

Exploring Cooperation in a Health Programme Based on Community Participation: The case of NWPSFH in Cameroon.

Ofeh, M. A and Njong, M. A,

Abstract

Many donor agencies view the problem of financing health care services in developing countries as a problem of cost recovery through user charges. Policy measures on this view are then intended to generate additional revenues to ensure sustainability. Based on survey study, this paper explores cooperation between the German Agency for Technical Cooperation (GTZ), the Ministry of Health and the local Community to ensure the health needs of provincial setting in Cameroon. These three stakeholders operating within the spirit of partnership constitute the North West Provincial Special Fund for Health (NWPSFH). Based on this community-participatory approach to ensure health services delivery, the paper provide evidence that the basic objectives of the NWPSFH project have been attained, though amidst some difficulties.

Keywords: NWPSFH, participatory approach, health and development, partnership, sustainability.

Introduction

Health is an important ingredient of the development of any nation. As Amida (2000) rightly puts it, "health is wealth". This is why health and related health services remain the bedrock for any other socio-economic activity. This important issue of health has attracted not only the attention of the sick person but equally that of the local community and the world at large. This, notwithstanding, WHO estimates that about half of the world's population has little or no regular access to essential drugs. Sub-Saharan Africa (SSA) is even worse off, since only one-third are thought to have access to drugs and health facilities (WHO, 1988b). With population growth increasing at the rate of about 3 % which is more than the growth rate of food production and budgets declining, most SSA governments have been unable to meet the health needs of the people. This dismal situation has attracted the attention of non governmental organisations (NGOs) in many economic sectors, particularly the health sector in Cameroon.

One problem with Cameroon, and perhaps with other SSA countries is the inception of development units in vital sectors such as health and education without the accompanying infrastructure. (Ibi, 2001). Most health units in the North West Province of Cameroon, in particular, and in other provinces in general, have existed with little or without health infrastructural services like pharmacies to cater for essential drugs. If they do not exist, users have often had to go for long distances on foot or on human back to be served due to poor road infrastructure. According to the Cameroon health map, 54 % of the population live at less than five km from an integrated

health centre. This average, however hides wide regional disparities, as people in the rural areas cover a distance five times greater than in urban areas to reach a first contact health institution. Again, 98.9 % of persons who live in the rural areas cover more than six km to reach a health centre(Cameroon Household Survey II, 2002).

This absence of sound health services has pushed the impoverished rural populace to contend themselves with the unorthodox traditional diagnosis and herb treatment. Of course, the results have been damaging, culminating to persistent illnesses with accompanying expenses and eventual loss of life. This situation could have been curbed to an extent, if the few existing health facilities in the provinces could be obtained at affordable prices. The remoteness and inaccessibility of some of the health units rendered it quite difficult if not impossible to be reached by government supply drug organs. Thus, health care services in the North West Province of Cameroon (especially in the rural areas) had been abandoned almost to nature and personal survival.

In responses, the Canadian government attempted with an all embracing primary health care programme before 1986. The programme which was functioning in partnership with local councils was short-lived, because of embezzlement and low sustainability of the programme. By November 1986, an NGO called the NWPSFH was created to salvage the inadequate health services.

NGOs are major contributors to health care delivery, yet until recently there has been a notable absence of knowledge about the nature of their activities. This lacuna has critical implications given the current trend among donors to channel funds to NGOs and encourage their role in social and human capital development. In an era of shrinking overall resources government's scanty knowledge about the activities of NGOs in the health sector is likely to impede the rational use of available resources for health.

This paper attempts to trace the cooperation efforts between the German Agency for Technical Cooperation (GTZ), the Ministry of Public Health, and the Local Community. This tripartite health cooperation is called the NWPSFH, and we shall analyse its modest successes as well as the many difficulties encountered.

The rest of the paper is organised as follows: Section 2 shall present an overview of the health system in Cameroon. Section 3 presents the NWPSFH project and the setting. Section 4 shall attempt an assessment of the health project while section 5 concludes and some recommendations are made.

The Health Delivery System in Cameroon

The Cameroon health system has undergone three major transformations.

