An Evidence Brief for Policy

Improving Governance for Health District Development in Cameroon

Executive Summary

This evidence brief for policy was prepared by The Centre for Development of Best Practices in Health (CDBPH) a research unit within the Cameroon node of the Evidence Informed Policy Networks (EVIPNet)

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For Best Practices in Health

CDBPS-H

Pour des Bonnes Pratiques en Santé

SURE
Supporting the Use of Research Evidence

EVIPNet
EVIDENCE-INFORMED POLICY NETWORK

Who is this evidence brief for?

Policymakers, their support staff, and people with an interest in the problem that this policy brief addresses

Why was this evidence brief prepared?

This policy brief was prepared to summarize the best available evidence about the problem which it addresses and solutions to that problem

! This evidence brief for policy includes:

- A description of a health system problem
- Viable options for addressing this problem
- Strategies for implementing these options

✗ Not included: recommendations

Full Report:

The evidence that is summarised in this policy brief is described in more detail in the Full Report

What is an evidence-based brief for policy?

Evidence-based brief for policy brings together global research evidence (from systematic reviews) and local evidence to inform deliberations about health policies and programmes

What is a systematic review?

A summary of studies addressing a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise the relevant research, and to collect and analyse data from this research
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1

Authors

Robert Marie Mba, PhD, Sociologist

Research Fellow, Centre for Development of Best Practices in Health

Central Hospital – Yaoundé, Cameroon

Email: robertmariemba@yahoo.fr

Dr Pierre Ongolo-Zogo, MD, MSc

Head, Centre for Development of Best Practices in Health

Central Hospital – Yaoundé, Cameroon

Email: pc.ongolo@gmail.com

Address for correspondence

Dr Pierre Ongolo-Zogo. P.O 5604 Yaoundé – Cameroon.

SURE – Supporting the Use of Research Evidence (SURE) for Policy in African Health Systems – is a collaborative project that builds on and supports the Evidence-Informed Policy Network (**EVIPNet**) in Africa and the Regional East African Community Health (**REACH**) Policy Initiative. SURE is funded by the European Commission's 7th Framework Programme.

www.evipnet.org/sure

CDBPH - The Centre for Development of Best Practices in Health is a research unit that was established in June 2008 at the Yaoundé Central Hospital. Its aim is to foster knowledge translation and exchange for better health in Africa. CDBPH is a knowledge brokerage unit designed to link health researchers with health decision makers within the Cameroon node of EVIPNet. This initiative aims to assist researchers by collecting, synthesising, re-packaging, and communicating relevant evidence in user-friendly terms that stakeholders at many different levels can both understand and use effectively. The CDBPH also intends to serve health decision makers by providing capacity building opportunities, providing evidence summaries, and identifying needs and gaps related to Evidence to Practice.

www.cdbph.org

The **Evidence-Informed Policy Network (EVIPNet)** promotes the use of health research in policymaking. Focusing on low and middle-income countries, EVIPNet promotes partnerships at the country level between policymakers, researchers and civil society in order to facilitate policy development and implementation through the use of the best scientific evidence available.

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Key messages
The problem

- During the mid-term evaluation of the 2001-10 Health Sector Strategy, stakeholders expressed dissatisfaction and identified poor governance and weak health district development as major reasons for Cameroon being unable to achieve its health-related Millennium Development Goals.
- Factors underlying this problem include the absence of standard operating procedures for district governing bodies and health services, a poor knowledge of the existing legal and regulatory infrastructure, a lack of skilled leaders among district management teams and community constituents. In addition, mechanisms and tools to ensure the appropriate use of information for planning, sound social participation, and transparency and accountability have been inadequate as well as the levels of incentives and resources for the implementation and realisation of the principles of participatory governance embodied in the national health policy.

Policy options

- Option 1: Fostering community engagement to improve participatory governance in health districts for sound participatory processes, improved accountability, and evidence-informed decision making.
- Option 2: Reinforcing leadership and management capacities in district health services.
- Option 3: Updating the regulatory framework for health district governance through a participatory approach in order to harmonise the existing inconsistent framework.

