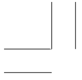
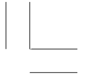
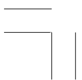
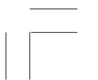
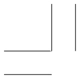
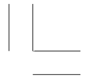
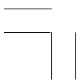
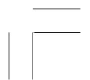





II

Governance and Health System Reforms

2

Governance and Primary Health Care Delivery in Nigeria

Omar Massoud

Introduction

The National Health Policy in Nigeria (NHP), with the main objective of 'Health for All' by the year 2000, was launched in 1988. The provision of an effective system of primary health care delivery at the local government level was one of the main goals of this policy. The central focus of the National Health Policy was a 'community-based health system in which primary, secondary and tertiary health care is organised at local, state and federal levels, with each mutually supporting the other'. Before then (in 1986), fifty-two local government areas (LGAs) had been selected as pilot project sites, with the purpose of strengthening Primary Health Care (PHC) at the grassroots. Each of these LGAs was linked with a university teaching hospital or school of health technology for the purpose of training their health officials. State governments were directed by the then federal military government to devolve all PHC responsibilities to local governments over a three-year period terminating in June 1990. The state governments were however left with the responsibilities of supervising and coordinating PHC activities, as well as playing an advocacy role. The local communities were supposed to be carried along in the programme in order to ensure its success. To this end, district and village health committees were constituted to ensure the participation of local communities. The input of these committees was to be in the form of providing information, giving suggestions for improvement, complaints, control, etc. The PHC programme as conceived then revolved around nine core functions:

- Public health education
- Nutrition improvement
- Adequate safe water and basic sanitation
- Maternal and child health care, including family planning

- Immunisation
- Prevention and control of endemic and epidemic diseases
- Provision of essential drugs and supplies
- Elderly and handicapped care
- Accident and injury care

It is almost two decades now since the NHP was launched but the ultimate goal of 'Health for all' by the year 2000 seems to be as remote as ever. Effective delivery of primary health care at the local level is almost non-existent. A study conducted in the mid 1980s and which is still relevant today shows that the spatial density of hospitals in Nigeria ranges from 415 square kilometres per hospital in Lagos State (in the South West) to 9716 square kilometres per hospital in Borno State (in the North East). The corresponding implied accessibility of hospitals ranges from 9.67 kilometres walking radius in Lagos State to 55.55 kilometres in Borno State (Idachaba: 1985:5).

Before the introduction of the NHP, it was not possible to make an accurate assessment of the health status of Nigerians. There was no system of collecting basic health statistics on births, deaths, the occurrence of major diseases, and other health indicators on a country-wide basis. There were estimates from a few centres where such data were collected from sample surveys as well as from institutional records and special studies, such as the one referred to above (National Health Policy Guidelines 1988:4). Within the framework of the NHP, Primary Health Care is defined as:

> [E]ssential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community and through their full participation and at a cost that the community can afford in the spirit of self reliance and self determination. It forms an integral part of the country's health system of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact with individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process (ibid:13).

Primary Health Care was envisaged to perform two functions under the NHP:

> To provide general health services of preventive, curative, promotional and rehabilitative nature to the population as the entry point of the health care system. The provision of care at this level is largely the responsibility of local governments with the support of state ministries of health. Private medical practitioners shall also provide health care at this level. Noting that traditional medicine is widely used, and that there is no uniform system of traditional medicine in the country but wide variations, with each variant being strongly bound to local culture and beliefs, the local health authorities shall, where applicable, seek the collaboration of the traditional practitioners in promoting their health programmes such as nutrition, environmental sanitation, personal hygiene, family planning and immunisations. Traditional health

> practitioners shall be trained to improve their skills and to ensure their cooperation in making use of the referral systems in dealing with high risk patients. Governments of the federation shall seek to gain a better understanding of traditional health practices, and support research activities to evaluate them. Practices and technologies of proven value shall be adapted into the health care system and those that are harmful shall be discouraged (ibid:13).

It was envisaged that local authorities would design and implement strategies to meet the health needs of the local population, and this should be done with the guidance, support and technical supervision of the state ministries of health. In addition, the local councils should be able to elicit the support of formal and informal leaders, traditional rulers, religious and cultural organisations as well as other influential persons and groups in support of community action for health. Local health authorities were given a free hand to adopt strategies to make the programme a success. In this regard, the NHP envisaged, among other strategies, that:

- Local authorities can determine how best to provide the essential elements of primary health care;
- Provide relevant health information to the people on such matters as personal hygiene, environmental sanitation, prevention and control of communicable diseases as well as such matters where a change of lifestyle of the people can have a significant impact on their health status;
- Design and operate mechanisms for involving the communities in the critical decisions about the health services; and
- Collect relevant data about the health resources, the health status of the community and their health behaviour, including the utilisation of health services. Such data shall form the basis of the information of the local health services.

However, Primary Health Care delivery has failed almost two decades after the introduction of the NHP. Both the United Nations Children's Fund (UNICEF) and the Federal Government of Nigeria unanimously agreed recently that weak Primary Health Care Centres have largely contributed to the high level of the disease burden in the country. According to the Master Plan of Operations for 2002-2007, jointly published by the two bodies, weak PHCs have exacerbated the problem of childhood morbidity, caused largely by malaria, measles, and, in recent years, HIV/AIDS. The Action Plan noted that coverage interventions known to reduce child and maternal mortality remain very low, and only about one per cent of children under five years were reported to sleep under insecticide-treated bed nets (*New Nigerian*, 21 March, 2005). It has been estimated that Nigeria now has the unenviable record of contributing approximately ten percent of the world's maternal death and eight percent of the world's child death, and this is a trend that has been on the increase over the years. Many such deaths could have been prevented with well known cost-effective interventions if they had been available to women and children who needed them.

The Birnin Gwari Case Study

We tried to find out through an empirical study in Birnin Gwari local government some of the main causes for the failure of primary health care delivery in the country, conscious, however, that the data gathered from this local government were by no means representative, nor a fair coverage, of the operations of most local governments in the northern part of the country. What we tried to do here is to investigate empirically (which, in the end, may either validate or falsify the reasons generally given for the failure of the programme) the reasons for the failure of PHC. The data collected were based on the following broad questions we had in mind:

- Is the local government well equipped with qualified personnel and materials to ensure the success of programme implementation?
- How much, in terms of financial resources, has been spent on the programme over the past five years?
- Are the people, as stakeholders, involved in the implementation of PHC as the blueprint for the programme suggests?

Based on these broad questions, the data collected from the local government were categorised into two:

Endogenous Data: related to the internal structure and facilities available to the health services of the local government. Data collected in this regard referred to the number of health clinics, and maternity centres in the local government area. The availability of trained nurses, midwives, etc. Also considered were the financial resources available to the LGAs over a seven year period, and the materials available to the LGAs - storage facilities, drugs, etc.

Exogenous Data: material collected here enabled us to examine demographic patterns in the local government; the causes of morbidity and mortality (by age and sex); the use of health services, including maternity and child health clinics, and the degree of involvement of the people in their own health care, including the use of traditional healers.

Located in the central part of Kaduna State (in North Central Nigeria), Birnin Gwari local government has a total population of 231,617. The local government is divided into three zones – the Central zone with a population of 84, 189; the Eastern zone with a population of 76,448; and the Western zone with a population of 70,980. (Source: Birnin Gwari Local Government Council).

An examination of the statistics made available to us shows that Birnin Gwari local government has a reasonable number of facilities to cater for the health needs of the local community. The central zone has eleven clinics; the Western zone has the same number, while the Eastern zone has seventeen. In terms of storage facilities, the following are available:

- 1 Refrigerator
- 3 Deep Freezers
- 8 Cold Boxes

- 160 Vaccine carriers
- 2 Ice pack freezers
- 480 Ice packs

To ensure a constant supply of electricity, the local government has one solar energy plant and four standby generators to serve the three zones. An examination of the staff strength of the health department reveals that it is adequately staffed, with 188 personnel. This is made up of fourteen Community Health Officers, fifty-six Senior Community Health Extension Workers, seven Junior Community Health Extension Workers, three Environmental Health Officers, two Environmental Health Technicians, ten nurses and midwives, three Dental Assistants, and ninety-three Health Attendants.

The PHC unit sends out District Health Superintendents to supervise field staff from the village level to the districts. They usually assess the performance of the field staff by observing the latter performing their basic functions. Once every three months, staff planning meetings are held. This is done with the aim of identifying problems in the field. For example, some of the problems employees encounter in the clinics and with the local community include a reticence to report cases of births and deaths in the local government area, and the lack of co-operation with officials of the health department during immunisation programmes. These problems may be due to religious or traditional beliefs. During such monthly meetings the PHC staff air their views and make suggestions as to how to overcome some of the problems encountered in the field. In addition, the PHC unit also sends out staff to the field to gather health statistics. This enables the department to assess its performance and it also helps to guide them on where to concentrate their efforts. Statistics gathered usually include mortality rates, accident rates, infectious diseases, expanded programme on immunisation (EPI) activities, and control of diarrhoeal diseases (CDD).

As enumerated in the blueprint of the NHP, district and village health committees have been constituted in all the wards of the local government area. There are also the Traditional Birth Attendants (TBAs) who are recruited to supplement the efforts of the village health workers (VHWs). The minimum qualification for the TBAs is usually a certificate in adult education. While the TBAs' main focus is on child birth, the VHWs are trained in preventive health care methods, first aid etc. According to the head of the health department of the local government, the District and Village Health Committees play significant roles in primary health care delivery in the local government. They do this through the mobilisation and sensitisation of the local communities about the need for total involvement in health care programmes; supporting and maintaining the drug revolving fund; providing voluntary work (for example, there are security guards for some of the clinics who are not on the payroll of the local government); and holding frequent meetings to discuss problems such as the use of medical facilities, staff punctuality, and guarding against malpractices committed by staff of the local government.

However, the health status of the residents of Birnin Gwari leads one to question the effectiveness of the district and village health committees in performing their duties. The inhabitants of Birnin Gwari local government are still afflicted by common diseases which normally should not pose a threat to them. Presently, the causes of morbidity and mortality in the local government area are:

- Measles (in children between the ages of 1–5 years, both male and female)
- Diarrhoea
- Malaria
- Deaths related to child births
- Tetanus A – caused by injuries sustained during farming
- Tetanus B (neo-natal) in new-born babies
- Cerebro-spinal meningitis
- Malnutrition in children and pregnant women
- Road traffic accidents

Source: Health Department, Birnin Gwari Local Government.

The prevalence of these common diseases and accidents points to one basic fact: that primary health care delivery has failed in the local government. This failure, we believe, is due to two main reasons. The first reason is attributable to the lack of close and effective contact by local health officials with the local communities, consequent upon the inefficiency of the district and village health committees. Visits by the health officials to the local communities total no more than three times a year, and this is only to collect data on diseases afflicting the local communities. The organic link which is supposed to exist between policy makers and the local communities, through the district and village health committees, is non-existent. Consequently instead of being stakeholders, local communities are mere 'beneficiaries' of PHC. They thus see in the implementation of the PHC programme a similarity with all other programmes embarked on by the local government, which often end in failure, despite the enormous resources allocated to such programmes. The resultant effect is that the officials of the health department of the local government do not know their target population sufficiently well. As Tom Gabriel (1991:2) succinctly puts it:

> Development programmes, basic needs strategies, primary health care schemes etc., all share a common requirement: each has to make the most efficient use of financial and staff resources at a time when development funds are actually decreasing. Yet those responsible for planning, funding and implementing these essential activities often possess scant knowledge of how their target populations live. Insulated from food security, chronic ill health, illiteracy or powerlessness, their good intentions or occasional field visits to nearby settlements cannot adequately replace this lack of fundamental knowledge. They are usually extremely remote from the living conditions of their clients.

The second reason for the failure of the PHC programme can be traced to the lack of transparency and accountability in programme implementation. Over the past five years, from 2001 to date, the health department has witnessed its share of total budgetary spending increase significantly, as the Table below indicates.

Table 1: Figures on Local Government Finances

Year	Budget of Local Govt	Allocation to the Health Sector	Total Budget for the Health Sector %
2001	216,200,253.00	21,100,000.00	9.71%
2002	261,940,082.00	31,500,000.00	12%
2003	259,000,000.00	20,000,000.00	7.72%

For the year 2001, the health sector received 21,100,000 naira which was 9.71 percent of the total budget of the local government which stood at 216,200,253 naira. In 2002, the approved estimate for the health sector was 31,500,000, representing 12 percent of the estimates of capital expenditure of 261,940,082 for the local government. In 2003, the health sector received 20,000,000 out of a total estimate of 259,000,000 naira for the local government. This represents 7.72 percent of total spending for that year. In absolute terms, these figures represent a marked increase in budgetary allocation for health over the preceding years where for example, the health sector received in 1993, 740,000 naira, representing 4.99 percent of the total estimates of 1,950,000.

The ineffectiveness of local governments in Nigeria to provide basic services to local communities has been mainly attributed to the lack of sufficient financial resources. Financial inadequacy, we believe, is not a key constraint or obstacle to effective service delivery. This is because although local governments do not receive as much, both in terms of absolute revenues per capita and in terms of the total share of public expenditures vis-à-vis the state and federal governments, their functional responsibilities are correspondingly limited. Apart from this, the total share of fiscal revenue accruing to local authorities from federal allocations has more than quadrupled over the past four or five years. A cursory glance at the revenues which have accrued to local governments in Nigeria from the federation account, shows that their revenue base increased tremendously over a nine-year period, from 1997 to 2001 as Table 2 shows.

The increase in revenues over the past five years points to one basic fact: that poor service delivery in the local governments cannot be attributed to inadequate finances. One major problem, which contributes to the failure of local governments in meeting target goals, can be traced to the lack of transparency and accountability in governance. For example, the annual financial estimates for the health department in Birnin Gwari local government are hardly made public. They are treated as secret documents and financial reports on disbursements are hardly made available to the community, who as stakeholders have the right to know.

Table 2: Revenues Accruing to Local Governments 1993-2001

Year	Total Revenue (in billions of naira)
1993	18.31
1994	17.32
1995	22.25
1996	29.61
1997	53.06
1998	65.98
1999	116.12
2000	244.14
2001	248.63

Source: Federal Office of Statistics.

Reports of financial spending are treated as documents only for the consumption of the personnel. Even the junior nurses and community health workers have only a skeletal knowledge of how the department operates its annual budget. This problem is not peculiar to Birnin Gwari local government alone, but is widespread all over the country. According to Dr Shehu Mahdi, the executive director of the National Primary Health Care Development Agency, 'official analysis show that 60 percent of the total health spending (in the country) between 1999 and 2003 went into settling out of pocket expenses. This, in a situation where primary health care services are not available to the majority of the people and where the services are available, the quality is so bad that people prefer to go elsewhere for the services' (*The Guardian*, May 30, 2005).

Conclusion

There is no doubt that severe problems have bedevilled the Nigerian state in health care delivery. The provision of an effective system of health care delivery, as a right, and not a privilege, is but a dream in Nigeria. The failure of the Nigerian state to provide an effective, functional and sustainable health care system has led to a situation where access to heath care is not possible for the majority of the populace. Coupled with this problem is the issue of brain drain, where medical practitioners, nurses, and midwives leave the country in search of better conditions of work, often to countries in the developed world. At the heart of the economic, political and social crises bedevilling Nigeria is the lack of transparency and accountability in governance, a situation which has led to the failure of many public policies. Often, reforms of the public sector, meant to address the failure of public policies, usually focus on structural issues, relegating the behavioural to the background. Reform of public institutions is a step in the right direction, but the ultimate goal of a reform being effective and functional may not be achieved without putting in place the mechanisms which will regulate the behaviour of the

individuals operating in the system. Rather than focusing on 'strong local governments' with adequate financial wherewithal, as a panacea for an ineffective service delivery, any reform, in order to be effective, should rather focus on the characteristics of the delivery system itself. To understand the failure of policy implementation, one must understand the motivations of the myriad of individuals who play major roles in the service delivery. The point made by William Dillinger (1993) cannot be clearer in this regard:

> There is no single institutional arrangement that can be universally prescribed for the delivery of urban services. What is important are not the organizational labels, but rather the relationships - the rules that govern the transactions between local political leaders, administrators and the urban dwellers. A 'good' arrangement is likely to be a very complicated one and one that is not defined merely by the designation of municipal responsibilities and revenue sources. Urban service delivery appears to be a problem that cannot be addressed by taking the organizational context as a given and attempting to change the behavior of one organization – municipal government – within it. Instead, it appears to be a problem of the public sector as a whole, and one that must be addressed by looking at the variety of factors that influence the performance of the public sector and those factors' implications for urban service delivery.

Primary Health Care Delivery has failed in Nigeria because there was no serious interaction between formal management structures and local residents. In the first place, this led to the absence of a local mechanism for ensuring public accountability and inducing greater transparency in governance. Secondly, because local communities were not seriously involved in policy making and implementation with regards to health care delivery, they did not see formal management structures in the local governments as particularly relevant to their existence. Thirdly, the local authorities, depending largely on subsidies from federally allocated revenues for their operation, saw no need to cultivate the local communities as their natural constituencies, and thus lacked the capacity to mobilise the local populace for the effective implementation of the project. This is true not only with regards to primary health care delivery, but with all other development programmes in the local governments. To enhance service delivery in the local governments therefore requires a new approach to policy making which will eliminate the prevailing dichotomy between the formal management structures and the informal sector. There is a need to put in place a unified management system injected with a strong dose of citizen participation. To achieve this, efforts must be made to ensure that:

- Local associations that have emerged to deal with particular problems in particular neighbourhoods are officially and legally recognised;
- These associations must be integrated into the normal processes of formal management;
- Efforts must be made to progressively build up the capacities of these neighbourhood associations to gradually align them with the existing modern urban management system.

These advances require the integration of traditional neighbourhood organisations into the governance of urban centres. It will be necessary, in this respect, to identify all the neighbourhood institutions in the local governments, to appreciate the nature of their leadership and their organisation, and seek to harness them for the overall administration of the locality. However, the leadership of these neighbourhood organisations must be entrusted to men and women of integrity, who have the trust and confidence of the community, and through whom information can flow from the local government council to residents of neighbourhoods and vice versa. This will have the effect of reducing the level of alienation in the local governments, because the people will know more about what is going on in the local government councils.