Colonial period to 1978

The provision of modern health care services in Cameroon throughout the colonial period remained largely in the hands of Christian Missions which were the first to expand health care services into rural areas. These church-affiliated organisations were few, and the state almost adopted a monopoly situation with little private initiative. Health services and drugs were free in government health centres as the state bore the entire costs. In addition, this period was characterised by :

- disproportionate concentration of health structures in urban areas at the expense of the rural milieu.
- high priority to curative activities at the expense of cost effective preventive measures.
- a passive participation of the population, and
- low priority given to traditional medicine by public authorities.

With growing economic crisis, this strategy became too expensive and unaffordable. Drugs and equipment could not be replenished, training of staff was a problem, and remote areas were abandoned to themselves. The system was bound to collapse.

The Vertical Primary Health Care Programme.

In the month of September 1978, Cameroon was one of the many countries and organisations that attended the WHO and UNICEF sponsored conference on Primary Health Care (PHC) in the East European Kazakhstan State capital, Alma Ata (Ghogomu, et al, 2000). Against the above background, the conference resolved that in many developing countries like Cameroon access to health services for the rural population was either poor or insufficient. It proposed a strategy for the promotion of health for all, termed Primary Health Care. It recognised traditional medicine and attached a lot of importance to that practice. The effective implementation of this policy in Cameroon started in 1982 (Ghogomu, et al, 2000). During its implementation the area of emphasis shifted from health professionals and classical health structures (hospitals and health centres) to community health workers (village health workers and traditional birth attendants) and their village health posts. This programme actually consisted in mobilising the community to :

- construct, allocate or rent a building to be used as a health post, and acquire essential drugs;
- form a village health committee for annexation and communication .
- select a child of the soil as village health worker or traditional birth attendant, and ensure their training.

At Rica, Russia, in 1987 a global mid-term evaluation showed that the PHC concept (what was better referred to as the vertical PHC approach) as outlined above had failed. Several reasons accounted for the failure of this approach :

- it was not sustainable and lacked field co-ordination and supervision.
- it was difficult to retain village health workers who either deserted, or got entangled into activities beyond their skills and competence.

The Reorientation of PHC

The present health system in Cameroon is based on the reorientation of Primary Health Care (PHC-RO) . It was introduced for implementation in 1990 as a result of the failure of the vertical PHC programme. It is the outcome of two African Conferences – the 1985 Lusaka, and 1987 Bamako conferences to redress the health situation (Lamnteh, 1996).

Using the results of the mid-term evaluation of the vertical PHC programme and the recommendations of both the 1985 Lusaka Conference, and the 1987 Bamako conference (styled Bamako initiative) Cameroon through the Ministry of Public Health began to recognise its health system under the name of the reorientation of Primary Health Care (Lamnteh, 1996).

The PHC-RO is a strategy in the national health policy which counts on the active and effective community participation for the management and functioning of health services. It stresses on the rationalisation of the management of resources either provided to or generated by the sector within the spirit of partnership between the state and the community.

The PHC-RO system in Cameroon has three levels (Ghogomu, et al 2000);

- the peripheral (operational) = Health District
- the intermediate level = Health province
- the centre level = National

These levels could be represented in the form of a pyramid

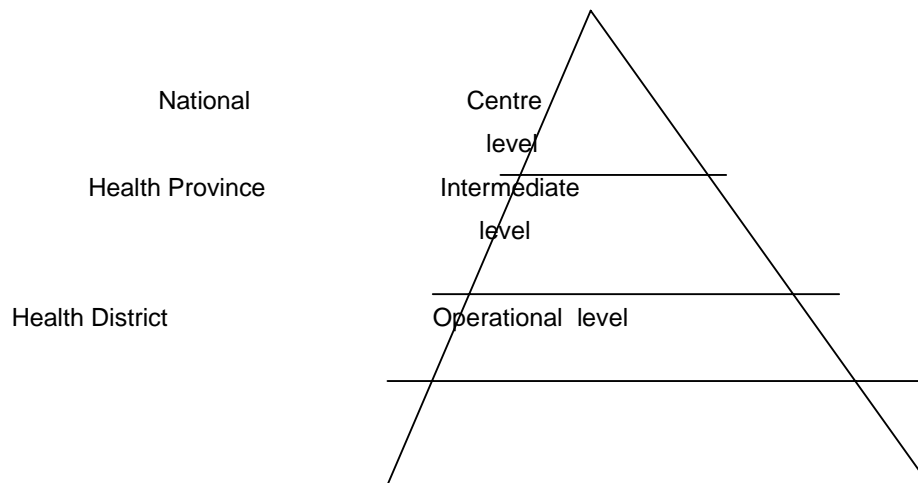


Fig. 1 : The PHC-RO System Pyramid in Cameroon.