Implementation considerations

- Barriers to implementing all three options include unclear political and administrative will, a lack of appropriate skills, a scarcity of financial resources, weak health information systems, rampant poverty, a poorly integrated national system for the enforcement of laws and guidelines, and resistance to change amongst some health bureaucrats.
- A staged capacity-building strategy for regional and district health teams, municipal executives and local communities in the areas of leadership, management, and accountability is likely to be effective.
- Participatory approaches in the domains of planning, education and training; budgeting, monitoring and evaluation could potentially raise awareness of district stakeholders and improve efforts to build the capacity and accountability of citizens and officials. These strategies could include local consultation, group dialogue, collective action, advocacy training, organisational development, and the transfer of power to participants.
- Advocacy strategies targeting municipal authorities could help to mobilise additional financial resources for health. Multi-faceted information, education and communication campaigns effectively raise awareness and sensitise citizens and stakeholders on matters related to health governance and development.
- Because of the scarcity and poor quality of the evidence related to the options and implementation strategies suggested above, rigorous monitoring and evaluation is needed in every district.

Executive summary

The Problem

In the early 1990s, Cameroon implemented a decentralised health system in accordance with the health district and primary healthcare frameworks recommended by the Africa Regional Office of the World Health Organization (AFRO-WHO). To enhance both responsiveness and equity and to foster participation in the financing and management of the district health system, community dialogue structures were established as governing bodies. Such participatory governance was intended to elicit the views of stakeholders (bureaucrats, health development promoters, community representatives, healthcare providers and patients), and to improve accountability and to strengthen district health systems in order to achieve better health status for the population.

During the mid-term evaluation of the 2001-10 Health Sector Strategy (HSS), stakeholders expressed dissatisfaction and identified poor governance and weak health district development as major reasons for Cameroon being unable to achieve its health-related Millennium Development Goals. Several underlying factors were identified for the failure to effectively implement the recommended changes within the framework of health decentralization reforms. Accordingly, recommendations were made for the improvement of district development governance as a key priority for the revised 2001-2015 HSS. The Technical Secretariat of the Steering and Follow-up Committee for the Implementation of the HSS asked the Centre for Development of Best Practices in Health (CDBPH) to summarise the available evidence.

The 2007 Systemic Quality Improvement assessment (SQI) in Cameroon revealed numerous characteristics of poor governance and weak health district development. Governance domain scores for almost all the districts reviewed were amongst the lowest recorded; equity funds to support provision of care to the poorest and most vulnerable people were ineffective in many districts; and less than 20% of the 174 districts had planned incentives for establishing good governance and ethics, and fostering community engagement, participatory monitoring and evaluation, or promoting health mutual organisations as a way of reducing out-of-pocket payments. Poor governance and poor management meant that during the SQI exercise, many districts were unable to produce an up-to-date health map, service utilisation data and details related to their financial resources. Non-declared conflicts of interests were reported as negatively impacting the quality of the deliberations within governing bodies. Despite regulatory provisions for setting links between hospital staff bonuses and local revenue levels, healthcare providers were frequently voicing their frustration by the lack of transparency of the benefit sharing mechanisms.

The current legal and regulatory health framework in Cameroon includes more than a dozen laws, decrees, ministerial orders and circulars. Interested parties include local administrative authorities, municipalities, public and private health care and service providers, and other diverse community actors. Governing bodies at the regional, district and local area levels are chaired by community representatives and are responsible for validating priority setting, budgeting, planning, and overseeing health activities in their jurisdictions.

However, a lack of familiarity with health planning and management, poor legitimacy and representativeness, and a failure to distribute policy documents widely or timely enough are factors that have prevented community representatives from contributing effectively. Key stakeholders – for example, women's associations, private healthcare providers, and local opinion leaders – may not actually partake in governing bodies. Similarly, few municipalities recognise

health as a priority for investment. Weak health management information systems prevent timely access to accurate figures related to health needs, health determinants, or the deployment of resources. District management teams were also shown to lack expertise and skills in health services management. Many health professionals recognised these limitations and their own discomfort with participatory governance procedures and social accountability requirements.