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3

Governing the Traditional Health Care Sector in Kenya: Strategies and Setbacks

Kibet A. Ngetich

Introduction

In Kenya, social, cultural and historical factors have led to the emergence of a plural health care system in which traditional and contemporary western medicine co-exist. The colonialists and even some westernised Africans initially regarded African traditional medicine as magic. Mission doctors described traditional health practitioners as witches and dismissed their practices as unscientific and irrational (Beck 1971, Sindiga 1995, Tinga 1998). The colonial administration outlawed witchcraft practices under which many traditional health practices were subsumed. Consequently, the colonial administration undermined traditional health practices by arraigning suspected witches in courts (Tinga 1998). These attitudes fuelled the belief that the traditional health care sector was full of fake, 'snake-oil' practitioners bent on capitalising on 'ignorant' patients and on the alleged shortcomings of modern health care.

The official recognition of traditional medicine in Kenya originated from the WHO's Alma Ata declaration of 1978 (WHO and UNICEF 1978). Since then, traditional medicine has gradually carved itself a niche in the provision of health care services in Kenya. However, this emerging sector faces a myriad of problems, of which governance features prominently.

By governance, I mean stewardship, management, leadership and guidance, which can be operationalised into organisation, supervision and control. These terms are used together in an attempt to more accurately convey the complex meaning of governance. Governance also engenders accountability and responsibility. For example, the weakening of modern health care systems in Kenya is reflected in the falling health status of the population. Over the years, the burden of disease has increased, leading to a decline in life expectancy (KDHS 1998, 2003). The decline in life expectancy is a clear indication of the modern health

care system's failure or at least inability to cope with growing health care demands (KDHS 2003). This is partly due to the weakening of health system structures and governance.

It is in the context of the increasing importance of traditional medicine and the failing health care systems as indicated by the falling health standards in Kenya that the issue of governance of indigenous medicine is considered. This paper, therefore, examines governance of indigenous health care resources in Kenya with specific attention to strategies of managing and the setbacks involved.

The Quest for Governance of the Traditional Medical Sector

In Kenya, both modern and traditional medicines co-exist as parallel systems but with little coordination between them (Owour 1999). Previous efforts to coordinate the activities of traditional and modern health practitioners in Kenya have not been successful due to mutual mistrust and suspicion between ethno-medical and biomedical practitioners. In 1989 for instance, a task force committee with the objective of linking the activities of traditional health practitioners, modern doctors, scholars and researchers was launched in Nairobi but hardly took off (Kimani 1981, 1995). This effort did not take into account forms of organisation of traditional health care activities and associated operational activities.

The health provision strategies have for a long time not taken into account what the patients think about their health and where they go for treatment. As a result, there has been a mismatch between the kind of health services provided and what people actually opt for in the event of illness.

In order to make health care provision policies responsive and sensitive to the consumer (patient) preferences there is a need to understand the dynamics of the utilisation of traditional health care services. Recent research findings (Nyamwaya 1992, Ngetich 2004) indicate that there exists interaction between traditional and modern health practitioners as well as their patients in terms of cross-referrals of patients. Yet, there is no protocol governing referrals of patients between traditional and modern health practitioners.

Thus, the quest for governance of indigenous health care systems raises a number of critical issues that need to be resolved. These include: intellectual property rights and patents claims, standards of traditional medical practices and care, legal, regulatory and control issues in the traditional medicine sector, as well as organisational frameworks of traditional medical practice and utilisation.

In the light of the above, the following key questions will be addressed:

- First, what are the problems of governance facing African traditional health care sector in Kenya?
- Second, what are the strategies of governance of traditional medicine in Kenya?
- Third, what are the shortcomings or limitations of governance strategies adopted in relation to traditional medical care?

African Traditional Medicine: From 'Magic' to Medicine

A study of the utilisation of traditional medicine falls within the realm of ethno-medical research, a component of health systems research. Health System Research is 'applied research, aiming at improving the quality of health care and optimising the use of available resources in order to meet health needs in a population' (Good 1987, Nuyens 1988). According to Good (1987:17) ethno-medical systems comprise 'all the resources and responses available to a community in addressing its health problems, organised partially and changing over time'. Ethno-medical analysis therefore, focuses on the actual experiences of people and examines how they are perceived, labelled, communicated and managed in interactions with family, social network and therapists (Good 1987).

Academic research on traditional medicine and health care systems in Africa can be traced back to the works of British colonial ethnographers (Rivers 1924, Evans-Pritchard 1937). Though not particularly focussing on African medicine, these studies provided for the first time detailed descriptions of medical practices of various African peoples. However, due to the structuralist approach which was then dominant in Britain, these studies gave attention to healing only with reference to magic and rituals. The overall impact of this approach was a reduction in the study of health and illness 'to studies of witchcraft, magic and in general curative or socially re-adjustive ritual practices, with herbalists and empirical rational diagnoses, treatment and prophylaxis as residual categories' (Foster 1976: xiv-vx). As Yoder observes, 'the study of medical belief and practices became subsumed under the rubric of magic, witchcraft and religion' (1982:4).

The above works shaped subsequent in-depth studies that focussed on medical knowledge and practices of different peoples in Africa. Works along this line were done among the Batabwa and Bakongo of Congo, the Bono of Ghana, the Zulu of South Africa and the Amhara of Ethiopia (Janzen 1978, Roberts 1979, Warren 1974, Young 1975). However, these studies tended to focus almost exclusively on ethnographic descriptions of African traditional medical practices of particular ethnic groups.

In an international conference held in Alma Ata, Russia, WHO called for the use of indigenous health resources in primary health care (WHO and UNICEF 1978). This declaration inspired many researchers, who sought to determine the actual and potential role or contribution of traditional medicine in national health care (Pilsbury 1982, Young 1983) as well as identify potential areas of cooperation, conflict and integration between modern and traditional medicine (Unschuld 1976, Pearce 1982, Green and Makhubu 1984). These studies found that traditional medicine was a highly valued medical resource in many third world countries that could be promoted and tapped for primary health care.

After the recognition of the actual and potential value of traditional medicine in primary health care, attention in policy and research shifted to how to integrate traditional medicine in modern health care (Pearce 1982, Rappaport and Rappaport

1981). But efforts to integrate traditional medicine in modern health care became limited to the incorporation of traditional healers, particularly Traditional Birth Attendants (TBAs), in the national health care system. This was mainly because TBAs were viewed as being closest to biomedicine. Nonetheless, traditional medicine maintained its identity and vigour resulting in the parallel co-existence of traditional and modern health care systems.

One way of promoting traditional health care in Africa was through professionalisation. Twumasi (1984), Last (1986) and Chivundika (1994) identified areas of increased professionalisation among traditional health practitioners in Africa. These developments have seen traditional medicine achieve some measure of organisation and recognition, which is an important step towards increased governance of traditional medicine.

Governing the Traditional Health Care Sector in Kenya

It is now widely acknowledged that about eighty percent of the world's population rely on traditional medicine for primary health care (WHO 1985). Yet more than eighty percent of state resources in Kenya are allocated to modern health care delivery (Republic of Kenya 1996). This clearly demonstrates that there is a discrepancy between what the government offers in terms of health care and what the people actually accept in the event of illness occurrence. Although this scenario may be partly rooted in problems of access, there is increasing evidence that even where modern medicine is fully accessible, the people still resort to traditional medicine (Ngetich 2004).

What this suggests is that there is a need for the government to provide stewardship in the traditional health care sector with a view to harnessing indigenous health care resources by shaping and guiding its development. Thus, in the quest for a health care system that is responsive to the people's health needs and a system of health administration that is responsive to the health care practitioners and health services users, the issue of governance of the traditional health care sector needs to be addressed.

Strategies

It is evident, at least from government policy documents such as annual development plans and seasonal papers, that the Kenyan government recognises the importance of traditional medicine. But the concern is, what has it done to improve or promote this sector in the pursuit of the Millennium Development Goals for health?

First, what is needed is licensing and registration. The government, at local government level i.e., municipalities and councils, as well as at national level (ministerial), registers and licenses traditional health practitioners. This is done through the Ministry of Gender, Sports, Culture and Social Services (Department of Culture). Within the Ministry, the Department of Culture is responsible for

registering the traditional health practitioners. The traditional health practitioners must also register their clinics with their local authorities as business enterprises. Through registration and licensing, the government exercises some rudimentary sense of control on the traditional medical practice.

Second, the formation of traditional healers associations is desirable. The Kenya Association of Herbalists (KAH) which has branches throughout the country, provides the individual herbal practitioners with a means to organise themselves and agitate for their interests. With swelling membership this organisation has increasingly gained some political clout and comments on issues affecting its members in various forums such as workshops, seminars and even newspapers. The KAH has increasingly moulded itself into an advocacy group seeking to promote the 'profession' and guard 'professional interests'. However, active members tend to be drawn mainly from urban areas. The bulk of rural traditional health practitioners remain relatively unorganised as they operate individually.

Third, training. The government has occasionally organised training sessions (usually seminars and workshops) for traditional health practitioners where it disseminates information on specific health issues such as the anti-HIV/AIDS campaigns. In most cases, the traditional health practitioners do not just passively receive information from the government but occasionally take the opportunity to express their concern in the training sessions.

Setbacks

Traditional medicine as a viable healthcare option faces a number of setbacks in Kenya. These setbacks, which range from policy, legal issues to attitudes, are outlined below.

First, the administrative separation of traditional and modern medicine. Traditional medicine is placed in the Department of Culture in the Ministry of Culture, Social Services, Gender and Sport, while modern medicine is placed in the Ministry of Health. This remains a major obstacle to cooperation between the two sectors, and consequently prevents the development of a coordinated and integrated health care system. What is going on between the two unrelated ministries is difficult to harmonise. This has led to major discrepancies in health policy formulation relating to the traditional health care sector. The fact that the personnel in the Ministry of Health are mainly diehard biomedics bent on seeing traditional medicine through a biomedical lens while those in the Ministry of Culture view traditional medicine through a cultural lens makes the harmonisation of issues concerning traditional medicine difficult. While traditional medicine is valued in the Ministry of Culture mainly as a cultural heritage, the Ministry of Health may want to see it from a purely medical aspect. Finding a meeting point for these two perspectives on the traditional medical sector and the formulation of appropriate health policy is primarily a governance challenge in the health care system.

Second, there is an aura of mystery and secrecy surrounding traditional health care. Also, secrecy may be understandable as a way in which traditional health practitioners guard their valuable health care knowledge on which their families depend. It has contributed to modern health practitioners finding it difficult to accept traditional medicine. As a result, many modern health practitioners have difficulties accepting religious, magical or cultural beliefs often associated with traditional medical practice. The modern health practitioners perceive these beliefs to be contrary to sound medical science, and for some, their Christian religious conscience. Thus, the association of traditional medical practice and traditional medicine in general with witchcraft and sorcery as well as the continued marginalisation of the entire sector constitutes a major setback to the utilisation of traditional medicine in Kenya.

Third, there is the lack of evidence. In spite of the acknowledgement of the continued utilisation of traditional medicine, its effectiveness in the management of various health problems is not documented. As such, the utilisation of traditional medicine continues to depend on undocumented testimonies of patients often spread through social networks.

Fourth, there is the low level of education. Most traditional health practitioners have a low level of formal education. They received their training through informal means and apprenticeship. As such, most of their knowledge is not documented, nor their practices. This poor educational level has led to poor record keeping. Furthermore, most of them have no or little formal training in basic health issues.

Fifth, the government has failed in its regulatory role. This is evidenced by the lack of adequate supervision and control of the activities of the traditional health practitioners. This has resulted in the sector being entered by quacks. This is particularly in urban areas where these healers enjoy anonymity. In this context, the clients are forced to depend on self-made claims, which may have little practical backing. Some give imagined testimonies of people whom they had previously successfully healed. This issue adds to our concern for quality care even in the context of traditional medicine. In the serious matters of health, traditional health practitioners should not be allowed to operate freely. The Association of Herbalists, which would act as a regulatory body, has no legal powers to enforce discipline among its members. As such errant members get away with malpractices.

Conclusion

The traditional health system and traditional practitioners continue to operate freely and with little control and supervision from the state. Such free operation makes traditional medical practice open to abuse by quacks bent on cashing in on the desperate patients. It is therefore clear that the state and the government in particular has failed to provide stewardship to the traditional health care sector. This has resulted in poor quality of services in the sector. Nevertheless, this paper concludes that although the traditional health care sector is peripheral in overall

health care in Kenya, it is emerging as a significant alternative that requires proper governance approaches.

Policy Recommendations

The following policy recommendations are intended to improve the governance of indigenous health care systems.

Legal and Regulatory Framework

The fact that many people still use traditional medicine alongside modern medicine demonstrates the need for the promotion of traditional health care. Furthermore, as a way of reducing apprehension among traditional health practitioners that they will lose their standing, there is a need to legalise their medical knowledge and discoveries through patenting. This will encourage traditional health practitioners to share their often secretive medical knowledge for the benefit of many in the society. It is therefore necessary to incorporate and implement policies and legislation governing intellectual property rights and the sharing of rewards derived from traditional medicine. Hence, a legal framework for professional health care practice among traditional health practitioners needs to be put in place as a mechanism to guard against malpractices and enhance fair play.

Quality and Safety Control

Traditional healers need to be trained in the processing and storage of medicines to minimise the dangers to which patients are exposed through the use of traditional medicine. Quality control mechanisms would ensure the safety of the medicines. This can be attained through the acquisition of appropriate drug processing and storage facilities, which few traditional health practitioners currently enjoy.

Governance Structures

In order to promote the governance of traditional medicine there is a need for some organisational and structural changes. One problem is that traditional medicine at present falls under the Ministry of Gender, Sports, Culture and Social Services (Department of Culture), while all other aspects of health care are under the Ministry of Health. For better management of health care provision, there is a need to bring all health issues, including traditional health care, under the Ministry of Health. In addition, the finance mechanisms disadvantage traditional health practitioners in that various health care financing schemes (whether private or public) such as private health insurance and National Health Insurance Funds do not cover health services provided by traditional health practitioners. There is a need for employers to consider including traditional health practitioners in their medical schemes. This would enable their employees to obtain support from their employers or health insurance for medical costs incurred for treatments by traditional health practitioners.

The Need for Cooperation

Governance strategies should aim at promoting cooperation between traditional and modern health practitioners. Since patients consult traditional and modern health practitioners, there is a need for the practitioners of both forms of health care to cooperate for the benefit of patients and the improvement of health care in general. Such cooperation can take the form of cross referral of patients, exchange of information on illnesses, and techniques of investigation. The cross referral of patients that already exists (though on a small scale) is a step in this direction.

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4

Corruption et crise des hôpitaux publics à Douala: le schémas d'une organisation tripolaire

Victor Bayemi

Introduction

Depuis la fin des années 1980, le système public de santé au Cameroun en général et à Douala en particulier, est confronté à une grave crise hospitalière qui a conduit à de profondes réformes. L'analyse des causes a conduit à la mise en relief d'une multitude de facteurs expliquant la décadence du système hospitalier par une politique sanitaire inadaptée qui, à travers la baisse de plus de 50% des salaires des personnels médical et paramédical et les mauvaises conditions de travail, a privilégié la faible productivité du travail. D'autres analyses ont mis en cause la rareté des ressources en soulignant qu'à Douala, il y a seulement: 1 médecin pour 7 023 habitants, 1 infirmier pour 1 784 habitants, 1 pharmacie pour 55 016 habitants. D'autres encore mettent l'accent sur l'iniquité du système dans la mesure ou les pauvres ont difficilement accès aux services de base et que les soins offerts sont de piètre qualité (Ministère de la Santé publique 2001).

A ces facteurs pertinents, il nous semble indispensable d'ajouter, pour une bonne compréhension de la crise des hôpitaux publics, la corruption comme une variable explicative essentielle.

En effet, depuis que le Cameroun a été classé, successivement en 1998 et 1999, au premier rang des pays les plus corrompus du monde, par l'ONG Transparency international, les dirigeants de ce pays ont pris conscience du fait que la corruption a élu domicile dans leurs administrations. Cependant, ces autorités ignorent l'organisation de la corruption qui prévaut dans ces administrations et, en particulier, dans le système public hopitalier.

À la suite de Rose-Ackerman (1978), la plupart des études [Shleifer et Vishny (1993), Cartier Bresson (1998)] soulignent que l'organisation des échanges de corruption peut être centralisée ou décentralisée. Dans le premier cas, les acteurs

acceptent une règle de jeu préétablie et le corrupteur qui verse une fois le pot de vin est sûr d'être servi. Dans le second cas, pour le même service demandé, l'usager peut donner plusieurs fois le pot de vin, sans l'assurance d'être servi. L'échange peut même être anarchique et caractérisé par les marchandages permanents (les montants instables).

Ces études sont importantes car elles montrent que la corruption centralisée est moins dommageable que la corruption décentralisée. Leur limite est due au fait qu'elles ne prennent pas suffisamment en compte les liens qui existent entre les pratiques de corruption dans le secteur public et le fonctionnement non seulement du secteur privé mais aussi du secteur informel.

L'objet de ce papier est d'étudier l'organisation de la corruption dans les hôpitaux publics de Douala et son impact sur l'allocation des ressources.

Plus précisément, dans un premier temps, en s'appuyant sur les entretiens effectués auprès des personnels des hôpitaux publics de Douala et sur les apports du modèle de monopole, nous allons montrer qu'à la suite de la baisse drastique des salaires, les médecins de ces hôpitaux ont changé de comportement à travers trois phénomènes:

- la perception des pots de vin;
- le transfert des patients de l'hôpital public vers l'hôpital privé;
- le transfert des malades de l'hôpital public vers le centre informel de santé.

Ces phénomènes sont à la base d'une organisation tripolaire de la corruption.

Dans un deuxième temps, nous analyserons les effets de cette organisation sur l'offre et la demande des soins de santé.

L'organisation tripolaire de la corruption

Nous allons construire un circuit de corruption où un médecin, en situation de monopole, fait face à une multitude de malades dans trois pôles: l'hôpital public, l'hôpital privé et le centre informel de santé. Avant de décrire le comportement de ce médecin face aux patients dans chacun de ces pôles, nous allons d'abord discuter des hypothèses qui fondent cette organisation.