The pyramid indicates that the health district or the operational level takes care of more people than does the intermediate and the central levels. It is there that community participation is practised. It is there that the community can express its real needs and be mobilised into action. The two upper levels are more specialised and provide technology and know-how. They provide the necessary support which entails:

- making laws, allocating resources and training health personnel

- supervises and may assist in the execution of the activities.

The present health care system in Cameroon further stresses that health is the concern of each and everyone and not the exclusive preserve of the Ministry of Public Health personnel. It thus promotes effective and active community participation in health by way of co-financing and co-management in a true and democratic sense of partnership between the state and the community, and between the users and the providers. This sense of partnership is demonstrated through the implementation of the concept of collaboration within and between the sectors in a very decentralised manner (Ghogomu, et al 2000). As such, allied sectors like education, social affairs, water and environment are indispensable partners in health development.

Having described the PHC-RO system in principle, we shall in the section that follows explore how it is being implemented in the North West Province through the activities of NWPSFH.

The NWPSFH Project and Context

Before we attempt to evaluate the NWPSFH project, we need to recall certain features of Cameroon development and economic situation. This will provide a background for understanding the basic problems that necessitated the intervention of the project.

The Setting

Here we look at the general economic situation, and health situation in Cameroon as a whole, and in the North West Province in particular.

General Economic Situation

Cameroon which stretches from 2° to 13°N has a diversity of physical environment, from mangrove swamp and dense tropical rainforest along the 200 km coastline to the dry Sahel Region in the Far North (Alan,1996). Cameroon has a population of 16.630 million and is diversified and very unevenly distributed on the 475,402 km² total area . Overall density is 50 inhabitants per square kilometre but very high in some areas(Alan,1996; NIS, 2003).

The North West Province, which is our specific area of study, is one of the ten provinces of Cameroon, and has a population of about 1.1 million, and a population density of about a hundred inhabitants per square kilometre (project PNUD,1999). The North West Province is made up of a range of volcanic mountains which determine the landscape, vegetation and climate. With a Savannah vegetation of short grasses and groups of deciduous trees, the North West Province constitute part of what is called “grassfields” (projet PNUD, 1999).

By 1984, Cameroon had an apparently strong and well balanced economy characterised by rapidly growing per capita incomes, 9.2%, a high rate of investment in relation to gross domestic product (GDP) and a balance budget. (USAID,1989). In a nutshell, the Cameroon government was widely regarded as committed to long- term balanced growth and an effective manager of the country resources. The period of rapid growth came to a sudden halt in 1985 and Cameroon started

experiencing economic crisis. The GDP declined by 2.8% in real terms in 1987, and by 8.6% in 1988. The situation with respect to public finance was more serious. USAID (1989) shows that in 1986 public expenditures increased by 32% while revenue dropped by 16% creating a deficit of about 464 billion FCFA. In 1988, the government signed a standby arrangement with the IMF and started implementing the Structural Adjustment Programme in an effort to redress the crisis which affect the country up till now.

The Health Situation

Government budgetary allocations for health in the early 1980s constituted as much as 6.3% of government services budget, compared with the WHO recommended average of 10% for low income countries. In 1988, however, the health budget declined by 4.6% (USAID,1989).With the economic austerity measures the health situation has further been exacerbated, as budget allocations for medication has further reduced by 50%. Again, a large allocation of the dwindling budget is ear-marked for administrative costs and personnel within the Ministry of Health, with the disproportionate share of personnel cost in rural and primary health care facilities. By 1990, there were chronic shortages of basic drugs and clinical supplies in all government services. According to the Human Development Report (1997), sanitary or health infrastructure in Cameroon by 1993 were insufficient and poorly distributed. By this report, more than half of the Cameroon population had no access to modern health facilities. No pharmacies existed by 1970, 50 existed by 1981, and the number climbed up to 180 and 215 by 1991 and 1993 respectively (Human Development Report, 1997). The number has increased since then but the irony is even that some of these pharmacies have existed without essential drugs, or when they exist, they could only be procured at uncontrollable and exorbitant prices.

