Structures

1. Educational Campaign to Explain the New Statutes

The COSA, COSADI, and FSPS statutes are fairly complex and give these structures powers which have not yet really been exercised by the existing community health committees. The new rules will have to be carefully explained not only to local communities and their COSA representatives, but also to the PHC personnel who will have to work with community representatives. The educational campaign should include the following components:

- Translate the basic texts into the local languages.
- Prepare texts, cassettes, and audio-visual materials in French and the appropriate local languages which explain the statutes in terms that can be easily understood by all segments of the population.
- Use radio and other media to provide explanations of new statutes.
- Organize training sessions with current community representatives on the existing health committees.
- Emphasis should be placed on understanding election rules, the powers and rules of procedures of the various organs, the respective roles and powers of *ex officio* and community officers, the rules governing the allocation and management of financial resources, and the mechanisms for resolving conflicts between health officials and community representatives within the health committee and disputes between different levels.
- Set up joint training sessions with health center and COSA members to discuss new rules. Psychodrama could be used to present examples of different kinds of problems that the two parties might encounter in the course of their collaboration.

2. Identify and Mobilize Existing Community Structures and Resources

The various health committees should not be seen as the only instruments for mobilizing community support for health care activities and participation in co-management structures. Project personnel should also make an inventory of existing community structures, explain the new health system, and enlist the support of the following groups:

- local churches and mosques.
- community hometown associations of elites working in the cities. For example, the elites of Nyambaka are planning to purchase an ambulance for their village.
- local tontines which bring people together and mobilize financial resources.
- traditional entraide associations.
- village development committees where they exist.
- local political leaders and deputies.

3. Improve Current Election Rules, Processes, and Enforcement of Rules

The quality of community representation in the COSAs often suffers from unbalanced representation, poorly educated members, and domination by traditional local elites with little interest in health affairs. Part of the problem stems from the fact the local communities perceive health committee members as political rather than technical representatives of the community. In Adamaoua Province, for example, this has led to the choice of illiterate and often uninterested notables as members of the committee out of respect for their high traditional status. Improvements could be made to rectify some of the above problems by:

- defining COSA, COSADI, and FSPS representatives as primarily technical delegates of the community specializing in health matters rather than its political leaders.
- setting up clear cut rules concerning the organization and overseeing of elections. In the past COSAs seem to have been set up on a haphazard basis.
- establishing rules to ensure some representation of women on health committees.
- establishing rules to prevent nepotism -- e.g., the pharmacy clerk can not be related to COSA representatives.

- establishing literacy and numeracy criteria as preconditions for serving on the COSA management committee
- 4. Conduct Operations Research to Track the Selection Processes and Social Profiles of Members and Officers of the Health Committees and Management Committees and the Pharmacy Clerks**

The results of this research would be used in reexamining existing recruitment and election rules and making rule changes to improve the community participation co-management system. Social profiles of the pharmacy clerk would include:

- ties with local power structure and current health committee members.
- educational background.
- past work experience and salary
- selection process.
- status within the community and commitment to stay in the community.
- satisfaction with the current job.
- expectations for higher remuneration.

Social profiles could also be drawn for the community representatives. The various social profiles could then be studied to see the correlation, if any, between certain patterns of social profiles, pharmacy clerk job performance, and the effectiveness of specific health and health management committees.

5. Provide Modest Financial Compensation for Community Members and Officers Commensurate with their Duties

Community representatives have complained about the lack of compensation for their work. While it would be a mistake for community representatives to be regarded as salaried employees, some modest effort should be made to compensate members for their efforts. In particular, some compensation should be given to the treasurer. The following suggestions should be explored and thought through in terms of their financial feasibility and acceptability to the local community:

Health Area COSAs

- provide a modest travel allowance to COSA members in the periphery for each COSA meeting attended.

- have the health center provide meals for COSA members attending meetings.
- provide a modest sum -- e.g., 100-200 FCFA for each meeting attended.
- provide compensation to the treasurer on the basis of a modest flat rate which can be adjusted upward or downward in accordance with his/her job performance.
- explore different forms of financial and non-financial incentives to compensate the president for his efforts.
- use some of the various financial and non-financial incentives discussed in the SESA II Project Paper social soundness analysis to reward individuals and communities with outstanding participation in the system.

District COSADIs

- Per diems and travel expenses are already provided to COSADI members attending meetings. COSADI members could also be given 500 FCFA- 1000 FCFA for each meeting attended.
- The COSADI treasurer with a very heavy work load needs to receive some financial compensation based on time spent performing duties and job performance. His/her compensation would be higher than COSA treasurer.
- Exploration of compensation mechanisms for the president similar to those discussed above for COSA president.