Les hypothèses de l'organisation

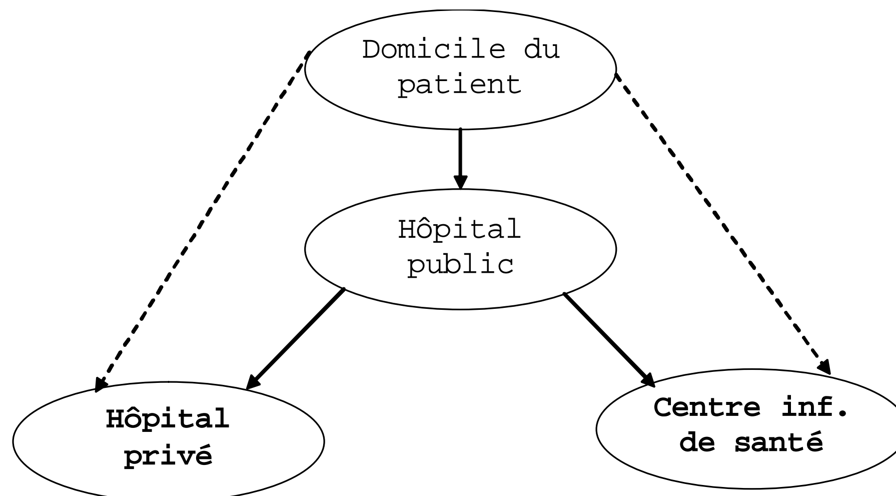
Nous distinguons trois hypothèses. Les deux premières sont relatives au comportement du médecin et la dernière concerne la stratégie des patients dans le choix de l'établissement sanitaire où ils doivent se soigner.

Dans la première hypothèse, nous supposons que nous avons à faire à un médecin en situation de monopole vis à vis des patients. Il a un pouvoir discrétionnaire qui lui permet de s'absenter de l'hôpital public et d'aller soigner les patients soit dans un hôpital privé, soit dans un centre informel de santé à des heures où contractuellement. Il devrait être présent à son poste de travail de l'hôpital public. En clair, il peut réduire l'offre de travail (Shleifer et Vishny 1993) sans être inquiété par la hiérarchie.

Cette hypothèse est restrictive dans deux cas. Premièrement, si le directeur de l'hôpital public veille au respect des lois et règlements en vigueur et, en particulier, à l'obligation de l'employé à venir à temps au lieu de service et à être présent à son poste pendant la durée officielle du travail. Cependant, elle devient réaliste, dans le cas où le directeur est laxiste ou joue de complicité avec le médecin. Deuxièmement, elle est restrictive si la pression populaire (Rijckeghem et Weder 1997) s'oppose à la corruption. Mais, à Douala, nous supposons que cette pression est faible.

La deuxième hypothèse est qu'à son poste de travail de l'hôpital public, le médecin a la possibilité de détourner les malades en les conseillant d'aller plutôt se faire soigner, soit à l'hôpital privé soit au centre informel de santé. Ce conseil est d'autant plus suivi que le médecin a un monopole informationnel sur le patient. « Dans les services médicaux, les discussions entre le patient et le médecin sont telles que ce dernier possède généralement un niveau de connaissances des problèmes immédiats (diagnostics et traitement) sensiblement plus grand. De plus, l'incitation à délivrer l'information n'est pas la même chez le médecin que chez le patient. Celui-ci veut visiblement informer le médecin, mais ce dernier n'a pas la même attitude. L'Obligation professionnelle, l'éthique et la responsabilité personnelle devraient amener le médecin à se montrer ouvert et honnête. Cependant, la simple motivation du profit peut le conduire à se comporter autrement. Pour dire les choses simplement, le médecin a la possibilité de tromper son patient et, ce faisant, de lui soutirer davantage d'argent » (Charles Phelps 1995).

Dans la troisième hypothèse, nous supposons que chaque patient part d'abord de chez lui pour se soigner à l'hôpital public. Lorsqu'il ne trouve pas la guérison dans cet hôpital, il va se faire soigner soit au privé soit à l'informel. Graphiquement, cet itinéraire thérapeutique est le suivant:



Cet itinéraire est restrictif dans la mesure où le patient peut partir de chez lui pour le centre informel de santé ou pour l'hôpital privé sans passer par l'hôpital public. Mais, en supposant que le patient cherche à bénéficier des prix moins élevés devant être pratiqués à l'hôpital public comparativement à ceux pratiqués ailleurs, il va d'abord dans celui-ci.

Une fois que ces trois hypothèses sont vérifiées, le médecin affiche un comportement que nous allons décrire à chaque pôle.

Le comportement du médecin dans les trois pôles

Nous allons décrire le comportement du médecin selon qu'il se trouve au privé, au public ou au centre informel de santé.

Le premier pôle: le médecin à l'hôpital public

La baisse drastique des salaires a poussé les médecins de Douala à adopter des attitudes relatives aux deux premières hypothèses. Le pouvoir discrétionnaire dont jouit le médecin lui permet de collecter les pots-de-vin auprès des patients en contrepartie des soins de santé offerts. À Douala, les pratiques de corruption se révèlent dans la quasi-totalité des services publics hospitaliers (Bernard Hours 1985). On peut distinguer ces pratiques selon qu'il s'agit de la radiologie, des examens de laboratoires, de la pharmacie, de la vente des médicaments et, enfin, des consultations.

Dans la radiologie et le laboratoire, la pratique la plus courante consiste à faire croire au patient que le service ne possède plus de consommables ou que les machines sont en panne. Les techniciens de la radiologie ou ceux du laboratoire lui suggèrent alors le paiement d'une certaine somme afin d'obtenir par exemple un film pour la radio ou un réactif pour le laboratoire. Les patients qui ne passent pas par ces circuits subissent des retards dans la réalisation de leurs examens de santé. Les consommables achetés pour les centres hospitaliers et auxquels les patients devaient accéder aux prix officiels, sont plutôt revendus à des prix plus élevés que ces derniers au profit des agents corrompus.

Concernant la pharmacie, la vente abusive des remèdes peut se manifester au moins de deux façons. Dans le premier cas, il y a des médecins qui vendent des échantillons médicaux. Pourtant, Il s'agit des remèdes qui leurs sont offerts, a titre publicitaire ou d'expérimentation, par des délégués médicaux et qui devraient être donnés gratuitement aux patients. Deuxièmement, suite à la consultation du patient, certains praticiens cupides (Vito Tanzi 1998) faussent souvent le diagnostic et, partant, la prescription médicale dans le but d'écouler leurs propres remèdes. À leur poste de travail, ils prescrivent des remèdes qu'ils possèdent et les vendent aux malades.

Pour ce qui est de la consultation, le principe veut que le droit d'être consulté soit payé à la caisse à un montant officiel connu de tous. Dans la réalité, on distingue au moins deux pratiques différentes de ce principe. Premièrement, certains médecins exigent que les malades leur versent une somme additionnelle en plus du paiement du droit officiel à la consultation. Deuxièmement, d'autres exigent

que chaque malade leur verse une somme irrégulière et ne cherchent pas à savoir si le malade s'est acquitté du versement de la somme officielle demandée à cet effet. C'est ces deux cas de corruption que Shleifer et Vishny (1993) appellent respectivement corruption sans vol et corruption avec vol.

Par ailleurs, à partir de son poste de l'hôpital public, le médecin peut inviter certains patients à le rencontrer dans un centre informel de santé.

Le second pôle: le médecin au centre informel de santé.

Soit un centre informel de santé qui est une propriété du médecin. Un tel centre est souvent situé au domicile de son propriétaire. Les soins de santé y sont offerts en contrepartie d'un paiement fixé par le médecin. Ces soins sont donnés de manière informelle dans la mesure où le propriétaire n'a pas l'autorisation d'ouverture d'un tel centre.

Dans ce centre, le médecin travaille, souvent, à des heures où contractuellement il devrait occuper son poste au sein de l'hôpital public. En le faisant, le médecin utilise pour son propre compte une partie du temps de travail contractuel avec l'État. Le domicile du médecin devient premièrement un lieu où se donnent des soins autrefois dispensés uniquement à l'hôpital, et deuxièmement, un lieu où se rencontrent diverses personnes dont on peut déterminer les responsabilités: une infirmière embauchée par le centre informel et qui seconde le médecin, un ou plusieurs membres de la famille de la personne malade dont le rôle est d'assister cette dernière (Eric Gagnon 2001). Mais, en dehors du centre informel de santé, le détournement des patients peut se faire au profit de l'hôpital privé.

Le troisième pôle: le médecin à l'hôpital privé

Contrairement au centre informel de santé, l'hôpital privé est un établissement formel reconnu comme tel par les pouvoirs publics et en particulier par le Ministère de la Santé. Juridiquement, les soins offerts au centre informel de santé sont illégaux contrairement à ceux du privé.

Du fait du transfert des responsabilités des services publics vers les services privés, cet hôpital apparaît comme un pôle actif dans l'organisation de la corruption.

En effet, sans courir les risques de sanction, à certaines heures de la journée, le médecin de l'hôpital public peut s'absenter de son lieu de travail et aller servir les patients dans un établissement privé. Dans ce dernier, il est payé généralement au prorata du nombre de patients qu'il soigne; il a donc intérêt à soigner un nombre élevé de malades. Pour accroître la quantité de patients soignés, le médecin a intérêt à détourner un nombre important de malades de l'hôpital public vers l'hôpital privé.

Le comportement du médecin qui soigne à domicile est différent de celui du médecin qui soigne dans un hôpital privé car, à domicile, il gère tous les paiements effectués par les malades en tant que propriétaire du centre, alors qu'à l'hôpital privé, c'est des employés qui gèrent les sommes d'argent que versent les patients.

Le propriétaire de l'hôpital privé paie l'impôt à l'opposé de celui du centre informel. Le dénominateur commun à ces trois pôles est que les actes de corruption qui s'y déroulent sont effectués par le même acteur principal à savoir le médecin de l'hôpital public. En détournant les patients de l'hôpital public au profit de l'hôpital privé ou de son domicile, le médecin utilise abusivement, pour son compte propre, la charge publique qui lui est confiée. Cette organisation de la corruption qui passe par l'hôpital public, l'hôpital privé et le centre informel de santé n'affecte pas de la même façon les différents acteurs qui sont: les médecins, les patients et les hôpitaux privés et publics.

Les effets de l'organisation tripolaire de la corruption

L'organisation de la corruption que nous venons de décrire révèle, pour le patient, trois confusions: entre la caisse de l'hôpital public et celle du médecin, entre l'hôpital public et l'hôpital privé formels et enfin entre l'hôpital public et le centre informel de santé. En mettant en relief ces différentes confusions, nous analyserons en même temps leurs effets respectifs sur les acteurs du domaine de la santé.

Premier effet: Une confusion entre la caisse de l'hôpital public et celle du médecin. Au Cameroun, il est courant de distinguer le trésorier de l'hôpital public du médecin. Le premier a pour rôle d'encaisser les paiements des actes médicaux alors que le second est là pour consulter et traiter les malades. Cette distinction repose essentiellement sur la répartition professionnelle des tâches que chaque acteur doit accomplir.

Or avec les changements que nous venons de décrire au premier pôle, cette distinction devient inopérante notamment dans le cadre de la corruption avec vol. Désormais les médecins perçoivent des pots-de-vin en contrepartie des soins offerts et les patients ne versent plus rien dans les caisses de l'hôpital public. Pour le patient, il y a confusion entre la caisse de l'hôpital et celle du médecin.

Par contre, cette confusion est moindre dans le cas de la corruption sans vol car, pour un acte médical demandé, le patient paie d'abord la somme exigée par l'hôpital public et ensuite le montant demandé officieusement par le médecin. Auprès du trésorier de l'hôpital public, le versement des sommes se fait en contrepartie d'un reçu qui atteste que le patient a effectivement payé.

Dans plusieurs hôpitaux publics de Douala, à l'instar de l'hôpital Laquintinie et l'hôpital Deido, les médecins chefs ont mentionné sur les tableaux d'annonces à l'intention des usagers: « payer à la caisse ». Par cette mention, les dirigeants de ces hôpitaux demandent aux malades de ne pas verser de l'argent dans les caisses officieuses des médecins. Le patient qui verse une somme irrégulière au médecin ne reçoit pas en contrepartie un reçu de versement. La distinction entre le versement effectué auprès du trésorier de l'hôpital et celui effectué auprès du médecin repose essentiellement sur l'existence ou non de ce reçu de versement. La confusion entre la caisse de l'Etat et celle du médecin cause beaucoup de tord aux patients et quelque avantage au médecin.

Pour le médecin qui se situe du côté de l'offre de la corruption, l'opportunité de perception des pots-de-vin permet un accroissement des revenus personnels. Toutes choses étant égales par ailleurs, le pouvoir d'achat augmente et le médecin peut retrouver le niveau de vie qui était le sien avant la baisse les salaires. Lafay (1990) déclare que: « certaines formes de corruption peuvent être un moyen de contourner des règles inutilement contraignantes, d'éviter des pénuries, d'atténuer les conséquences de décisions politiques inadéquates ou même d'attirer des fonctionnaires efficaces (en leur permettant d'obtenir un complément de leur salaire officiel) ».

Si on considère que le fait de diminuer de plus de 50% les salaires au Cameroun est une décision politique inadéquate, on peut penser que les sommes irrégulières que les médecins perçoivent à Douala, en contrepartie des soins médicaux permettent d'atténuer les effets pervers de cette décision: « si le gouvernement a pris une mauvaise décision, la voie ouverte par la corruption peut bien se révéler meilleure » (Leff 1964). Cependant, les cas de corruption socialement désirables sont vraisemblablement très limités, car l'avantage précédent s'accompagne souvent des coûts encore plus importants.

En effet, pour les patients, l'accès aux soins de santé nécessite désormais plus de dépenses qu'auparavant, dans la mesure où ils doivent payer le prix officiel des soins auprès du trésorier sans oublier la somme irrégulière à verser auprès du médecin (corruption sans vol). Pour le patient, le non-versement d'un pot-de-vin au médecin peut causer l'accès tardif ou le non-accès aux soins médicaux. La hausse de prix ne permet plus à certains habitants et, en particulier, aux démunis, de se soigner. L'état de santé des plus pauvres se détériore.

Du côté du trésor public, la hausse des prix des soins médicaux entraîne la diminution des recettes dans la mesure où, du fait de la hausse des prix, certains malades évitent désormais de se soigner à l'hôpital public. Cette réduction des revenus détériore, en retour, la qualité des services publics offerts (Bearse, Glomn et Janela 2000). Les usagers évitent d'acheter les services de mauvaise qualité réduisant ainsi les recettes de l'État et l'habilité du gouvernement à offrir des services publics de qualité (Gupta, Davoodi, et Tiongson 2000).

Deuxième effet: une confusion entre le public et le privé formels

Cet effet résulte du fait que le malade qui va se soigner à l'hôpital public est détourné de celui-ci au profit du privé. Au Cameroun, comme partout ailleurs, on distingue généralement l'hôpital public de l'hôpital privé par le fait que le premier a pour objectif de favoriser l'accès de la majorité des populations aux soins de santé alors que le second a un but lucratif et vise surtout à soigner ceux des malades qui ont un pouvoir d'achat élevé. Cette distinction repose essentiellement sur une vision d'intérêt général par opposition à l'intérêt privé.

Compte tenu des changements que nous venons de décrire au troisième pôle, cette distinction n'est plus pertinente pour deux raisons au moins. Premièrement, au sein de l'hôpital public, le fait que le médecin demande aux patients d'aller se faire soigner au privé [alors qu'il aurait pu les soigner, à bas prix, dans l'hôpital

public] atteste le transfert de responsabilités du public vers le privé. Deuxièmement, à partir du moment où le prix du soin médical comprend le prix officiel et le pot-de-vin, les prix pratiqués dans les hôpitaux publics peuvent égaler et même dépasser ceux des hôpitaux privés. Pour les patients, les différences de prix entre le public et le privé, qui les attiraient vers le premier tendent à disparaître. Il y a confusion entre le privé et le public.

Le secteur privé contribue à la diminution du nombre de patients devant se soigner dans le secteur public et à l'expansion de la corruption grâce au poste de travail qu'il offre au médecin de l'hôpital public et qui conduit parfois ce médecin non seulement à abandonner le public au profit du privé, mais aussi à détourner les malades du public au profit du privé. La corruption n'est plus seulement connectée au secteur public, mais aussi au secteur privé (Vito Tanzi 1998). En dehors de la confusion qu'on observe entre le public et le privé formels, le brouillage peut aussi naître entre le public et l'informel.

***Troisième effet*:** une confusion entre le secteur public et le secteur informel

Au Cameroun, il est courant de distinguer les soins formels des soins informels de santé. Les soins formels sont offerts par les établissements officiels publics ou privés alors que les soins informels sont donnés par les établissements officieux. Les établissements d'offre de soins formels sont supposés avoir rempli les conditions réglementaires imposées par les pouvoirs publics à tous ceux qui veulent obtenir une autorisation d'ouverture d'un tel établissement. Il s'agit non seulement de disposer de moyens matériels et humains permettant de faire fonctionner un centre de santé, mais aussi de payer l'impôt.

Les usagers sont généralement sûrs de la compétence des personnels qui travaillent dans les établissements formels, car on suppose que ces établissements remplissent les conditions d'ouverture imposées par les pouvoirs publics. Au contraire, des établissements informels caractérisés par le non-respect de la réglementation en vigueur n'offrent pas de garantie aux usagers. Par conséquent, aux yeux des patients, la compétence des personnels médicaux qui travaillent dans les établissements informels est généralement douteuse. La distinction entre l'informel et le formel repose finalement sur le respect ou non de la loi et de la réglementation en vigueur et, en particulier, les conditions d'ouverture d'un établissement de santé. Cette différentiation est souvent utilisée par les chercheurs pour séparer le formel de l'informel.

À Douala, le fait que le médecin de l'hôpital public travaille à la fois à l'hôpital public et au centre informel, et le fait qu'à partir de l'hôpital public le patient est invité par le médecin à aller se soigner à l'informel rendent inopérante une distinction entre le formel et l'informel. Pour le malade, il y a confusion entre le service public et le service informel, puisqu'il peut accéder aux soins médicaux offerts par le même médecin ici ou là. Tout se passe comme si le centre informel de santé est un pavillon de l'hôpital public. Cette confusion entre l'informel et le formel affecte différemment les patients, les médecins et le trésor public.