As of 1993, only seven hospitals existed with pharmacies in the North West Province. These pharmacies provided scanty pharmaceutical services, and were situated basically in the Divisional Headquarters. This necessitated the rural population to trek for long distances to obtain drugs

The NWPSFH Project

In 1993, the Ministry of Public Health published the National declaration of the PHC-RO to salvage the deplorable health situation in the country. This followed the declaration at Lusaka in 1985, and Bamako initiative. By this declaration, the Ministry of Public Health was poised to take advantage of the existing habits of Cameroonian in general towards self-help and community participatory spirit. The North West Province as noted with dynamic traditional and communal set-ups for this self-help initiatives was chosen as the pioneer zone to lunch the PHC-RO

The PHC-RO in the North West is implemented through the NWPSFH. From inception, NWPSFH existed as North West Pro-Pharmacy since 1986, changed its name from North West Pro-Pharmacy to NWPSFH following the law of associations in 1991. The NWPSFH is a dynamic tripartite partnership – the government through the Ministry of Public Health, the Community and

GTZ. Existing since 1986, long before government recognise its health system, GTZ pumped in an initial revolving capital of 205 millions FCFA into the project. Each of the actors in this partnership has specific activities to perform. This, to avoid unnecessary overlapping of functions, and to rationally use the health structures and ensure health quality care. Thus, each level of actor assumes a minimum package of activity that it can deliver.

In this light GTZ which provided the financial base, today provides technical expertise (training of its pharmacists attendant, advising, etc). The Ministry of Public health is responsible for

- the training, recruitment and payment of salaries of health personnel
- creation and construction of health units
- supply of basic as well as sophisticated medical equipment

The Community is responsible for

- payment of services rendered to them
- purchase essential drugs and other needs
- assist in logistics (construction or renting of health infrastructure, etc).

This minimum package of activity per actor can be summarise as follows :

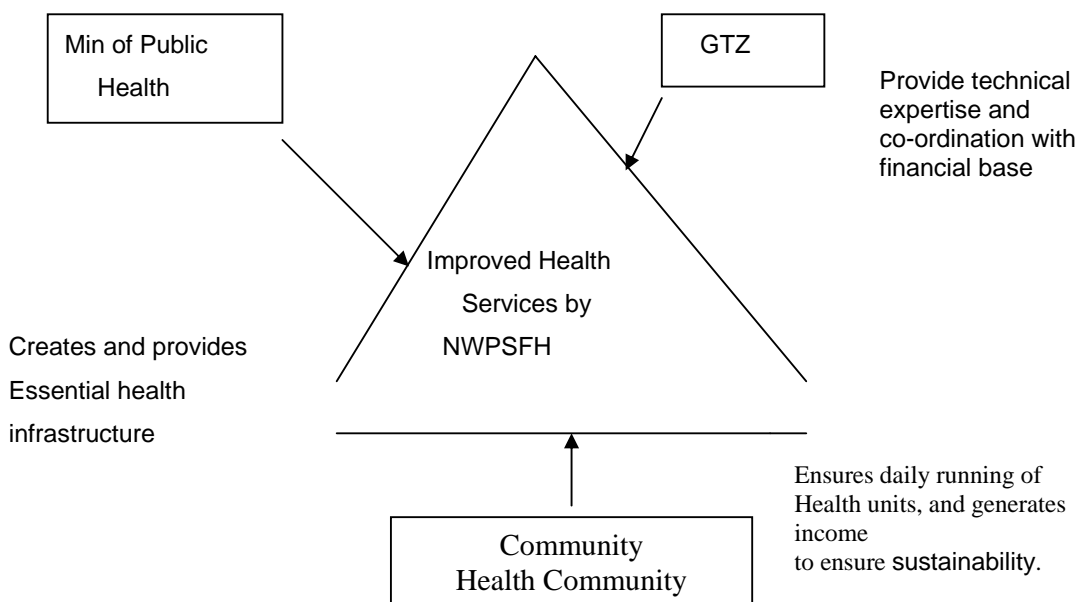


Fig. 2 : Functional system of the NWPSFH

From the above, the NWPSFH has three basic health objectives

- assist the Cameroon government in financing the establishment and running of health service units in order to monitor health problems in the province
- supply pharmaceutical products and other health consumable goods through the health units.