FSPS

- Less needs to be done at this level because per diem and travel are provided for. Moreover, the General Manager performs the functions of treasurer performed at the COSA and COSADI levels by a community member, while the president of the management committee is the PHD rather than a community representative.

6. Examine More Closely COSADI Structures and the Potential for Urban-Rural Cleavages

Logistical problems will make it more difficult for rural COSADI representatives to participate as fully as those living in health district headquarters. This could lead to a power imbalance between rural and urban constituencies. The organization of health care, (urban dispensaries and urban health centers) at the district level also differs from that at the health area level and may lead to different priorities. These factors should be considered in determining rules for community participation and district health action plans.

7. Explore Various Measures to Get Women More Involved in Health Activities

Since women and the children they take care of are the principal beneficiaries of the PHC system, women need to become more actively involved in defining health needs and priorities and involved in providing PHC services. Some of the following measures could be explored to achieve this objective:

- make a greater effort to recruit more female personnel to work at the health center and health district level.
- set up women's health clubs.
- mobilize women's tontines to become involved in health activities.
- finance women's project related to health -- e.g., vegetable gardens for more balanced diets.

8. Operations Research to Explore Individual and Community Responses to Illnesses and Other Health Problems

This kind of research could help PHC planners to formulate more efficient strategies concerning the kinds of health care services they can provide and the relative importance of other sources of PHC -- e.g., self-medication, traditional healers, private sector, church missions, etc. It could also provide socio-cultural information which could be used to overcome resistance to participation in certain health activities like vaccination campaigns.

B. Recommendations Concerning the PHC System

Issues affecting the effective implementation of the new PHC system have already been identified and discussed in section V of the report with specific suggestions made for dealing with them. A summary of specific recommendations are as follows:

- set up a creative financial and non-financial incentive system to motivate PHC personnel.
- move slowly in setting up collaborative institutional arrangements with the confessional sector and begin by setting up an experimental model district in which a church hospital serves as the referral hospital in an area where the MOPH and church hospital director have agreed on the rules of collaboration.
- take measures to reduce inequities in the system and reduce tensions between doctors and nurses and hospital and PHC services. This could mean, for example, providing nurses and other hospital personnel a share in a revised quote-part system.
- reorganize PHC structures to fit the new health district boundaries and eliminate unnecessary bureaucratic layers and supervisory functions.
- Provide clearer job descriptions and reinforce sanctions for poor job performance.
- Clarify supervisory responsibilities and authority lines in the hierarchy and within the different health care levels -- provincial, district, and health area.
- Increase the level of understanding of PHC personnel of the new COSA, COSADI, and FSPS statutes and the implications and potential difficulties involved in sharing management responsibilities with community representatives.
- Make a careful analysis of the different sources of funding for PHC and hospital activities at the provincial, district, and health area level to determine the feasibility of different level action plans and incentive programs.
- Use the North West Province Special Fund model as a starting point for setting up institutional arrangements for the utilization of FSPS surpluses.

One of the main objectives of the MOPH's reorientation of PHC strategy is to decentralize decision making. Much has been done to decentralize decision making authority from the central administration level to the province. Further decentralization under SESA II is to take place at the health district level. Because of systemic constraints, it is not feasible

to provide heads of district health services with the authority to control most aspects of financial and personnel management. However, it would be very interesting to create a model health district which would have the authority to disburse its own funds without having to go through the Ministry of Finance and the power to shift PHC personnel within the district without going through the Civil Service Ministry.

One could build an operations research project along the lines suggested by Dr. Claude Bodart, SESA I national project coordinator, to test the advantages of a decentralized health district system having the power to dispose of financial resources more rapidly and to transfer personnel. To simplify the project and to make its implementation more feasible and acceptable to various government authorities, his proposal to give the district health head the authority to impose sanctions and elaborate an incentive system for district health personnel should be dropped. On the other hand, the rest of the proposal should be kept intact.

To conclude, the Cameroonian SESA/MOPH experiment is an exciting one, which, if successful, could serve as a model for improving PHC delivery systems in other African countries.