Concernant les patients, les effets se révèlent à deux niveaux: d'abord, le médecin devient indisponible au sein de l'hôpital public puisqu'il soigne à l'informel au moment où il devait être à l'hôpital public. Dans ce dernier, les longues files d'attente de patients se constituent pour attendre l'arrivée du médecin. Cette attente réduit l'accès des patients aux soins de santé. Ensuite, les services vendus au centre informel de santé étant lucratifs, les malades reçus payent généralement plus cher comparativement aux usagers qui sont soignés dans les hôpitaux publics sans verser les pots-de-vin.

Du côté du médecin, le mode d'intervention à l'informel entraîne deux conséquences positives. *Premièrement,* les revenus des médecins s'accroissent puisque, ce que les patients versent pour payer des soins revient directement au médecin propriétaire du centre informel. De plus, ce médecin continue à percevoir le salaire auprès du Ministère de la Santé publique. *Deuxièmement,* au sein de l'hôpital public, l'absence du médecin à son poste d'emploi oblige les patients à créer une file d'attente qui devient, pour lui, une source de revenus. À son arrivée tardive à l'hôpital, le médecin a l'opportunité de collecter les pots-de-vin auprès des patients prêts à payer un surprix pour obtenir un accès privilégié (Lui 1985).

Conclusion

Dans ce papier, nous avons analysé l'organisation de la corruption et discuté des effets de cette organisation sur les principaux acteurs du fonctionnement des hôpitaux publics de Douala. Il apparaît que la corruption prospère dans ces hôpitaux à travers un circuit qui comprend l'hôpital public, l'hôpital privé et le centre informel de santé. Le fonctionnement de ce circuit crée trois confusions chez les patients: entre la caisse officieuse du médecin et la caisse du trésorier de l'hôpital public, entre ce dernier et l'hôpital privé et enfin entre l'hôpital public et le centre informel de santé. Ces confusions affectent négativement les revenus des patients et de l'hôpital public et positivement ceux de l'hôpital privé et du médecin. Cependant, on peut se demander quel est l'effet global net de ces confusions sur le bien-être des populations de la ville de Douala? Dans la mesure où la corruption suscite l'accroissement des prix des soins médicaux, elle empêche à l'hôpital public d'accomplir sa mission qui consiste à faciliter l'accès de la majorité de la population aux soins. De plus, cette corruption interfère sur la confiance des patients vis-à-vis des hôpitaux public et la crédibilité du système d'offre publique de soins. Dans le but d'améliorer la santé des populations de Douala, il est nécessaire d'engager une réflexion profonde pour combattre l'organisation hospitalière de la corruption à Douala.

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5

Health Sector Reforms in Kenya: User Fees

Alfred Anangwe

Introduction

Health sector reforms were introduced under the umbrella of Structural Adjustment Programmes (SAPs) implemented in the 1980s, necessitated by the debt crisis. The economic crisis was evident in the diminishing financial abilities of government to provide social services such as health and education. With or without Structural Adjustment Programmes, African governments were faced with the challenge of sourcing funds in order to continue financing social service provisioning. One of the ways of sourcing funds was located in the potential to pay by users, hence the introduction of cost sharing.

Cost sharing is variously called by such terms as user fees, co-financing, and cost-recovery. In Kenya, the introduction of user fees was the first reform in the health sector. As part of health sector reforms, cost sharing in public health facilities was meant to improve the provision of quality health care services. Funds generated from user fees would supplement government's diminishing expenditure allocated to health care services and, therefore, would ensure continued provision of health care services through supply of drugs and medical equipment, as well as in maintaining and expanding health facilities.

Health sector reforms in Kenya were tailored to meet Kenya's health sector policy goal of providing accessible, affordable and efficient health care services to all Kenyans. Before their implementation, it was feared that health reforms would marginalise the poor and vulnerable in accessing health care. However, the government of Kenya took care of this concern by introducing the system of waivers and exemptions. Under exemptions, certain categories of patients were automatically exempted from user fees. These included those seeking family planning, children under five years, sexually transmitted disease patients, and those

suffering from HIV/AIDS. Exempting children under five years was in realisation of the fact that such children have a low immunity development, which predisposes them to sickness. Indeed, statistics on malaria morbidity attests to this fact, as children under five years are the most affected both in terms of morbidity and mortality.

On the other hand, waivers were supposed to take care of those who could not afford to pay for health services because of their inabilities. Waivers and exemptions were put under the care of medical staff and social workers at the hospitals who were charged with the responsibilities of assessing the financial position of patients and waiving part or all of their bills. This paper discusses the impact of health sector reforms, especially users fees, on Kenya's health policy objective of "Health for All'.

Meeting Kenya's Health Policy Objectives

Over the years, Kenya's health policy was designed to achieve the following objectives:

- Increase coverage and accessibility of preventive and promotive curative health services especially in rural areas.
- Consolidate urban and rural curative and preventive/promotive health services, i.e. rural-urban referral system.
- Increase emphasis on Maternal-Child Health (MCH) and Family Planning (FP) in order to reduce morbidity, mortality and fertility through related public health education programmes.
- Strengthen the Ministry of Health's Health management capabilities, with emphasis being placed at the district level in order to take care of management problems such as facility management, drug supply, and transport and equipment maintenance.
- Increase inter-sectoral coordination between the Ministry of Health and other ministries such as agriculture, water, education, social ser-vices, information and NGOs.
- Increase alternative mechanisms for financing health care programmes.
- Improve and expand the National Health Insurance.

In pursuing the above health care objectives, the Government of Kenya targeted achievement of its long-term goal of Health for All by the year 2000 (Owino 1997). The government realised that this objective would be achieved if citizens lived within a radius of ten kilometres of the nearest health facility, and if primary and preventive health care services were extended countrywide. As a result the Government of Kenya pursued various initiatives: It constructed new health facilities in 'under-served' areas and upgraded existing ones. Grants were provided to church or mission hospitals to complement the government in providing health

care services. The government made efforts aimed at ensuring that essential medical supplies and equipment were made available through the construction of depots in strategic locations. It encouraged and promoted community and NGO participation through grants for capital development. Training opportunities and career development for health personnel were expanded through the government's continuing education and on-the-job refresher and residential training programmes.

Kenya's health policy, at independence, was shaped by both historical and global factors, and was designed to achieve both political and health objectives. Many independent African countries began their lives as populist regimes (Walt 1994), and came up with populist policies. In the case of Kenya, health services were made 'free' in order to meet health needs of all Kenyans while at the same time making the government popular among the masses. In fact the introduction of 'free' medical care in government facilities was done in line with the guidelines of the Kenya African National Union's (KANU) manifesto (Odada and Ayako 1989). By then KANU was the political party, which had won elections at independence and formed government. Providing 'free' public health care services served two very important functions. One function of 'free' health care was to discontinue African experiences of the colonial past. Africans were not accorded the best health care services, as was the case with members of the European descent in the period of African colonisation. The second function was to make the government popular among the people. 'Free' health care delivery was part of the government's scheme of centralising its functions and having control and discipline over its population. The Government of Kenya designed a health care delivery system that would serve its entire population both in the rural and urban areas. The Cold War that underlined global politics at the time contributed to this situation because supplementary financing for health care could be easily obtained from foreign debts and aid depending on a country's political leaning.

Kenya's health care delivery system, which is charged with meeting health policy objectives, is organised around the Ministry of Health (MoH). The Ministry of Health headed by the Minister is charged with the responsibility of setting policies, coordinating the activities of Non-Governmental Organisations (NGOs), and managing, monitoring and evaluating policy implementation (Owino 1997). Kenya's Ministry of Health is the largest provider of health care (curative, preventive and promotive) and undertakes environmental protection and pollution surveillance (Odada and Odhiambo 1989). In general, the Ministry of Health is involved in six-health related programmes, namely promotional and preventive health care, family planning and population control, environmental protection and programme supervision, special programmes (such as disease control projects), and research. The Government of Kenya has also encouraged the plural system of health service delivery. Other providers of health care services include local authorities which, by law, are required to undertake public health activities, supported by

public finance. They provide curative in-patient and out-patient care. In addition, there is a for-profit private sector, which comprises private hospitals and nursing homes and concentrates on curative services. Missions and religious groups charge fees for their curative services but much below the prices charged by the for-profit private sector. Parastatals and private companies provide curative services for their staff within their own facilities. Finally, the traditional medicine sector is often a resort of those in ill-health.

Kenya, in pursuit of its health policy, was able to achieve much in the field of health care provisioning especially in the 1960s through to the late 1980s. This was demonstrated over the years through increasing the number of, and expanding, health facilities and training medical personnel. The government dominated the provision of health care services and by 1996 'it provided 43 percent of the total sector funding and 70 percent of hospital beds of which the Ministry of Health (MOH) provided 62 percent. As a result, the government realized a decline in crude death rate from 20 per 1000 persons in 1963 to 13 in 1987, and 12 in 1991; life expectancy increased from 40 years in 1960 to 58 years in 1994; infant mortality declined from 126 per 1000 in 1962 to 60 per 1000 in 1994; and the immunization coverage rose to 70 percent in 1994 from less than 40 percent at independence in 1963' (Kenya Development Plan, 1997/2001). According to Rae et al. (1989), measles immunisation coverage increased from about 55 percent in 1982 to about 60 percent in 1987 as a result of the Kenya Expanded Programme on Immunisation (KEPI).

Declining mortality rates are some of the indicators of improvement in the health status of society (Rae et al. 1989). As the table below shows, Kenya made remarkable reductions in infant mortality rates since 1948.

Table 1: Mortality and Life Expectancy, Kenya, 1948-1987

Year	Crude death rate per 1000 population	Infant mortality rates per 1000 live births	Life expectancy at birth
1948	25	184	35
1962	20	120	44
1969	17	119	49
1979	14	104	54
1987	13	84	58

Source: Kenya Contraceptive Prevalence Survey 1984 – First Report.

In 1979 'Kenya had one doctor per 10,107 population, and this had risen to about one doctor per 7,542 in 1987 despite population growth' (Rae et al. 1989:54).

Table 2: Estimated Personnel/Population Ratio 1979-1987

Type of personnel	1979 (ratio)	1980 (ratio)	1981 (ratio)	1982 (ratio)	1983 (ratio)	1984 (ratio)	1985 (ratio)	1986 (ratio)	1987 (ratio)
Doctors	10,107	10,408	8,898	8,850	8,368	7,482	7,535	7,473	7,542
Nurses	1,144	1,142	1,138	1,107	1,058	1,039	1,038	1,009	1,004
Clinical officers	11082	10,889	10,623	10,506	10,306	10,290	10,163	10,013	9,834

Source: Rae *et al.* (1989:55).

However, constraints resulting from the debt crisis, which was evident in many developing countries in the late 1980s, curtailed government's ability to continue with its expansion of the health sector. Challenges occasioned by new diseases such as AIDS notwithstanding, the success story of the pre- SAPs began to diminish resulting from government's diminishing per capita expenditure on health. According to Owino (1997:4) the increases in nominal funding notwithstanding, Kenya's Ministry of Health's 'total and recurrent spending as a percentage of the GDP and treasury budget allocations were on the decline, which coincided with the implementation of adjustment in the early 1980s'. The story in other countries is the same. For example, in Zimbabwe it has been noted that 'child mortality figures have began to rise reversing the gains made in the previous decade as a result of declining per capita expenditure on health and the declining quality of health services' (Bijlmakers et al. 1996:14).

Faced with financial constraints, inefficiency and inequities, poor management and inappropriate pricing of services, there was a need to rethink a proper method of improving quality health care delivery. These formed the background of health sector reforms, especially cost sharing.

Rationale of Health Sector Reforms

Cassels (1995) asserts that reforms are triggered by crisis, which may be economic or political. The economic crisis of the late 1980s formed the background for Structural Adjustment Programmes (SAPs). Health sector reforms were an outcome of SAPs. Health reforms try to correct system-wide problems that hinder the delivery of priority health services (Dmytraczenko et al. 2003). Kenya introduced health sector reforms in line with its health sector policy objectives of providing affordable, accessible and efficient health services for all (Kenya Development Plan 1997/2001). The rationale of introducing health reforms was predicated on the realities of the 1980s - the debt crisis - in which the government found itself unable to continue financing health services yet at the same time was committed to achieving health for all. As a result, the government introduced cost-sharing or user fees. The user fees were intended to enable individual health facilities to meet their financial demands that would in turn make possible the

provision of drugs and medical equipment. The same funds generated would also cater for those who could not afford health care. Aware that there was a poor section of the population that could not afford to meet the user fees, the government introduced a system of waivers and exemptions in order to ensure that health care was accessible to all. In general, therefore, reform policy in the health sector was in line with the general health policy as it was geared towards improving accessibility, affordability and efficiency of health services for all.

The World Bank (1992) admits that 'implementation of macro-economic adjustment policies causes various groups to become vulnerable and these include the poorest in society, the relatively scattered rural communities who have not benefited greatly from public expenditure and are facing discontinued subsidies during SAPs, and the urban dwellers who, prior to reforms, have disproportionately benefited from quality public services and subsidies like the civil servants and other middle income groups and the poorest groups'. Several scholars debated the side effects of SAPs on vulnerable and poor groups in society as early as 1989. According to Rae et al. (1989) the various components of SAPs, which fall under six broad categories, were considered to have a direct and indirect impact (positively or otherwise) on the health sector. The six SAP components were the devaluation of the Kenyan currency; cuts in government spending on social services, especially in health and education; additional taxation on mass consumption goods; the removal of price controls; the removal of subsidies on food, etc.; and improvements in public sector planning and execution.

Scholars projected possible impacts of various SAP measures outlined above on the delivery of health care services and health status of vulnerable groups. Rae et al. (1989:60-61) outlined some of them as in Table 3.

Even though SAPs entailed negative impacts on the health sector, the need to institute health reforms rested on the positive side of SAPs because waivers and exemptions, which the government would provide to the poor and vulnerable, would contain the negative effects of SAPs. As a result health sector reforms were instituted.

Health Sector Reforms in Kenya

The cost sharing programme was mooted in the 1984/88 Development Plan (MoH 1984, Owino 1997). The most forceful policy statements on user fees are contained in the Ministry of Health 1984-88 Development Plan, Seasonal Paper No. 1 of 1986, and the Ministry of Health Concept Paper of 1989 on cost-sharing. Details about overall health sector reforms are contained in the Health Policy Framework Paper (MoH 1994). These health reforms, which were to be implemented over fifteen years, included mobilising additional resources; enhancing the role and participation of the private/NGO sector in health care delivery; redefining the role of MoH in health care delivery; organisational and management adjustments; and resource reallocation.

Table 3: Possible Impacts of Various SAP Measures on the Delivery of Health Care Services and Health Status of the Vulnerable

SAP measure	Negative effect	Positive effect
Devaluation	*Rise in domestic prices of imported goods such as drugs, vehicles and medical equipment *Increase in cost of health inputs *Rise in the cost of availing safe and clean water *Fuel inflation further causing rises in prices of commodities *Placing of more burden on vulnerable groups	*Stimulation of exports hence raising incomes and employment. When poverty declines, health improves *Protective effect on domestic industries as import prices rise
Cuts in public spending	*Reduction of funds for buying drugs, vaccines and other medical supplies *Reduction in available training funds, reduced number of trained manpower and reduced access to trained health personnel *Limitation of the ability of MoH to employ more health manpower, thereby inhibiting further improvements of ratios of health manpower to population *Reduction of funds for preventive and promotional health interventions	*Reduction of government deficits and debt *Fall of rate of inflation and rise of purchasing power *Improvement of health status *Release of resources for development expenditure and capital formation for further economic growth *Benefit to vulnerable groups
Additional taxation on mass consumption goods	*Further training of the already trained will be slowed down *Welfare of poor households will be reduced	*Fall of Central government *Improvement of health status
Removal of subsidies on basic foodstuffs and other basic needs	*Reduction of access to food and increase of malnutrition *Poor Housing	*Reduction in government deficits and debt. Fall of inflation and benefit to vulnerable groups as purchasing power rises
Removal of price controls	*Cause of additional burden on vulnerable groups because of the tendency of prices to go up	*Creation of incentives for more production and employment in the medium and long term vulnerable groups benefit
Improvements in public sector planning and execution		*Increase of efficiency of health care delivery resulting in savings on resource inputs and enhancing the quality of health care services

Source: Rae *et al.* (1989:60-61).

Of all of these, health financing was identified as the key constraint to increasing the efficiency and quality of health services in the public health sector. For the same reason, reforms in the health sector were mainly focussed on developing alternative financing mechanisms to those provided by government. On the list are strategies such as increased cost recovery, social insurance, maintaining health facilities through communal fundraising efforts (the 'harambee' spirit) and community-based health care. A priority area became the introduction of user charges. The main objectives of cost-sharing were to encourage increased cost-recovery from users of public health facilities as one of the ways of mobilising additional revenue to augment the financing of the under-funded non-wage recurrent expenditure items, minimise on excessive use of services, promote functioning of the referral system, and improve access by the poor to health services by charging those who make most use of the curative care and who are most able to pay, and channelling the subsidies to those least able to pay (Owino 1997).

In August 1989, the results of the discussion on cost-sharing, which took place between the Government of Kenya and its development partners (mainly donors), were put before the Kenyan cabinet, which basically endorsed the proposed system of health financing for the public sector. The Ministry of Health expressed its fears about the introduction of user fees and complained to the World Bank that the proposed fees to be charged were high. The introduction of user fees also coincided with the introduction of multi-party politics in Kenya and this threatened the popularity of the ruling party KANU among the masses. The opposition political parties took advantage of the introduction of user fees to challenge the government's inability to provide 'free' health care services to its citizens. Generally, the government was not willing to introduce user fees and even after their introduction, revisions were continuously announced, mostly at public rallies, in order to rally the support of the masses. User fees charged on patients was deemed as low in the first instance, but the statistics regarding hospital attendance began to take a downward trend, prompting the president to intervene. The president called for a reduction from 100 to 20 Kenyan shillings per day at Kenyatta National Hospital for in-patients (Dahlgren 1990). This was done after it was realised that the utilisation of the hospital service had fallen drastically due to reasons related to affordability, and subsequently bringing to the fore the issue of accessibility. But despite all this, Ake (1996) asserts that 'Africa still lost out as it continued complaining while implementing SAPs, imposed on these societies by the World Bank and the IMF as a condition for additional extension of credit'.

A system of waivers and exemptions was provided in the new policy to address the concern that the policy could not be affordable to the vulnerable who would in turn be denied access to modern health services. Initial beneficiaries of this system included children under five years, prisoners, the destitute and the

mentally handicapped, patients attending family planning, antenatal and post natal care, child welfare, sexually transmitted diseases, psychiatric illnesses, tuberculosis, leprosy, AIDS, and patients referred 'downward' or 'upward' within the Ministry of Health system.