- Contribute in the improvement of health services and ensure sustainability

With these broad-based objectives, the NWPSFH operates a trilateral functional system putting more emphasis on community participation for improved health services. From figure 2 the project may collapse if the community health units are not able to pay services rendered to them, and thus generate income for sustainability. This gives the community an essential role in the trilateral partnership.

Evaluation of THE NWPSFH Project

Methodology

Assessing the impact, particularly the social impact of a health development project on the population presents serious methodological problems. It may be necessary to evaluate the before and after health status of the population. However, direct baseline data on the population before the inception of the project are not available. Because there are no baseline data it is impossible to directly assess changes over time in status of a population.

Two sets of questionnaires were designed. One was used to interview groups of village inhabitants at the community level. It solicited information on village characteristics, preferences for health care, decision-making mechanisms, and community willingness to participate in the health project. A second questionnaire was administered to health workers and mid-wives to gather information about these health personnel, the physical structure of the health units and on the stock of drugs and clinical equipment. In addition, a number of individual interviews were conducted with GTZ and NWPSFH management, and some officials of the North West Delegation of Public Health.

In all, the interviews were asked to retrospectively assess the status and living situations, and the changes that had occurred over time. This method though far from ideal, nevertheless provides us with some basis for comparing the perceived rate and level of change.

In other to survey as diverse a population as possible, the administrative regions of Menchum, Bui, Momo, Donga-Mantum and Mezam located in different parts of the province were selected as they represent various ethnic groups, religious and cultural values. It was decided that the sample would include district health posts in the villages that were reasonably accessible. Based on these criteria 72 of the 110 health units were sampled.

Major Findings

The results of this study will be discussed in the light of the goals of the NWPSFH project and the following research questions:

- is the project cost recovery?
- how do the different stake holders perceive the cooperation efforts?
- what are the major achievements and difficulties of the project?

- how can the partnership operate to enhance cooperation, sustainability and provide better health services?

The above research questions are answered in the discussions that follow.

Comparing the health care situation in the province before the inception of the project, all partners were unanimous that remarkable achievements have been made. The province is now served by 110 Health Units spread all over and into the most remote villages of the province. This was not the situation before as only seven pharmacies existed via the seven divisional hospitals. In addition the numerous pharmacies today are equipped with essential drugs and other pharmaceutical and or clinical equipment. The availability of these health units has greatly reduced the long distances travelled in the past by patients to get to the nearest health unit. For instance the whole of Momo Division was served by two pharmacies, Mbengwi Central Hospital and Acha-Tugi (a mission hospital). Patients from Njikwa and Ngie Sub-Divisions were served by the Acha-Tugi Hospital. This implies that the 43 km separating Njikwa and Acha-Tugi Hospital was covered on foot by patients. This is no longer the case today, because the NWPSFH has pharmacies in the health district of Njikwa made up of Njikwa, Nkonda, Kuttin and Oshie health units which provide the essential drugs for the Sub-Division.

Respondents were equally very satisfied with the low prices and quality of services provided at the health units. We observed that most essential drugs supplied by the NWPSFH project were on average 40% cheaper than before the project. For example Amoxycillin tab. 500mg which sold between 60FCFA and 100FCFA depending on the distance from the nearest pharmacy today sells at 37FCFA, and Paracetamol tab. 500mg today is 2FCFA instead of 10FCFA.

These low prices and reduced distances have given the possibility to patients to acquire quality health services, avoid counterfeit drugs from hawkers and accumulate savings which could be used for other socio-economic activities.

As concerns the question whether the project is cost recovery and thus sustainable, the findings showed that initial cash pumped into the project has almost tripled showing a persistent upward trend. This is clearly evident from table 1.