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Ronald Harvey,	Deputy Director
Derek Singer,	Human Resource Development Officer
Richard Greene,	Health and Population Officer
Regina Nana,	Population Coordinator
Bess McDavid,	Human Resource Development

SESA Officials

Dr. Claude Bodart,	National Project Coordinator
Joan Shubert,	IEC Coordinator

GTZ Mission

Dr. Heinrich Berg,	Primary Health Care Project Officer
Dr. Bergis Schmidt-Ehry,	Health Project Coordinator

UNICEF

Dr. Safiou Raimi-Osseni,	Primary Health Care Officer
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MOPH

Dr. Chouibou Ncharre,	Deputy Director of Rural and Preventive Medicine Directorate
Dr. Moustapha Lapnet,	Director, National Pharmacy Directorate
Benoit Etoa,	Head of Community Health and Traditional Medicine Service

Consultants

Dr. Cosmas Cheka,	Health Law Consultant and Drafter of Cameroon Health Committee Statutes
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B. NORTH WEST PROVINCE

Dr. Charles Tiba, Chrysanthus Yah, Clement Mume, Joan Komtangi, Delegation	Provincial Delegate, Preventive and Rural Medicine Acting Manager, North West Provincial Special Fund for Health Provincial Nutrition Officer Senior Midwife, Provincial Health
Alfred Nukuna, David Desire Manfouo, Jacob Bakoh, Dr. Charles Tiba, Grace Mbe Asongwed, Eric Miakwang, Immelda Yufanji, Clement Funijwe, Veronica Atauegar,	Head of Provincial Sanitation Bureau Provincial Delegation Supervisor External Auditor, J.N. Bakoh & Co. Director, Acha-Tugi Presbyterian Hospital Head of Mendankwe Health Post Nurse, Mendankwe Health Post Midwife, Nkwen Health Center Nurse, Nkwen Health Center Pharmacy Clerk, Nkwen Health Center

C. ADAMAOUA PROVINCE

Dorothy Madison, Dr. Leonard Mbam Mbam, Nouhou Alim, Dr. Longa, Dr. Moustapha Daouda, Oumarou Koue, Treasurer, Village Chief, Chef de canton President, Community Residents Bassirou Alpha, Moussoume Ekouangue, Dr. Aku, M. Daniel, Surveillant General, Daniel Zebaze, Paul Maounde Issa Akao Zaiko, Marthe Docei, Community Members, Pharmacy Clerk, Deputy Chief, Community Members,	SESA Provincial Coordinator Provincial Health Delegate Provincial Supervisor and Head of Anti-Leprosy Campaign Provincial Delegation Team Provincial Delegation Team Governor, Adamaoua Province Nyambaka COSA Nyambaka Nyambaka Nyambaka COSA Nyambaka Pharmacy Clerk, Nyambaka Health Center Head of Nyambaka Health Center Chef-Médecin, PMI Meiganga Divisional Coordinator, Meiganga Meiganga Hospital Sous-Préfêt, Djohong Subdivision Head of Yarmbang Health Center Auxiliary Health Worker, Yarmbang Health Center Midwife, Yarmbang Health Center Yarmbang COSA Yarmbang Health Center Ngaoui Health Center Ngaoui COSA
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Nourou Mamanou, COSA members, Imam, Rosalie Abbe Laboratory Aide Laurent Ngbwa, Pharmacy Clerk, President, Dr. Mamadou Saly Dr. Edgard Lobze, Head, Community Members, Chefs de Quartier, Celestin Kamga, Alphonse Ndande, Nana Mbardouka,	Pharmacy Clerk, Ngaoui Health Center Kombo Lako Health Area Kombo Laka Midwife, Kombo Laka Health Center Kombo Laka Health Center Head of Dir Health Center Dir Health Center Dir COGE Divisional Head of Primary Health Services, Tibati Head of Divisional Hospital in Tibati Tibati Urban Health Center Tibati COSADI Tibati Préfêt, Djerem Division Nurse, Beka Gotto Health Center Auxiliary Health Worker, Beka Gotto Health Center
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D.SOUTH PROVINCE

Dorothy Madison-Seck, Pierre Signe, Dr. George Ngufor Fotoh, Director, Members, Pharmacy Clerk, Head, Coordinator, Traditional Healers, Head, Nurse, Pharmacy Clerk, President, Traditional Healer, Secretary, Female Member, Head, Pharmacy Clerk, Coordinator, Dr. Etyaale, Head, Head,	SESA Provincial Coordinator Provincial Coordinator Provincial Health Delegate Provincial Statistical Service Divisional Health Team, Sangmelima Ebolowa Urban Dispensary Ebolowa, PMI Service Djoum Primary Health Care Service Sangmelima Melem Health Center Melem Health Center Melem Health Center Melem COGE Melem Bipindi COSA Bipindi COSA Bipindi Health Center Bipindi Health Center Subdivisional Primary Health Care Service, Lolodorf Director, Enongal Presbyterian Hospital, Ebolowa District Mfouladja Health Center Oveng-Yemvak Health Center
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