Exemptions were also extended to civil servants including spouses and children under 22 years old. The responsibility of adjudicating the system rested with the individual facilities. Those entrusted to grant waivers included clinical officers and community nurses at the health centres, and clinical or medical officers in the case of hospitals. After the first consultation, patients were referred to the area chief or sub-chief with an exemption form for endorsement to certify the person's hardship. After this, the authorised officer issued an exemption certificate valid for a period of one year. The whole system of cost sharing with its attendant waivers and exemptions was not able to work efficiently enough to guarantee every Kenyan adequate heath care. This is based on a number of reasons as stated below.

Firstly, several changes have been made to the system of exemptions such as a rise in the exemption ages to 10 and later to 15, excluding civil servants and omitting certain diseases and categories of patients originally included. Secondly, there was limited consultation between government and stakeholders in the design of the programme, and the modalities of its implementation. Thirdly, the six-week period given for the implementation was too short to build acceptance of the policy (Mbugua 1993). Fourthly, the management and administrative structures for implementation were either not in place or inappropriate. Fifthly, funds raised during the initial period of the programme were tied up in bureaucratic obstacles or lay idle in bank deposits, instead of being used to improve the quality of health services (Owino 1993).

As a result of the above reasons the cost-sharing programme was suspended in 1990 in order to put in place institutions that would solve the administrative and management problems. The first institution was the Health Care Financing Division (HCFD), which was set up in 1991 to improve revenue generation and the utilisation of such funds. The second institution to be set up was the District Health Management Board (DHMB), in May 1992, to oversee the operations of the cost-sharing programme at the district level. Thereafter, there were fee adjustments and then the re-introduction of the cost-sharing programme in early 1992.

The management of financial resources deriving from user fees was entrusted to the Health Care Financing Division (HCFD), centrally placed under Ministry of Health headquarters. This division was in charge of controlling revenue generated from the cost-sharing programme and authorising expenditure by public health facilities (MoH 1994). HCFD was inadequately prepared to handle this immense task. In 1993, HCFD was overburdened by the additional responsibilities of strengthening the National Hospital Insurance Fund (NHIF) and rehabilitating major equipment in the health facilities, comprising eight provincial hospitals, ninety-four district hospitals, and four hundred health centres (Owino 1997a).

HCFD could not afford to carry out these responsibilities given its lean technical staff of six at the secretariat. Its performance was inadequate and this translated into deteriorating health standards in health facilities, bringing into debate the issue of quality and efficiency of health services. This time again, the 'free' media highlighted the problem. Deterioration in health services was evident in the lack of curative patient care items like drugs and laboratory reagents, poorly maintained medical equipment and buildings, and congestion (Owino 1997). It was against this background that a proposal was mooted to transfer financial management to lower levels in the health care hierarchy to strengthen and empower districts and individual health facilities in order for them to develop and build capacities in modern management and planning. The rationale was to improve organisation and decision making abilities at the local level, greater community involvement in health programmes, closer integration of the activities of the government, the NGO sector and the private sector, and reductions in red tape.

This did not, however, mean that the DHMBs were fully authorised to determine their user fees and implement them. They were required only to propose budgets and forward them to the HCFD for approval. The result was that it took too long for the HCFD to respond to individual proposals and this resulted in individual facilities implementing their proposed, but yet to be approved, changes. This translated into increases in fees beyond the reach of the poor. Corruption led to further deteriorating conditions of the health facilities because the money raised from user fees for improving the quality of health services ended up in the pockets of individuals, thereby impacting on efficiency. This further put Kenya's health policy objective into question as well as the rationale of health sector reforms. Studies on user fees have provided empirical evidence for the negative impact of user fees on the poor and vulnerable.

Impact of Health Reforms on the Poor and Vulnerable

Bijlmakers (2003:104) asserts that 'the effects of user fees on clinic attendance in low-income countries have been documented extensively in the international literature'. Studies undertaken during the early years of the introduction of user fees give different results of the impact of user fees on hospital attendance. There are studies which have documented major and long-lasting declines in the use of health services as a result of users fees (Waddington and Enyimayew 1989, Moses et al. 1992). Others have claimed that after an initial period of decline, utilisation gradually reverted to 'normal levels' after some time (Nyonator and Kutzin 1999), or even that there was no significant decline at all (Chawla and Ellis 2000).

It has been noted that there is no universally accepted definition of the quality of health (Campbell et al. 2000). Definition is subject to perceptions of the different stakeholders – users, health care providers, health care managers – who have different perspectives of quality of care based on different dimensions in

their definitions, such as availability of physical structures, adequacy of staff, technical quality of clinical care, the nature of interpersonal interaction between the provider and the user, the efficacy outcome of treatment and user satisfaction. These varying perceptions also impact on the conceptualisation of the impact of users fees on access to quality health care.

Health sector reforms are aimed at correcting system-wide problems (Dmytracsenko 2003). In the case of Kenya, 'Cost-sharing aimed at making people more responsible for their own health care by sharing in the cost of the services they received' (Quick and Musau 1994). Ngugi (1995), Mwabu (1992) highlight the rationale for the introduction of cost sharing which was to relieve the government of the financial burden of providing public health services. Cost sharing mobilises resources to supplement government contributions so as to improve the quality of services provided.

Decentralisation regarding the determination of the level of user fees has led to health institutions putting their fees so high as to be beyond the ability of poor people to pay (Owino 1998, Sauer et al. 1994). The latest case of arbitrary increases in user charges took place at Kenyatta National Hospital in January 2004, in which the daily bed charges for in-patients rose from 300 to 450 Kenya Shillings, while clinic consultation charges shot up from 200 to 350 Kenya Shillings. The registration fee also went up from 150 to 200 Kenya Shillings. The question of raising fees notwithstanding, there is evidence that funds generated through user fees were diverted through corruption. According to recent internal audit reports (Nos. KNH/1A/57/51 and KNH/FIN/35) at Kenyatta National Hospital, senior management officers have defrauded the hospital of 51 million Kenya Shillings.

This sum of money was enough to buy anti-retroviral drugs for 17,000 people living with AIDS, or for building two well-equipped operation theatres to boost the already strained hospital theatres. The systems of waivers and exemptions put in place to cushion the poor are continually collapsing (Owino 1998). Since its inception, several changes have been made to the system, which have included raising the exemption ages to 10 and later to 15, excluding civil servants, and omitting certain diseases and categories of patients originally included. The collapse in the system of exemptions and waivers has had the greatest impact on the vulnerable population, especially children under five years whose immunity to common diseases like malaria is very low. For example, Kenyatta National Hospital introduced user fees for children under five in January, 2004. Children who had previously been exempted from user fees now have to pay the mandatory 200 Kenya shillings as a registration fee besides their parents meeting the costs of any further medical investigations or treatment (*Daily Nation* 2004). According to Doctor Fred Were, chairman of Kenya Paediatricians' Association, the new policy will worsen the already poor child survival rate.

The consequences of de-exempting children are already emerging at the Kenyatta National Hospital where the number of children under five years attending the hospital has gone down. Statistics indicate that there has been a drop in seeing between 300 and 500 children a day to less than 200 (*Daily Nation* 2004:25). Several studies have revealed a declining demand for public health services with the introduction of fees (Ngugi 1995, Mwabu et al. 1995, Quick et al. 1994, Kirinjia et al. 1989). Findings from these studies reveal that the introduction of user fees where none existed before may create the perception of a high percentage increase and also that the demand for health services is highly sensitive to price levels. According to Rae et al. (1988:61), 'cost-sharing through charging fees for health services at public institutions worsened the plight of the vulnerable groups'.

Experience in Zimbabwe is also telling. Bijlmakers et al. (1996:13-14) have observed that during the 1980s, infant mortality especially among children under one year of age in Zimbabwe declined from pre-independence levels of 120 to 150 per 1000 live-births, to 61 by 1990. In addition, they observed that child mortality among children one to four years also declined from 40 per 1000 in 1980, to 22 in 1990. However, there is accumulating sad evidence that mortality figures have started to rise in the 1990s, and that 'the gains made in the previous decade are being reversed'. They have attributed this to several reinforcing factors, namely: the declining per capita expenditure on health and the declining quality of health services, the drought, the HIV/AIDS epidemic and the general deterioration in the living conditions of large segments of the population. Turshen (1999) is among the outspoken opponents of user fees in Zimbabwe and has observed that Structural Adjustment Policies were, in general, designed to reduce the demand for public health services, and user fees, in particular, were a mechanism of rationing care. This assertion has been reinforced by studies conducted in Chitungwiza and Murewa Districts in Zimbabwe, which have added evidence to the existing literature on user fees and service utilisation, and bring in the dimension of quality of care to help explain the relationship between user fees, quality of care, and clinic attendance. Creese (1997) makes a very important observation, arguing that user fees have detrimental effects on health seeking by the poor and the vulnerable. He adds that user fees are a political strategy for shifting health care costs from the better off to the poor and sick and that this method of raising revenue and maintaining access to care is based on need rather than ability to pay.

The concept of stewardship as it relates to the issue of good governance demands that government should try to overcome its inadequacies in terms of enhancing responsiveness, improving and maintaining health, and assuring fairness of financial contribution (Sama 2004). According to Sama (2004), the poor emerge as receiving the worst level of responsiveness as they are treated with less respect, given less choice of service provision, and offered lower quality amenities.

Governments have failed to address the question of corruption (black market) in the health sector and this has further worsened the situation because the few funds generated from user fees end up in private pockets. Through involvement,

governments can achieve good stewardship through receiving information that would help improve and correct system-wide problems in the health sector. Stewardship 'encompasses the tasks of defining the vision and direction of health policy and collecting and using information' (Sama 2004).

Conclusion and Recommendations

Studies on user fees in Kenya have shown that cost-sharing is having a negative impact on attendance at health facilities. User fees have denied access and created inequity in health care seeking. This study proposes two ways that will promote access to health by the poor and the vulnerable, namely advocacy and the expansion of the Kenya National Insurance Fund (NHIF).

The first recommendation is advocacy. Health is a human right (Committee on Economic, Social and Cultural Rights 2000) and the 'core element of the right is prevention of ill-health' (Packer 2002). The state is duty-bound to respect and protect the human rights of its people, otherwise, under the International Law, the state is held responsible for its omissions (Packer 2002). It is therefore, the recommendation of this paper that advocacy groups engage the health agenda in their activities. Advocacy in the area of health has worked under certain circumstances such as in women's reproductive health. Advocacy groups have questioned the usefulness of certain cultural practices, which have posed risks to women's health and thereby contributed to the violations of the right to health, such as female circumcision, early pregnancy, and incisions in pregnancy, some traditional birth practices and delivery taboos. Advocacy groups have opposed these practices and made some progress. Advocacy in conjunction with the media can bring desired ends in the field of health care access. An example is the Kenyan government's legislation against female circumcision, and this has gone a long way in improving women's reproductive health. In order for advocacy to be effective, those advocating must come up with a scheme that can work to ensure that all Kenyans have access to health as a basic right. One such scheme is social health insurance.

The second recommendation, therefore, is the expansion of the Kenya Health Insurance Fund (NHIF). This Fund was established in Kenya in 1968 as a social insurance fund. In its initial years it was meant to assist Government employees to gain access to higher quality private hospitals, thereby relieving congestion in the 'free' public hospitals. NHIF provided a cover for the contributors, including their families, for in-patient care in NHIF-approved hospitals. Contributions, benefits and reimbursement rates remained static until mid-1990, after which they were reviewed upwards. The importance of such a scheme has been indicated by Owino (1997) and Kraushaar and Akumu (1993), who have observed that the NHIF's potential reimbursements to public health facilities alone could increase the state's vote for preventive and primary health care funds by about 25 percent. Together with the mandatory enrolment requirement and long experience in handling third party payments for health care, the future impact of the

NHIF on financing, coverage and access to health services could be very significant. Other than the government, and despite its low population coverage, the NHIF remains the largest financier of health services, apart from direct government funding, providing approximately 50 percent of actual revenue generated from the cost-sharing programme.

All that the NHIF requires, therefore, are necessary reforms, which include broadening its functions and coverage, promoting competition, and providing an enabling environment for its operation and expansion (GoK 1995). Reforms should be targeted to solve current problems and inadequacies of the NHIF, which include provision of low benefits for in-patient care, weak administrative mechanisms, lower than expected returns on investments, poor incentive for health care providers to meet high standards of quality health, low claims at public health facilities, accumulated huge surpluses that bear no relation to the claims volume, lack of transparency in the management and accountability of funds, among others. Only a small population of Kenyans has coverage from commercial health insurance and, in its present form and structure, the NHIF covers between about 20-35 percent of the total population (that is the contributors and their dependents). The rest of the population cannot qualify for the more traditional insurance, and need to be enrolled in some flexible risk-pooling schemes. A state health insurance scheme is the only feasible insurance cover for the poor and vulnerable who cannot meet the insurance costs of private insurance companies from their pockets.

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6

Decentralisation of Health Care Spending and HIV/AIDS in Cameroon

Christopher Sama Molem

Background Information

As Claude Ake pointed out in 1981, 'productive forces (comprising labour power, objects of labour and means of labour) express the overall capacities of a society. They tend to develop over time. When one talks of the development of productive forces, one may be thinking of the quantitative and qualitative improvements in labour power, for instance when people acquire more scientific education and technical skills. One could be thinking of the improvement of natural assets such as the irrigation of arid land to make it arable. One could also be thinking of the development of the technology with which man produces. The importance of the development of productive forces to society cannot be overemphasized. The state of the development of productive forces decisively influences social organizations, culture, the level of welfare and even consciousness'.

Labour power comprising the physical, psychological and intellectual capabilities of people constitutes the subject matter of productive forces. Good health is a major determinant of labour power and consequently, the health sector is generally one of the most sensitive of any in the economy and usually attracts a lot of attention from governments and institutions. Improved health contributes enormously to economic growth and development in four ways: it reduces production losses caused by worker illness; it permits the use of resources that can be totally or nearly inaccessible because of disease; it increases the enrolment of children in schools and makes them better able to learn; and it frees resources for alternative use that would otherwise have to be spent on treating diseases or illnesses. This implies that good health leads to productivity

gains and therefore improves the efficiency in the use of our scarce and depleting resources. Economic gains are relatively greater for poor people who are typically most handicapped by ill health and who stand to gain the most from the development of underutilised resources. Throughout Africa, the privatisation of health care has reduced access to necessary services. The introduction of market principles into health care delivery has transformed health care from a public service to a private commodity. The outcome has been the denial of access to the poor, who cannot afford to pay for private care.

The relation between economic change and health has been of interest to both social and medical scientists. Empirical studies have generally focussed on mortality or its opposite, survival, expressed as life expectancy at birth, probably because of the difficulties of collecting sound morbidity data, particularly in developing countries. Although a long-run general relation between economic and health conditions is evident in both cross-sectional and longitudinal analyses, the debate has centred on the relative importance to mortality reduction of income gains and of improvements in public health or medical technology. Most studies suggest that there is a very strong relationship between per capita income and life expectancy in the long-term (Wagstaff 2000). Historical records also show that mortality rates do respond to short-term economic fluctuations, particularly in poor and agricultural settings. The usage of health care facilities depends on the availability and accessibility of these facilities to users. The government, in most countries, plays a leading role in this regard. Existing literature also shows that the usage of health care facilities is sensitive not only to availability and accessibility alone but also to the quality of health care provided by each facility (Collier et al. 2002).

Over the past fifty years, life expectancy has improved more than during the entire previous span of human history, although the last twenty years have been ravaged by the HIV/AIDS pandemic. In 1950, life expectancy in developing countries was forty years; by 1990, it had increased to sixty-three years before dropping to below fifty-five by 2002 due to the HIV/AIDS pandemic. In 1950, twenty-eight of every one hundred children died before their fifth birthday; by 1990, this had fallen to ten (World Bank 1993). Despite these remarkable improvements, enormous health problems still remain. New fatal diseases like HIV/AIDS and to a lesser extent SARS, have surfaced; whereas old ones that were already under control like tuberculosis are reappearing. Absolute levels of mortality in developing countries remain unacceptably high. Child mortality rates are about ten times higher than those in developed countries. In addition, every year, seven million adults die of conditions that could be inexpensively prevented or cured. Surprisingly, remarkably few attempts have been made to estimate total national financing or expenditures from all sources and relate them to their various uses by all the health providers within the context of national health priorities. This study therefore is structured to answer the following questions that are essential

in evaluating the success of the decentralisation of health care spending in Cameroon:

- Who finances health care, how much and for what?
- Are expenditures consistent with health priorities (including the fight against HIV/AIDS)?
- How can resources be mobilised by the health providers and are the generated resources used more efficiently to reduce the spread of the HIV pandemic?

Objective of the Study

The main objective of this study is to examine the effectiveness of the decentralisation of health care spending in Cameroon. Specifically the study is structured to achieve the following minor objectives:

- Identify the respective sources of finances and the health care providers;
- Examine the changing trends in public and private health spending;
- Assess the trend and socio-economic impact of the HIV/AIDS pandemic;
- Make policy recommendation on the way forward.

Methodology

The main sources of data for this study are secondary. The data are extracted from reports of ministries involved in health related issues. Principally, the Ministry of Public Health provides the bulk of information, and to a lesser extent, the Ministries of Planning and Regional Development, Finance, Armed Forces, National Education, Higher Education and Social Affairs. Other relevant data, particularly on the external financing of health, are collected from the World Bank and World Health Organisation documents.

Basic analytical tools include descriptive statistics. These are complemented by the National Health Accounts Framework (NHA) technique. Peter Berman developed this technique in 1997. The choice of the above methodologies is aimed at ensuring simplicity in the analysis such that results should be more policy oriented.

Theoretical Considerations

When economic functions are shared among the various tiers of government with each tier handling its own activities, efficiency is enhanced. Efficiency, which is concerned with the need to finance or provide services in a way that maximises the well-being of the people, can be divided into two, namely, allocation and internal efficiency (World Bank 1997). Allocation efficiency, with respect to health care, for instance, involves the pursuit of health care programmes or services whose benefits are maximised. To be worthwhile; they must be expanded up to the point where marginal benefit equals marginal cost. Internal efficiency, on the other hand, deals with the avoidance of waste, which may be an aftermath of deficient administrative or managerial resources within the production process.