Table 1: Financial Growth of the NWPSFH Project

Year	Financial Growth(Turnover)	No. of health units (outstations)
1996/97	350 989 000	92
1997/98	418 560 000	96
1998/99	405 560 000	110
1999/00	460 997 596	113
2000/01	465 449 544	113
2001/02	613 762 366	121
2002	748 621 781	127
2003	887 562 543	136
2004	865 452 959	145
2005	929 586 024	152

Source : June 2000, 2002 and 2005 Reports presented to the Annual General Assembly.

The drop in the financial growth in 1999 was attributed to a rapid increase in the number of outstations which necessitated initial expenditures. Cost recovery through user fees at health units ensure that initial drug supply is continually replenished and thereby ensuring sustainability of the project.

We were equally informed that the NWPSFH has been actively intervening in immunisation campaigns by providing finances and logistics (vehicles and staff). For example it provided one million francs CFA as assistance for the Misaje Health Unit after a wind disaster and has also taken care of the outbreaks of meningitis epidemics in Bafanji and Ashong. The NWPSFH has equally been able through its technical staff to identify about 2900 Aids cases in the province between the period 1998 to 1999 and a lot of sensitisation on the Aids pandemic is going on.

When inquired about the obstacles hindering the smooth operation of the project, NWPSFH officials cited one major difficulty. The project has blocked savings to the tune of 210 million FCFA in liquidated banks. As part of its restructuring programme, the government liquidated some banks in the country among which Meridian-BIAO, with 205 million FCFA of the NWPSFH project savings and Credit Agricole with five million FCFA. This financial deadlock is very worrisome to the management of the project and has hampered the creation of more health units or improvements in health care services.

Another problem raised was that of an outstanding deficit of 52 million FCFA from the sales of drugs. This was attributed to embezzlement by civil servants who were formally employed as pharmacy attendants. This set of workers in the North West Province pilfered drugs and set up private commercial clinics, or sold the drugs to peddlers or other drug vendors. The parallel activities of these health personnel have been quite detrimental to the project's financial situation.

Another problem faced by the project is the poor road infrastructure in the province. This is not of the nature to facilitate the smooth functioning of the project.

Conclusion and Recommendations

This study is attempted to explore the provision of health care services in a provincial setting in Cameroon. Using the NWPSFH project as case study, we observed that the question of health services are best dealt with through partnership and effective cooperation. The partnership between the state, German Agency for Technical Cooperation (GTZ) and the Community is enhanced by the preponderant role played by the Community Health Committee.

An evaluation of the programme revealed that the project is highly rated. All respondents rated the overall performance of the project activities as positive. However, a number of factors have

hindered the smooth functioning of this programme. Notably the blocked savings of the project in some liquidated banks, parallel activities of some health workers and lack of accountability in some cases.

From the above, we make the following recommendation in the domain of health care delivery services. These recommendations are an attempt to answer the research question of how the partnership could operate to enhance cooperation, sustainability and provide better health services.

First and most importantly sustainability should not only be ensured through cost recovery by charging user fees, but also through the conception and implementation of community development projects. Health care is sustainable when there is a long-term ability to mobilise and allocate sufficient resources to ensure self-sufficiency after the initial investment of funds. Finances generated through cost recovery from a well managed health programme can effectively sustain the programme. However, a health development programme can be part of a larger development project, this will provide productive activities to finance those which are not self-supporting. For example in 1993, the health committee of Kedjem Ketingoh health post planted a fuel plantation and also managed a sweet potatoes farm (Kwate, 2000). These farms yielded money for the post. We were informed that last year, wood from the plantation was used to repair the health post structures.

Second, accountability and parallel activities in the project must be checked. Community representatives in collaboration with their management committees should follow up the utilisation of all funds and ensure that funds are utilised to the best interest of the populations. The exercise of parallel activities through the sale of drugs pilfered from health post pharmacies in private clinics must be checked and punished. Other measures can be taken against drug counterfeiting include improving the legislative framework and increasing quality control inspection. Counterfeit or fake drugs must be seized and offenders prosecuted. All of this can effectively be monitored if the community has a broad-based facilities to sustain life in the environment where the community is found.

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