Both forms of efficiency manifest themselves in the health sector in various ways. Examples of allocation inefficiency include under-funding of health services, misallocation of resources among the primary, secondary and tertiary subsectors etc., while over-centralisation of financial decision making and underfunding of specific complementary inputs like drugs, fuel, working vehicles etc., are examples of internal inefficiency (World Bank 1987). Efficiency, whether allocation or internal, covertly or overtly relates to equity. Equity deals with access to health care services, especially for the poor in society. It looks at distribution rather than the processes through which distribution is achieved. More so, it does not necessarily emphasise an equal degree of health care for everyone, rather, its emphasis is on accessibility in physical and financial terms.

The efficiency and equity arguments tend to show why decentralisation is appropriate primarily for services provided directly to people in dispersed facilities, where there are user charges for drugs and curative care. This agrees with the argument that access to improved quality of health care through effective sharing of health care functions enhances, to some degree, the performance profile of labour, which, in turn, will increase productivity for the betterment of health care delivery.

Health Problems in Developing Countries

The characteristics and performance of the health sector vary tremendously among developing countries. However, in most cases the sector faces three main problems. It is argued here that each of these problems is due in part to the efforts of the government to cover the full cost of health care for everyone from general public revenues.

The first problem concerns the allocation of insufficient spending on cost-effective health activities. Current government spending alone, even if it were better allocated, would not be sufficient to fully finance for everyone a minimum package of cost-effective health activities, including both the truly 'public' health programmes noted above and the basic curative care and referral services on health. Not enough funding goes towards basic cost-effective health services. As a result, the growth of important health activities is slowed despite the great needs of fast expanding populations to pay at least some of the costs of health care.

The second problem concerns the internal inefficiency of public programmes. Non-salary recurrent expenditures for drugs, fuel, and maintenance are chronically under-funded, a situation that often dramatically reduces the effectiveness of health staff. Many physicians cannot accommodate their patient loads, while other trained staff are not productively employed. Lower level facilities are underused while central out-patient clinics and hospitals are overcrowded. Logistical problems are pervasive in the distribution of services, equipment and drugs. The quality of government health services is often poor; clients face unconcerned or harried personnel, shortages of drugs, and deteriorating buildings and equipment.

The third problem refers to the inequity in the distribution of benefits from health services. Investment in expensive modern technologies to serve the few

continues to grow while simple low cost interventions for the masses are under-funded. The better off in most countries have better access to non-governmental services, because they live in urban areas and know how to use the system. The rural poor benefit little from tax-funded subsidies to urban hospitals, yet often pay high prices for drugs and traditional care in the non-government care sector.

Decentralisation of the Health Sector in Cameroon

The decentralisation of the health sector in Cameroon has generated a lot of controversy, especially because of the concern for effective and rapid provision of health services nation-wide, given the threats of HIV/AIDS in the country.

The movement from colonial to independent state in the 1960s paved the way for Health Sector Reform in Cameroon. The colonial master, as was the case in other African countries, established health services in towns where the poor had little or no access. More so, the model of health care was purely colonial, intended to serve the needs of colonial administrators and expatriates, with separate or secondary provision made for Africans. It was characterised by the irrational distribution of health infrastructure, as hospitals were concentrated in the urban areas to the detriment of rural areas. It was also more curative than preventive oriented. Critical in the colonial period was the mobile medical team initiated by Dr Eugen Jamot to treat sleeping sickness and malaria with the aid of community members. Patients were treated on the spot and through preventive strategies. The post-independent period saw Cameroon in an experimental stage.

The DASP zone was introduced to replace the mobile team for the fight against endemic diseases with vertical programmes. Extension workers were trained and new institutions were created like the University Teaching Hospital (CHU). Although the DASP zone proved that communities were ready, to a certain degree, to finance health care and organise them to create village hospitals, it lacked inter-sectoral collaboration and was cost-ineffective, hence subject to revision.

For effective implementation of the decentralisation policy, the Cameroon health system adapted a pluralistic system because it was characterised by multiple sources of financing and health care providers. The main financing sources nowadays are the government, public enterprises, and foreign aid donors. Private enterprises, households, religious missions, NGOs, government health facilities, public enterprise health clinics, private clinics, pharmacies and drug retailers, and traditional doctors are the providers of health care. It is also a vertical system in the sense that financing sources deal directly with the providers without going through intermediaries or financing agents.

The Declaration of Health Sector Policy organised health services at three levels. The Cameroonian government clearly defined the roles and functions to be performed by each tier of government in its 1990 circular letter.

The constitution stipulates that the central government should support in a coordinated manner, three sub-systems of health care. The Ministry of Health

(MOH) prepared the schedule of responsibilities assigned to the different levels in such a way as to provide effective health services at all levels. These levels are:

a) Local health centres, usually staffed by certified nurses and providing preventive and basic curative care to the surrounding population;
b) Provincial and central level hospitals providing specialised medical services;
c) District and Departmental hospitals usually staffed by at least one physician and providing first referral health services.

Co-management of the health system, linked to both decentralisation and cost recovery measures, has been promoted since June 1990 when the minister of public health signed a 'lettre circulaire' authorising the creation of community health and management committees at the village, health centre and sub-divisional levels. Health Committees (called COSA) are being established for each catchment area and will have responsibilities for planning activities and expending resources made available to the community health facilities. A subcommittee of COSA (called COGE) will be responsible for managing the funds obtained through cost recovery. At the district level, COSADI are being established with similar responsibilities.

Financing the Health System

Cameroon's public health care system is financed by the national budget, revenues from the authorities to retain the proceeds from cost recovery at the local level, and external aid.

Government Financing

The government finances health care service delivery through the use of buildings and land ceded to the Ministry of Public Works; from civil servant medical and para-medical staff salaries paid by the Ministry of Finance; and from investment and operating support provided by the Ministry of Public Health.

Overall government spending on health has never substantially exceeded five percent of the national budget (compared with the ten percent recommended by WHO) but did attain approximately US$12 per capita (35.58 billion CFAF, or eight percent of the national budget) in 1985-86. The economic crisis forced deep budget cuts in 1986-87 and 1987-88. Since 1988-89 the budget has remained selectively stable both as a percentage of the national budget and in absolute terms, while obviously declining in real terms.

Community Financing

Since 1964 all health facilities have been authorised to charge fees for services, which, except for a percentage retained by consulting physicians as incentive payments, were retained by the treasury. Laws passed in 1990 and 1992 are designed to significantly increase financial resources available to meet operating expenses.

The drug financing law of 1990 authorises public health care facilities to establish community-managed drug revolving funds through which drug sale revenues can be retained locally. The Hospital Financing Law of 1992 authorised selected tertiary-level hospitals to retain fifty percent of fee-generated revenues.

The existing system of cost recovery in Cameroon (confessional health centres, bilaterally funded projects, and private non-profit health facilities) exhibits a wide variation in the kinds and amounts of managing revenues. The fundamental issues affecting the viability of cost recovery include the availability of essential drugs, an equitable pricing policy, and common approaches for dealing with chronic under-utilisation of health services.

External Financing

The principal sources of external support for Cameroon's health sector include the traditional multilateral donors (WHO, UNFPA, UNICEF, EU) etc.; a wide range of bilateral donors, several with many years of experience in the country (Germany, USA, Belgium, and France); and a significant non-profit sector comprising both international NGOs and local confessional groups. Germany (GTZ) is involved in the development of the decentralised health districts in the South West and North West Provinces. USAID financed maternal and childcare programmes in the Adamoua and South provinces. France for its part is providing assistance in hospital management in the North and Littoral provinces.

Discussion of Results

Sources of Funds to Providers of Health Care

A matrix of the sources of funds to providers in the Cameroon NHA for the 2000/2001 fiscal year is presented in Table 1. This Table illustrates the decentralised health care spending in the country. It portrays not only the allocation inefficiency but also the internal inefficiency in the utilisation of resources at the disposal of public health care providers. Sources of financing are presented at the top, and providers on the left, of the matrix. The country's total health expenditure for that year was estimated at CFA francs 2,225,103 million - equivalent to about US $347 million. Total GDP that year stood at CFA Francs 6,320 billion (US $8.262 million). National health expenditures represented 3.3 percent of GDP, equivalent to an annual per capita expenditure of CFA francs 13,332 (US $26.7). Total public spending on health (government plus state-owned enterprises plus foreign aid) was CFA francs 665,539 million, equivalent to US $6 per capita or 0.9 percent of GDP; while private spending (households, private enterprises, and religious missions/NGOs) totalled CFA francs 1,013,820 million, equivalent to US $20.6 per capita or 2.42 percent of GDP.

Table 1: Financial Sources to Providers Matrix (in millions of CFA francs)

Providers	Ministry of Economy & Finance	State Owned Enterprises	Foreign Aid	Private Owned Enterprises	House-holds	Private Non Profit	TOTAL
Ministry of Public Health	56.3,148		38.285			55.2,172	149.8,17
Other Ministry Facilities	4.1,292				27		31.1,292
State owned Enterprise Facilities		6.0,853			1,472.5		1,478.5853
Non Profit Facilities					90.1,542	5.58	95.7,342
Pharmacies & Drug Retailers		13.3,796		12.7,255	206.5,034		232.6,085
Private - Profit Clinics		3.3,511		7.6,353	9.1,388		20.1,252
Traditional Healers					27.1,033		27.1,033
TOTAL	60.4,440	22.816	38.285	20,360.8	2,022.4	60.797.2	2,225.103

Source: Data for this core matrix was obtained from numerous sources

The Providers of Health Care

In Table 1 we observed the allocation of health spending among the various categories of providers. The most important single use of expenditure in the Cameroon health system is for drugs, which came to CFA francs 232,608 million or 88.9 percent of total household health expenditure. This Table includes the actual cost of drugs in public and private health facilities, private pharmacies, drug retail stores, as well as sales by roadside vendors. It does not include profits on drugs in public and private health facilities. Unfortunately, no information is available permitting a breakdown by facility. The amount reflects the high cost of drugs in the country, due partly to the fact that virtually all drugs are imported, and partly to major inefficiencies in the drug procurement system. These are due to the long and cumbersome administrative procedures as well as the lack of transparency in the authorisation of drug imports.

In terms of the allocation of health spending between public and private facilities, CFA francs 1.478.585 million went to government facilities. Private not-for-profit and private for-profit providers received, respectively, 95.7,342 million

and 3.3511 million, while 27.103.3 million was estimated to have gone to traditional healers.

There has been a long-standing debate in Cameroon concerning the relative importance of the public and private sectors in the provision of health care. On the basis of the frequency distribution of patient consultations by category of health provider, information from the 1995 household budget-consumption survey suggests that 14.8 percent of these consultations were with traditional healers. As far as consultations in modern health centres are concerned 43.8 percent took place in public facilities and 56.2 percent in private facilities, even though services in the latter are 50 percent more expensive, and the former outnumber the latter by a ratio of 3:1.

These percentages are also confirmed in the North West province where excellent records of monthly consultations at health centres during the period 1989-1995 show that in 1995 there were 173,450 consultations in religious mission facilities and 129,569 at government facilities (Ghogomu et al. 1996). This is testimony to the superior quality of private sector health services. The household budget-consumption survey did not, however, provide any indication of the relative importance of public and private inpatient care (such as the total number of inpatient days for the two categories of facilities). But the records of monthly hospital consultations in the North West province show the domination of the government sector with 154,396 consultations in 1995 as opposed to 92,274 for the missions and 16,327 for the private for-profit sector. The evidence from the North West province during the past several years also suggests a steady decline in health care provision by the government sector: the share of the government sector in both health centre and hospital consultations fell from 72.9 percent in 1989 to 50.1 percent in 1995, while the share of mission and private sectors increased from 25.5 percent to 47 percent, and 1.6 percent to 2.9 percent respectively (Ntangsi 1996). The main reason cited for the declining role of the public sector was the economic crisis, which has drastically reduced resources for the maintenance of facilities and led to the demoralisation of health staff following the more than 60 percent cut in civil servant salaries in January 1991. Owing to a rapid deterioration of facilities the bed occupation ratio at the General Hospital in Yaoundé fell from 45 percent in 1985 to 23 percent in 2001, and since then this has been reported to be a generalised phenomenon throughout the country. These figures strongly demonstrate the ineffectiveness of the decentralised health care system in Cameroon. Also it explain the raison d'être for the increase of out-of-pocket expenditures by respective households.

High Transaction Costs in Government Spending

The low levels of government health spending and the advent of the economic crisis in 1985, combined with shrewd political expediency, ushered a new and harsh reality into the Cameroon budgetary system, which has had far-reaching

consequences for health care. Year after year, and in an apparent attempt to satisfy the demands of various political constituencies, government budgets approved by the National Assembly (Parliament) and allocated to ministries in the form of treasury vouchers (with the exception of salaries which are paid directly to staff by the Ministry of Economy and Finance) have largely failed to reflect the severe and steady decline in government revenues. The approved budget exceeded actual government revenues by 42 percent in the fiscal year 2000/2001. The total value of treasury vouchers issued in any one year for the purchase of goods and services has far exceeded government revenue, and a substantial number of vouchers have remained unpaid for several years. Treasury offices have been besieged by long queues of suppliers and other contractors waiting to be paid, but without any pre-established order of priority for payment. The end result has been that treasury officials at various levels of the bureaucracy have capitalised on the situation by extorting 'commissions' or bribes of up to 60 percent of the value of a voucher as a condition for payment.

Since the non-salary health expenditures by government involve substantial transaction costs, one must distinguish between expenditures for health and expenditures for health care. Expenditures for health are the resources that have actually been mobilised for the health sector. In the 2001 fiscal year they amounted to CFA francs 60.4434 billion of which 19.2 billion was in the form of salaries (for government health personnel). The expenditure balance of 41.24 billion in the form of treasury vouchers would have involved transaction costs evaluated at 20.62 billion (assumed to be approximately 50 percent of nominal value). This means that actual expenditures on health care were therefore only 20.62 billion. In NHA, transaction costs are counted as health expenditures even though they are not spent on health care; they are viewed as a penalty or a toll that must be paid in order to have access to the 20.62 billion. This is a demonstration of the internal inefficiency inherent in the health care system in Cameroon.

In a recent analysis of the Cameroon budgetary system undertaken for the European Union by AEDES, consultants Jean Benoit Burrion and Philippe Vinard made the following assessment:

> Whatever the level in the health pyramid, the testimony is unequivocal: the delegated credits [approved budgets to the regions] are utilized at no more than half their nominal value for the purpose for which they were intended. Some speak of 30% but it is difficult to evaluate. At any rate this is not rumor or widespread prejudice but a reality lived and experienced by everyone.

For about ten years the Treasury has experienced an acute shortage of liquidity. At first this shortage induces a 'waiting line' of suppliers for the settlement of their claims at the counters of the treasury. Delays of payment can be long (sometimes a couple of years). In the long-run an informal system of management of the waiting line installed itself based on the law of supply and demand. Given the limited resources of the treasury, these are sold to the most intransigent suppliers.

Progressively the informal system becomes a near institutionalised system in which everyone follows their interests. The system transforms itself into a network of complicity.

The system has two consequences. The first is some sort of natural selection of suppliers who are capable of negotiating their claims or who are financially solid. The second is the regulation of the market, which results in 'the law of 50 percent'. However, according to the authors, it is not that the authorities are ignorant of what is going on. At least one cabinet minister attempted unsuccessfully to fight the system. Indeed, as the authors have implied, far stronger action is needed at the highest political level to change the system. 'The system is known to everyone and the authorities at the central level are fully conscious about what is going on. Given the interests in play, it is very unlikely that an improvement of the liquidity situation or that a few exemplary "sanctions" will be sufficient to change the "system"'.

Equity Considerations

Given the low level of per capita incomes in sub-Saharan Africa, large segments of the population may not even have access to the basic package of health care. An important policy by its stewards should therefore be to improve equity of access through an appropriate distribution of health expenditures, either across geographical regions or across income groups. This is because stewards of the health system are entrusted to provide an optimal control and intervention package to reduce the prevalence of HIV/AIDS and to minimise the unfair financial burden.

The NHA sources regarding geographical regions and prevalence of AIDS matrix and the distribution of household per capita health expenditures by population deciles (which is a partial source to income group matrix) are presented in Tables 3 and 4. They are used to discuss equity as concerns of the spending in health care, given the challenges of HIV/AIDS.

The NHA geographical distribution analysis demonstrates that some regions are disproportionately penalised over the others in the allocation of public funds. Table 3 reveals more dramatic inequalities. Cameroon's political strategy, like in any sub-Saharan country where universal coverage has not been achieved, was to ensure that the limited public resources benefited the rural poor. A careful review, using national health accounts data revealed that, contrary to policy intentions in Cameroon, the allocation of resources for the rural poor disfavour the regions with greater epidemiological challenges such as HIV prevalence. The sources to regions matrix shows considerable inequalities in the distribution of health expenditures between urban and rural areas (and also to a lesser extent among rural areas).

Table 2: Sources to Geographical Regions and Prevalence of AIDS Matrix (in $ per capita)

Regions	Govern-ment	Public Enter-prises	Foreign Aid	Private Enter-prises	House-holds	Religious Missions	Total by region	HIV preva-lence rate by region %
Yaounde	13.1	4.5	4.3	4.0	77.9	-	103.8	2.023
Douala	6.5	5.4	4.3	2.9	82.9	-	I02.0	27.9
Other towns	5.4	6.3	4.3	-	29.5	-	45.5	31
Rural Forest	5.4	6.4	4.3	-	32.4	-	48	34.1
Rural Plateau	4.5	-	4.3	-	33.8	-	42.6	32.054
Rural Savana	4.0	-	4.3	-	43.6		51.9	52.545
All Regions	6.8	2.4	4.3	2.2	43.6	68.1	127.6	34.1

Source: Computed by the author, 2004.

Following the presentation in the household surveys, Douala (the country's largest town), Yaoundé (the capital) and 'other towns' are treated as regions (they held some 40 percent of the country's population in 2000/2001) and there are also three rural regions: the forest area (covering the Centre, South and East provinces), the plateau area (covering the North West, West, South West, and Littoral provinces) and the savannah (covering the Far-North, North, and Adamaoua provinces).

As can be seen, per capita health expenditures were respectively $102.0 and $103.8 in Douala and Yaoundé compared with $42.6 and $51.9 in the rural plateau and rural savannah respectively. The high expenditures in Douala and Yaoundé are explained by the combination of high household expenditures (due to high incomes), high government spending, and a concentration of public-owned and private-owned enterprises. In other words government expenditures have helped to aggravate, rather than attenuate, existing regional inequalities in health spending by the other sources.

A cursory look at the distribution of health expenditures across income groups reveals more dramatic inequalities. Per capita household expenditure for health by the poorest ten percent of the population was only $11.4 while for the richest ten percent it was $191.2.

Table 3: Household Per Capita Health Expenditures by Decile of the Populations

Deciles of Population	Total Per Cap. Expenditure (C F A Francs)	Per Capita Health Exp. (CFA)	Per Capita Health Exp. (in dollars)	Total Population	Percentage of Total Population
1	87.2	8.3	11.4	1,894,784	12.47
2	132.7	12.7	17.3	2,097,108	13.8
3	161.5	15.5	21.1	2,048,879	13.48
4	200.7	19.2	26.2	1,815,854	11.95
5	236.2	22.6	30.9	1,661,053	10.93
6	291.5	27.9	38.1	1,379,780	9.08
7	373.1	358.1	48.8	1,362,861	8.97
8	489.6	470.0	64.1	1,107,016	7.28
9	679.5	652.3	89.0	921,984	6.07
10	145.9	140.1	191.2	907,868	5.97
Entire Pop	324.7	311.7	42.5	15,197,500	100

Computed by the author, 2004.

As noted earlier, the World Bank has evaluated the cost of a basic package of health care delivered to ninety percent of the population in a low-income country like Cameroon per capita to be approximately $50 (World Bank 2003). On the basis of our estimate the actualised cost in 2000/2001 was $42.2 per capita. This means that the sixth deciles of the population (with a per capita household expenditure of $38.1) all by themselves could not have been able to afford the totality of the basic health package. However, if it were assumed that the government expenditure of CFA francs 41.24 billion (after transaction costs) were to be distributed equally to the population (15 million in 2000/2001), this would have resulted in an extra per capita expenditure of $2.6. If foreign aid expenditures of $5.8 per capita were also added the extra expenditure would increase to $8.4. Expenditures for the sixth deciles would now be $46.5 (38.1 + 8.4) and the basic health package would become accessible. However, for the first five deciles of the population corresponding to a population of approximately five million (about forty percent of the total population) the health package would still not be accessible. At any rate, as we have seen, government expenditures are not distributed equitably, and therefore far more than five million would not have had full access to the health package. This is partly responsible for the high prevalence of HIV in the poorer segment of the society as demonstrated in Table 3 above. Also it is an indication of the allocation inefficiency, internal inefficiency and inequity in health care spending in Cameroon.

The Prevalence of HIV/AIDS

The low levels of government health spending coupled with gross mismanagement and misappropriation of funds in the health sector, usher in a new and harsh reality in fighting the spread of the HIV/AIDS in Cameroon. It is evident that the problems of budgetary allocation inefficiency, management inefficiency and inequitable distribution of revenue associated with decentralisation of the health system in Cameroon has resulted in poor maintenance of health care facilities, low incentives for health personnel, lack of essential infrastructure and in most cases insufficient hospital beds for patients. All these have culminated in an increase in the HIV/AIDS pandemic. According to the analyses of the Ministry of Public Health, the incidence of HIV/AIDS in the sexually active population of Cameroon was eleven percent in 2000, which is twenty-two times greater than its incidence in 1987 when it was only 0.5 percent. The World Health Report (2003) reported that the number of persons living with HIV was estimated at more than 937,000: one person out of nine in the sexually active population.

The prevalence rate in Yaoundé and Douala stood respectively at 10.33 percent and 9.0 percent, the rural forest and savannah stood at 16 and 11 percent respectively. It is worthwhile to note that the HIV prevalence rate in pregnant women in rural areas stood at 18 percent compared to 13.59 percent of pregnant women in urban areas.

Prevalence among ante-natal clinic attendees in twenty-eight sites was 10.8 percent; HIV prevalence in Yaoundé was 11.2 percent, and median HIV prevalence in Douala was 11.6 percent. In areas outside the major urban centres, the HIV prevalence among ante-natal attendees increased from less than one percent in 1989 to eight percent in 1996 and has continued to rise. In 2000, median HIV prevalence in 25 sites outside the major urban areas ranged from six percent to thirteen percent. HIV prevalence in 2000 among the 20-24 years old was 12.2 percent. HIV prevalence among sex workers tested in Yaoundé increased from 5.6 percent in 1990 to 45.3 percent in 1993.

In 1994, 21 percent of sex workers tested in both Yaoundé and Douala were HIV positive; in 1995 the rate was 17 percent. A couple of studies among truck drivers, conducted between 1993 and 1994, found that between 9 to 17 percent of those tested were HIV positive. In 1996, 15 percent of military personnel tested were HIV positive. HIV prevalence increased among male STI clinic patients tested from 5.6 percent in 1992 to 16 percent in 1996. Outside of the major urban areas, HIV prevalence among STI clinic patients tested in six sites had reached 8 percent in 1992. In 1994, 9 percent of patients tested in Banka, Central province were HIV positive (UNAIDS 2002).

Although HIV/AIDS-related issues affect everybody, they affect the vulnerable, the poor and women more. Details are contained in Table 4.

Table 4: Country HIV and AIDS Estimates, End 2003

Adult (15–49) HIV prevalence rate	6.9% (range: 4.8%–11.8%)
Adults (15–49) living with HIV	520,000 (range: 360,000–740,000)
Adults and children (0–49) living with HIV	560,000 (range: 390,000–810,000)
Women (15–49) living with HIV	290,000 (range: 200,000–420,000)
AIDS deaths (adults and children) in 2003	49,000 (range: 32,000–74,000)

Source: 2004 Report on the global AIDS epidemic

In response to this growing social and economic threat of the HIV/AIDS epidemic for the population, the Prime Minister launched a strategic plan in September 2000. This document, entitled 'A Strategic Document for the National Plan for the Fight against AIDS in Cameroon 2000–2005', better known by its French acronym 'Comité National pour la Lutte contre le SIDA (CNLS)', sets out the basis for collaboration between the state, national actors and bilateral and multilateral partners in countering the epidemic. The Minister of Public Health chairs this committee. The Committee's Central Technical Group coordinates the implementation of activities throughout the country, with the assistance of ten provincial technical groups run by ten provincial coordinators.

The CNLS is made up of thirteen representatives of the public sector, including the offices of the President of the Republic and the Prime Minister, representatives of the private sector (an employers' organization and a trade union), national and international NGOs, the representatives of the two networks of associations of people living with HIV, the representatives of donors, and in particular la Coopération Française, GTZ, the European Union, the members of the Theme Group, including the UNAIDS country coordinator and representatives of parliament. The CNLS holds two statutory meetings per year, convened by its chair.

Its joint monitoring Committee supervises the action of the CNLS. This is an audit and control body, which also serves as an advisory body to the CNLS. The Ministry of Territorial Administration and Decentralisation meets it four times a year. It approves the annual and quarterly plans of action and the annual activities report. The Theme Group takes part in its work.

The Country Coordinating Mechanism has just taken its place in this organisation, specifically in connection with the follow-up of activities funded by the Global Fund. The Country Coordinating Mechanism has thirty members and is chaired by the Chairman of the CNLS.

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National initiatives such as agreements signed between the government and the private sector are subject to a further level of coordination, determined by their specifications and at the proposal of the private sector.

The main objectives of the plan are to preserve the health of children, women, and men at home, or at work, at leisure and in hospital. This is to be achieved through a series of measures: minimising the risk of contamination with HIV/AIDS among children aged five to fourteen by promoting a healthy lifestyle and the development of responsible sexual behaviour, developing information mechanisms aimed at bringing about changes in the behaviour of the sexually active population, reducing the risk of transmission of HIV from mother to child, minimising the risk of infection through blood transfusion, and developing a national mechanism for solidarity with persons living with HIV/AIDS.

The strategic plan adopted a decentralised sectoral approach aimed at reducing the spread of the virus and involving among others the educational, agricultural, transport and military sectors. A summit bringing together several African First Ladies, international experts and other delegations was held in Yaoundé in November 2002 with the theme 'African Synergy against HIV/AIDS and its Sufferings'. In order to ensure adequate financing for the implementation of the National Plan for the Struggle against AIDS, the government of Cameroon committed itself to setting up mechanisms to mobilise resources for the campaign from internal and external sources and to ensure rigorous and effective management of the resources.

UNAIDS Support to the National Response

Given the inherent limitations of the decentralisation of the health sector, in 2004 the government of Cameroon embraced the activities of the United Nations HIV/AIDS. The activities focused on the following points.

For the first time ever the country team organised a retreat to draw up the United Nations plan in support of the national response to HIV/AIDS (2004-2005). This retreat was divided into two phases: first of all, the heads of agencies defined priorities, after which the technicians translated the priorities into operational terms; the outcome was the plan referred to above.

The country team held three meetings with the Chairman of the National Committee to draw his attention to the following needs: the organisation of a forum among partners involved in the HIV/AIDS control effort, follow-up for major interventions (prevention of mother-to-child transmission, access to antiretroviral therapy, and the private sector), documentation of best practices, assessment of the impact of HIV and AIDS on the national economy and on the main sectors of activity (private sector, agriculture, and education), an increase in the national budget allocated to the other ministerial departments for AIDS control and the urgent need to introduce efficient management mechanisms for activities funded by the Global Fund. Also planned was the production and dissemination

of a liaison bulletin highlighting actions by the United Nations system in the field of HIV and AIDS. Technical and financial support for activities was linked to DHS (funding) through UNFPA and the World Bank. In addition, there was input for activities linked to the Global Campaign and to World AIDS Day by helping to draft the appeal made by the First Lady. Finally, implementation was planned together with the government and with synergies from Africans of the NO SIDA (AIDS) Caravan in all of Cameroon's provinces.

The Socio-economic Impact of HIV/AIDS

HIV/AIDS follows a different pattern in each locality. Geographical and ethnic factors, agro-ecological conditions, religion, gender, age and marital status play a role in the pattern and impact of HIV/AIDS and in people's perceptions of the disease. Urban and rural disparities in infection rates have also been observed. Initially, the prevalence was more in townships in Cameroon but is gradually engulfing rural areas at a more rapid rate. This has critical implications for the design of HIV/AIDS interventions.

HIV/AIDS is disproportionately affecting poor households, and particularly people in the most productive age groups. Women are more exposed to infection than males. There are far more AIDS widows than widowers. Young widows with dependent children tend to become entrenched in poverty as a result of socio-economic pressures related to HIV/AIDS. The HIV/AIDS stigma, for instance, which largely results from the prevailing stereotype that it is the women who are responsible for transmitting HIV, is undermining traditional coping mechanisms accessible to young widowed women and changing the socio-economic fabric of the extended family.

The socio-economic impact of HIV/AIDS is beginning to have an effect on the value system of the family in Cameroon as traditional norms and customs are breaking down under the pressures triggered by the HIV/AIDS epidemic. The result is that the social fabric of the extended family is showing signs of erosion and the close bonds that hold family members together are disappearing. To give but some examples:

The stigma attached to those infected with HIV/AIDS is as discussed above, in some cases, breaking up families and distancing widows from their children. Parents are forced to either send their children to work or to take them out of school. In both cases, youths are being deprived of family life education, which is instrumental in establishing a code of conduct between men and women and husbands and wives. Family life education is critical in the social development of young men and women, ensuring the transmission of family values, mores and norms, establishing a social and sexual code of conduct and setting limits in sexual conduct. Many parents attribute early sexual activity and multiple or casual partners to the disappearance of family life education.

In some areas in the country, families are being forced to adjust burial rites and ceremonies to cope with economic pressures resulting from HIV/AIDS. Firstly, the mourning time is being shortened to only two to three days. Secondly, less money is being spent. And thirdly, the drinking and socialisation taking place during burials is changing to discourage substance abuse and casual sex. Traditions such as ritual cleansing and wife inheritance are threatening the well being of the extended family as a result of HIV/AIDS but no acceptable alternative mechanisms have been developed.

Apart from affecting the value system of the family, HIV/AIDS has the potential to create severe economic impacts in Cameroon. It is different from most other diseases because it strikes people in the most productive age groups and is essentially 100 percent fatal. The effects will vary according to the severity of the AIDS epidemic and the structure of the national economies. The two major remarkable economic effects are a reduction in the labour supply and increased costs.

On the labour supply side the loss of young adults in their most productive years affects the overall economic output. If AIDS is more prevalent among the economic elite, then the impact may be much larger than the absolute number of AIDS deaths indicates.

On the costs side, the direct costs of AIDS include expenditures for medical care, drugs and funeral expenses. Indirect costs include lost time due to illness, recruitment and training costs to replace workers, and care of orphans. If costs are financed out of savings, then the reduction in investment could lead to a significant reduction in economic growth.

The economic effects of AIDS are felt first by individuals and their families then ripple outwards to firms, businesses and the macro-economy. The household impacts begin as soon as a member of the household starts to suffer from HIV-related illnesses. There is a loss of income of the patient (who is frequently the main breadwinner). Household expenditures for medical expenses increase substantially. Other members of the household, usually daughters and wives, miss school or work less in order to care for the sick person.

Death results in a permanent loss of income from less labour on the farm or from lower remittances; from funeral and mourning costs; and the removal of children from school in order to save on educational expenses and increase household labour, resulting in a severe loss of future earning potential.

Conclusion and Recommendations

Developing countries such as Cameroon that achieved a remarkable reduction in morbidity and mortality in twenty years are now confronted with the HIV/AIDS pandemic. An unfortunate collateral effect of the disease is the resurgence of certain almost eradicated infectious diseases like tuberculosis. This has increased the demand for the conventional services of hospitals and physicians. In Cameroon

where managerial resources are scarce, communication is difficult, transportation is slow, and many people are isolated, decentralisation of the government service system should be considered as one possible way to improve effectiveness in the fight against this deadly disease.

Decentralisation is appropriate primarily for HIV/AIDS intervention services, provided directly to people in rural households. These programmes are more effective if they are contracted out to local health providers. These health providers could easily create awareness of the existence of HIV/AIDS and knowledge on how the rural people can protect themselves. Myths, misconceptions, superstitions, stereotypes and stigmatisation are widely prevalent in poor, illiterate households. The less people know about the disease, the more negative they tend to be about HIV/AIDS-afflicted and affected families and the stronger the stigmatisation. What is particularly significant is that individuals tend to blame their partners for transmitting the HIV virus, not themselves for engaging in high-risk sexual behaviour.

Decentralisation of financial planning should include the general principle that revenue collected in the form of user charges should be retained as close as possible to the point at which they were collected. This improves the incentive for collection, increases accountability of local staff within limits that ensure that the choice of expenditures reflects local needs, and fosters the development of managerial talent at the community level.

To encourage community-run and private sources of health services that could enhance the fight against HIV/AIDS in the country, there is the need to reverse past tendencies toward unnecessary restrictions, hostility and neglect. Other positive steps in this direction include helping community-based non-governmental organisations. Government could start by increasing public funding for training and backup support, including technical supervision and assistance in procurement of the anti-retroviral drugs. The provision of technical and financial assistance to private voluntary organisations for training (especially such areas as management) and the coordination of activities are very desirable.

Other steps include making credit accessible (especially where markets are restricted) to private ventures that want to expand or upgrade services and facilities for major interventions.

One possibility is transferring the operation of government facilities to non-governmental health providers (through sales, lease or contract). Such a step is appropriate for preventive facilities where the benefits of care and support accrue directly to those served.

It is necessary to mobilise support for people with AIDS or people who are vulnerable to HIV/AIDS. Young widows/widowers whose families have been affected by AIDS could be involved in HIV/AIDS education and related activities and possibly given some incentives. They can also be assisted with information on how to live positively with AIDS within the community, and instructed how to make wills.

The promotion of condom use should include extensive sensitisation, covering issues such as how to raise the subject with their partners, when to use condoms, how to use them properly, how to dispose of them properly, underscoring the importance of consistent use, especially under the influence of alcohol.

Perhaps the most important role for the government in the fight against HIV/AIDS is to ensure an open and supportive environment for effective programmes. Governments need to make HIV/AIDs a national priority, not a problem to be avoided. By stimulating and supporting a broad multi-sectoral approach that includes all segments of society, governments can create the conditions in which prevention, care and mitigation programmes can succeed and protect the country's future development prospects.

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7

Another Look at Community-Directed Treatment (ComDT) in Cameroon: A Quality Challenge to Health System Development

Martyn T. Sama and Richard Penn

Introduction

Onchocerciasis is the world's second leading infectious cause of blindness with an estimated 123 million people under risk, and about 18 million people in the world suffering a grave burden imposed by the disease (WHO 1997a). In Africa, some 17.5 million people are infected with *Onchocerca volvulus* (WHO Technical Report Series no.852). It is estimated that more than 6 million people are suffering from Onchocerca skin lesions and severe itching (Remme, Murray, and Lopez 1990).

The vector *Onchocerca volvulus* produces millions of microfilariae worms which migrate to the skin and the eyes of the human host, causing severe itching and pigmentation. The most severe manifestations of onchocerciasis are irreversible: ocular lesions of both the anterior and posterior segments of the eye, resulting in impaired vision and ultimately total blindness. In Africa, it is one of the leading causes of visual impairment and blindness. Rarely life threatening, but causing chronic suffering and severe disability, onchocerciasis constitutes a serious obstacle to socio-economic development (WHO 1996).

Mass-treatment of onchocerciasis is carried out in meso- and hyper-endemic areas once a year, and in hypo-endemic areas, treatment is clinic-based. The target population is persons of five years and above, with the exception of seriously sick persons, pregnant women, nursing mothers whose babies are aged below eight days, and very old persons.

The process of Community-Directed Treatment (ComDT) with Ivermectin (CDTI), has been adopted for onchocerciasis control in some places of Africa. A multi-country study (WHO 2002) conducted in some of the endemic countries has demonstrated that Community-Directed Treatment (ComDT) is an effective

strategy for drug distribution. Those communities are deeply involved in their own health care on a large scale. An assessment by the African Programme for Onchocerciasis Control (APOC 2000) showed that ComDT is effective also for other health and development activities like distribution of Vitamin A, Malaria control, Guinea worm control, and Sanitation. Despite the success, several questions remain unanswered about community and health system interaction for sustained coverage of Ivermectin distribution (WHO 2002a).

Ivermectin distributors, the Community Directed Distributors (CDD), are supposed to be members of their community chosen by the community through a democratic process, trained to distribute Ivermectin and supervised by health services staff. Ivermectin is considered safe enough to be administered by non-health personnel.

Treatment coverage varies between contexts where ComDT has been tried. The mean reported coverage over different ongoing projects is 70 percent. Problems in the selection of CDDs, inadequate supervision by health staff and limited community participation in decision making are common obstacles. The following problems are common to all project sites, these range from poor selection of CDDs, inadequate supervision by health staff to limited community participation in decision making (APOC Technical Report 2002). The urgency of research on ComDT is underscored by the fact that advocates of ComDT want to also use it for other community-based interventions.

This paper reports on a study of ComDT Ivermectin treatment in Cameroon. More specifically we give results on coverage and the views of the CDDs, the health personnel and the community on the ComDT of Ivermectin. The study is an exploratory single case-embedded design, seeking to understand the factors influencing the effectiveness of community-based approaches to drug distribution, in this case ComDT Ivermectin treatment.

Methods

The study was conducted in the south western part of Cameroon where the NGO Sight Savers International (SSI) currently has a Community-Directed Ivermectin Treatment (CDTI) programme. The South West Province lies between 5º20 and 4º N and 8º45 and 9º45 E. The study area includes the health districts of Muyuka, Kumba, and Konye. The areas were purposely selected for this study because they were among the meso- and hyper-endemic communities. Two of them are hyper- and one meso-endemic, thus meeting the criteria for mass treatment with Ivermectin. The study area has a very rich network of drainage systems, most of which flow from high altitude and are interrupted by numerous cascades, rapids, and waterfalls. These streams provide sites for *Simulium* vectors, which can be found at high altitude in the area.

A traditional chief heads each community, and links the communities and the administration. However, the influence of the chieftaincies over the communities

varies from one ethnic group to the other. In some communities the people are better organised around the administrative authorities.

Several channels of communication are used. Each community has a town crier whose role is to transmit messages in the local languages to the community. Churches and 'Njangi houses' are also commonly used for disseminating information. Other traditional channels include the talking drum, and flute.

For this study information was obtained from the study population which consisted of different actors involved in the process of ComDT with Ivermectin at the community level. These include the CDDs, the health facility staff, and the community members and their leaders. At the Local Government Area/District level, the heads of the other health and developmental activities operating within the study communities were also studied. The team that conducted the study comprised of a social epidemiologist, a medical doctor, an anthropologist, a communicator, a bio-statistician (part-time) and six interviewers.

The interviewers were under-graduate students of the Department of Sociology and Anthropology at the University of Buea. Training was carried out for two weeks on the techniques of using quantitative and qualitative instruments for data collection. Confidentiality protection was guaranteed by demanding and receiving oral reports from all CDDs, households, community leaders and health workers to insure data quality before interviews.

Quantitative Data Collection

Forty communities within which at least two CDDs were found were randomly selected for data collection. In each community, two CDDs who covered a minimum of fifteen households were selected for surveys - hence a total of eighty CDDs, seventy-five male and five female, who met these criteria, were interviewed. A semi-structured questionnaire was administered to each CDD to collect information on the different health and development activities in which he/she was involved, how and when they got involved, their motivation, the number of days spent on each activity, similarities to the other activities in their work as CDDs, and how their involvement in the other H&D activities affect their work as CDDs.

A total of 1200 households in which the eighty CDDs worked were surveyed to estimate for household treatment coverage, using a pre-tested standard household survey form. Fifteen households per CDD were used to collect information on sex, age, treatment coverage, period of treatment, treatment effect and side-effects. Information on actual coverage was obtained from 1185 households with 5812 individuals, consisting of 2919 (50.2 percent) males and 2893 (49.8 percent) females.

Qualitative Data Collection

Forty focus group discussions (FGDs), one per community were conducted; twenty male FGDs and twenty female FGDs. Each FGDs ranged from eight to

twelve persons. A FGD guide was used to direct the moderator, note-taker and observer during the discussions.

Forty in-depth interviews were conducted with each community leader using an in-depth interview guide. In-depth interviews were conducted with all nine people (eight nurses and one DMO) from health facility staffs that supervise the CDDs in the study communities. An in-depth interview guide for health staff was used to guide the interviewers.

Quantitative Data Analysis

EPI-info was used for entering data from the household surveys and CDD surveys and for the questionnaire's descriptive analysis. For more detailed analysis, SPSS was used to examine variation and correlations.

Qualitative Data Analysis

Data were transcribed from tapes to records. MSWord was used for entry and transfer to text files. Textbase-Beta was used for content analysis.

Results

Quantitative Results

Two questions in the household survey give estimates of the proportion of persons that report they received tablets and those that report they swallowed the tablets. The overall estimates for persons five years and older were 73.5 percent and 72.6 percent (14 percent of the persons in the household survey were under five). Among those that reported tablets swallowed, 46.3 percent reported side effects and 3.5 percent reported having taken any health care action. Table 1 shows the detailed estimates by age and sex. Both sexes report lower coverage in the age groups 15–34 years. Children and older people have higher frequencies of persons that received and swallowed tablets. Women have generally lower coverage. The proportion having swallowed tablets was about one percent lower than the proportion that received tablets quite systematically. Women more often reported side effects than men and also sought health care more. Both these proportions were larger for the older groups.

There is a large variation between CDD areas and between households within these areas. The coverage estimated from reported numbers in the CDDs questionnaire is considerably lower, less than 50 percent. No correlations were found between the coverage estimated from the household survey and the information from the CDDs. We did not find any correlation between CDD age, sex and educational level, time spent on CDTI, involvement in other activities and motivation. An attempt to use a multiple regression model gave the result that the CDD variables only explained 1.9 percent of the variation in coverage between the areas where CDDs operated. The model was not statistically significant, i.e. all correlations were fully explainable by chance variation.

There were five female CDDs among the eighty that filled in the questionnaire. The ages ran from 22 to 59 years. Ten reported having attended secondary school. Seventy percent reported having been selected by the village leaders and most of them were appointed during 1999. As many as 77 reported that they had spent two weeks or more in a year on CDTI.

Some opinions expressed in the questionnaire answers are summarised in Table 2. There are some doubts about CDTI working well. The question on support from the health sector was mainly answered positively but a reasonable number of CDDs did not share that opinion. The views on CDDs' improvement, community involvement and the feasibility of taking on other tasks were quite uniform. Generally, the last four questions point to the negative view regarding other tasks. Table 2 provides data on the responses from the CDDs.

Table 1: Estimated Coverage, Proportions of Persons that Received and Swallowed Tablets, Frequencies of Side Effects and Health Care Seeking Actions by Age and Sex in the Household Survey

	Male				Female			
Age	Receive tablets	Swallow tablets	Side effects	Health care seeking	Receive tablets	Swallow tablets	Side effects	Health care seeking
5-14	77.1	76.8	36.1	2.4	77.6	76.8	42.3	1.8
15-24	68.7	67.2	40.7	3.0	62.7	61.5	46.6	5.3
25-34	73.6	72.6	48.4	2.5	66.7	66.2	56.8	8.6
35-44	77.7	77.4	48.9	1.3	76.8	76.2	54.2	6.2
45-54	78.9	77.8	46.5	1.9	77.8	76.5	56.4	3.3
55-	80.4	78.8	56.2	3.4	74.3	74.3	55.5	2.7
Total	75.4	74.5	43.4	2.5	71.7	70.9	49.4	4.5

Table 2: Frequencies of Responses to CDTI Given by CDDs in Questionnaire

Question	Do not at all agree				Agree fully
CDTI works satisfactory	21	41	1	15	2
The support received is enough	6	31	2	22	19
The CDDs are capable for the job	3	12	5	44	16
CDDs have improved during work	21	48	7	2	2
Community is involved in process	13	49	3	12	3
CDD should not do other acts.	1	3	3	47	26
Other acts would be helpful	41	37	0	1	1
CDD will have to do other acts.	20	45	3	11	1
CDD will enhance health	31	47	1	1	0
Better monitor. With other acts.	19	48	10	3	0

Most CDDs reported that community members selected them during gatherings or general meetings but some reported that the procedures did not follow CDTI guidelines. A CDD could be selected by the village chief alone or with his cabinet or by a health worker. The village head could also appoint himself, by village head alone, or by a health worker and village chief together.

Various problems in carrying out activities were identified in the process of preparing for and implementing the distribution of Ivermectin. Transportation was a major concern. Several CDDs complained because they received no provision to cover the transportation cost needed to collect Ivermectin. Some complained that they spent their own money. Shortages of Ivermectin were noted creating tension between CDDs and community members. Poor storage facilities existed. Batches of supplies were often known to have expired because of bureaucratic delays in the system.

The issue of the fear of side effects and the impact on compliance concerned several CDDs. They noted that the issue is complicated by the lack of drugs that relieve side effects, for example itching. CDDs reported low morale due to the lack of incentives and compensation for time spent on distribution. CDDs observed that people were often absent during distribution, and this required the CDD to make repeated additional home visits. The CDDs often complained that 'I have no time of my own. People can come to me any time of the day'.

Several CDDs said they faced difficulties in reporting and documenting their activities. The problems were said to be caused by the short time for training and by community members not providing towards buying or recording supplies like notebooks and pens.

The overwhelming majority of CDDs reported they received no assistance from the health facility. Only a few reported receiving assistance, which took the form of the mobilisation of community members and making announcements about the availability of drugs. Training on implementation, reporting and management of side effects was not sufficient. Supervision and monitoring of CDD activities from the health sector was not at an acceptable level.

In a similar manner, CDDs often reported that community members did not play an active role in the distribution of Ivermectin. One response that summed up a common reason for low community involvement was: 'Nobody assisted. They did not know about the procedure. They did not receive any information about it'.

Views and Experiences of Health Workers

Selection and training of CDDs were reported to present problems. It was difficult to find literate candidates; even semi-literate CDDs find it difficult to cope with the task and the training. The health staff, as well as the CDDs, face transportation problems in getting to the training venue. Health workers also noted the lack of response and support from health authorities: 'We have written a proposal on how to train CDDs but we have not received any response yet'.

Most front-line health workers were not involved in CDD or programme supervision. This was actually left in the hands of the onchocerciasis coordinator of the District Health Service. The need for reinforced supervision was clearly recognised.

Management of side-effects was another important task discussed by health workers. They noted that 'Some people fear side-effects so they don't want to take the drug. They complain of itching, swelling of body, dizziness, and stomach-ache'.

A finding from the in-depth interviews with health personnel was that supervision of CDDs was a major problem:

'CDTI is a very difficult programme. I am the chief nurse, mid-wife, consultant, leprosy inspector and in charge of delivery and outreach activities. The CDTI programme is a burden to me. It adds too much work on me'.

The DMO for Muyuka noted: 'Some nurses are not competent enough to manage and handle records, especially financial reporting. The programme lacks a good information management system. More so, issues of onchocerciasis endemicity are not yet clear to the community members. They do not understand why some people are supposed to be treated in the hospital and some through mass treatment in the communities'.

The perceived roles of the health worker were captured in the following statement. 'Delivery has been regular for the past three years. The health worker spends about one hour to discuss health issues but they rarely talk about onchocerciasis'.

Views and experiences of community members

In a female FGD it was noted that CDD selection criteria were not always observed. 'We do not know who chose them. We only saw them with the nurse moving from house to house taking our names, after which they came with Mectizan. They said we should take it to treat our filaria'. Some community members were of the opinion that the CDDs were chosen by the health personnel. 'To me, I know that he was chosen by the mid-wife to help to distribute Mectizan. We were not asked to choose them'. In an in-depth interview, a community leader admitted having appointed all the CDDs in his village after he 'received a letter from the chief of post, to select four people and send to him for training. I called three of my councillors and my daughter and sent them for the training course'.

A major issue raised in FGDs, in-depth, and key informant interviews with community members was that of ownership of the programme. The majority of respondents said that CDTI belonged to the community. On why they thought that the programme belonged to the community, they gave responses such as: 'we are the beneficiaries', 'we plan the distribution', 'we do the distribution', 'we select the distributors', 'the distributors is ours', and 'because we are told so'.

Those who thought that the programme does not belong to the community stated that it belonged to the government or the ministry of health. 'It is the

government that brought this programme to us but we have been told that in the near future, it will be our own.' Most community members saw their role in CDTI as mainly passive.

Community members also identified other problems with the programme. These included non-involvement of certain segments of the population (especially men). On the subject of absenteeism, one woman said, 'Our men are sometimes not present when distribution takes place'. Others observed poor compliance, including both low turnout and refusal to take the drug. Others noted that there was a lack of awareness of the importance of the drug. This problem is compounded by the wrong messages which are sometimes passed to community members. Community members also pointed out organisational problems. The major complaint of communities with no health facility is that they do not have an opportunity to discuss their health needs with health workers.

Discussion

The study provides an overall estimate of Ivermectin treatment coverage as about 73 percent - not much lower than the long term sustained 75 percent stipulated as necessary to effectively interrupt transmission. The results from this study show that the overall treatment coverage (68.2 percent) is low in the study area.

In order to interrupt transmission, APOC sets a minimum coverage rate of 75 percent sustained for a long period (APOC 2002). However, there are large variations in coverage between districts as well as between households within districts. No single factor can conclusively be identified as responsible for coverage variations. Some suggestions are that overall low treatment coverage may be attributed to: poor selection and training of CDDs, poor supervision of CDDs, management of severe side effects, and the distribution process. The quantitative analysis fails at this point. Different mechanisms might be the reason for low coverage in different districts. The qualitative analysis reveals some of these.

In the CDTI approach the community, as an administrative, geographical and social construct, plans their own distribution system. They make decisions on who should distribute the drug, the mode (house to house, central location) and place (chief's compound, school, or church) of the distribution system. Communities collect Ivermectin from the collection point if it is not located far from them and decide when to distribute. The CDTI approach is an evolution from other community-based delivery strategies. It is supposed to promote active community participation as an integral part of Ivermectin distribution, to improve access to the drug and give a sense of community ownership of the process.

The information obtained in interviews reveals that the guidelines for selection and training of CDDs were sometimes ignored by some health personnel and community leaders. In addition, the health system generally did not provide adequate training skills to the health personnel. CDDs to some extent lacked the skills to conduct a household census, keep good records, maintain treatment

registers, observe and identify side-effects, report severe side-effects and give information to the community about side-effects. The lack of management skills of side-effects provided a major barrier to high treatment coverage of Ivermectin. The programme for side-effect management did not train nurses. When severe side effects occurred, nurses were not available for management. The referral and counter referral system was not working.

A lack of adequate supervision during distribution was reported, and can be one reason for low coverage. Enormous supervision problems existed at the level of the health system. There was a gross lack of transportation for the local health staff to supervise CDDs during distribution. Many of the health facilities are under-staffed and the health personnel are not properly trained to conduct supervision. No incentives were provided for supervision; therefore no health personnel were motivated to supervise the CDDs.

The Ivermectin distribution process appears to be flawed with various systemic problems. There were no drug distribution plans for CDDs, communities were given responsibility to take decisions on the mode, time, and place of distribution, but were not empowered in the decision-making process. Although the entire community should decide the selection of distributors, the decision-making process that may exist in a given community prior to the commencement of the control programme led to village leaders in some communities selecting themselves or relatives as distributors (Amazigo 2001).

A TDR Report identifies constraints influencing the task of Ivermectin distributors as: delays in the delivery of Ivermectin from the port to the country; follow up and treatment of the members of the community who are absent during the period of mass treatment (absentees); refusals; the house to house mode of distribution; and the complex record keeping demands. The schedule and work load of distributors resulted in some instances in a high attrition rate among distributors.

The success of Community-Directed Treatment with Ivermectin (CDTI) using Community-Directed Distributors (CDDs) in Onchocerciasis control has drawn attention from other disease control programmes (Walsh 1979). However, the health system is faced with quality challenges regarding their selection, training, supervision, management of severe side effects, and the distribution process. There are systemic issues that need to be addressed before ComDT can take on its role as an entry point to community-based healthcare interventions at a time when there is a need to critically examine determinants of treatment coverage of Ivermectin distribution. The main purpose here is to propose some basic conceptual elements that may help establish a consistent basis for policy, action, and research before CDDs can take on additional health care activities.

There have been various attempts in Cameroon to use a Community-Directed Treatment System and Community-Directed Distributors for other health interventions but the implications of this development for the treatment coverage

of CDTI are not clear. It is expected that the integration of additional community level heath care activities into CDTI would enhance treatment coverage. However, treatment coverage may be at risk if the health system starts using CDDs for other activities without ensuring sustained high coverage. Overloading CDDs without sustained treatment coverage can erode the health system. Opinions have been expressed, rather strongly, as to the negative effects of the ultimate consequence of overloading CDDs with programmes built essentially on top-down approaches on the effective implementation of CDTI. (Brieger 2000; Zekus and Lysack 1998; Schwap 1997, Walsh and Waren 1979). What this means is that more evidence on the nature of the effect of involving CDDs in other health and development programmes on CDTI implementation is needed. This study points to some major weaknesses.

Conclusions

Community-Directed Distributors find it difficult to achieve high coverage and sustain it due to programmatic obstacles in their selection, training, supervision, and management of severe side effects and non-empowerment of the communities in decision-making.

Although coverage is not extremely low overall, there are large variations and pockets of the population are left without treatment.

At the organisational level, the issue of the quality of the distribution process has not been addressed, and because of this, the programme suffers from technical inefficiency.

Serious systemic problems still exist, and need to be rectified before community-directed distributors can take up additional health and development activities.

The communities are not involved in decision-making regarding selection of distributors, mode, place, and time of Ivermectin distribution, hence ownership and sustainability of the programme seems to be eroded.

The support from the health sector in terms of training, supervision and assistance is not sufficient everywhere since health facilities are under-staffed, poorly equipped, and poorly paid.

It is necessary, therefore, for health systems to address systemic programmatic and organisational issues before undertaking large-scale implementation programmes like community-directed treatment with Ivermectin.

To obtain high and homogenous coverage there is a need to use better routines for the selection of CDDs and select only persons that can be effectively trained. CDDs must be given better training for strengthening the health system involvement. It is necessary to give the CDDs information and knowledge about the management of severe treatment side effects including the capacity to report adequately and inform the community. Communities must be empowered to take decisions. The linkage between research-to-policy-to-action-to-practice should be clear.

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