The increasing privatization, formal and informal, of health activities threatens the stewardship role of the state at the peripheral level because district health services currently operate both as providers and regulatory authorities, and a majority of public health workers have dual practice. District governing bodies are failing in their role as the shapers and implementers of health strategies for equitable and responsive health services partly because of the power imbalance, the poor sense of accountability among stakeholders, the lack of means to enforce legislation and sanctions, the existence of outdated regulations, and an insufficient recognition of the concerns of the public. These weaknesses are reflected in a review by Transparency International, which showed that the health sector in Cameroon ranked as the 9th among 20 most corrupt sectors in 2006.

These failures of health governance practices relate to what Lewis and Petterson in a World Bank working paper on health sector governance would categorize lack of standards, inappropriate skills and incentives and, insufficient processes and mechanisms to ensure accountability. Similarly, such failures relate to what Siddiqi and colleagues would describe as the lack of regulatory and administrative mechanisms and, inappropriate resources to translate principles into practice. The actual regulatory framework includes outdated, incomplete and contradictory content – weaknesses echoed in qualitative health studies in other African contexts. Underlying structural factors shaping such situations include formal factors, political contexts, and technical sources; while related factors include the attitudes and abilities of stakeholders, the flow of communication and information, the mechanisms for community involvement, and incentives for effective functioning. For other authors, proximal factors are trust, incentives, stakeholder capacity, community organs and functioning mechanisms and health systems; while the underlying factors are community voice, policy documents and political mandates, and legal, ideological and political frameworks.

In summary, the poor governance in Cameroonian health districts stems from a lack of clear and consistent operating procedures for district governing bodies and health services, power imbalance between district managers and community representatives, and insufficient knowledge of the existing legal and regulatory frameworks. In addition, district management teams and community members lack skilled individuals who are able to lead the health decentralisation reform. Mechanisms and tools to ensure the appropriate use of information in the planning process, to ensure effective participation, and to enforce transparency and accountability on a district level are inadequate. Finally, incentives and resources for the implementation of the participatory governance embodied by the national health policy are inadequate.

Policy options

Option 1: Fostering community engagement to improve participatory governance in health districts

Engagement between officials and communities is a two-way process for sharing and exchanging information, understanding different views, listening and responding to suggestions, and developing trust and dialogue to support effective working and collaborative relationships for the benefit of all those involved. Community engagement aims to achieve empowerment, meaning to

increase the community's ability to take action in order to improve their health status and to effectively collaborate with health officials. Reviews of qualitative studies suggest that initiatives targeting community empowerment should create and sustain a 'virtuous cycle' of community capacity building and, supportive actions for community organisation and responsibility, and strategic thinking. Such initiatives should enable changes in behaviours, bureaucracy, modes of learning, problem solving, and actions amongst stakeholders to enhance participatory planning, transparency and accountability.

Interventions can include:

(i) training district health teams to promote and sustain community engagement, foster citizen participation, establish clear and open channels of communication and support community needs assessments and problem solving;

(ii) sensitising and building capacity of community members on health-related topics such as decentralisation, governance, planning, monitoring and evaluation, health promotion, and meeting organisation; and

(iii) sustaining an administrative and regulatory environment that supports community input, representation, consultation and involvement, opportunities for collaboration with district management teams and, the strengthening of the institutional and financial capacities of health committees and boards.

Successful strategies build on and reinforce authentic participation to ensure autonomy in decision making, a sense of community and local bonding, and the psychological empowerment of the stakeholders.

Community engagement can potentially enhance the responsiveness, effectiveness and efficiency of health services. Improving the performance of district governing bodies could potentially impact positively on health equity and improve the access to and uptake of primary health care and services. In addition, it could also lead to greater transparency through more explicit and informed decision making. Better role definition might also enable improved monitoring and therefore greater accountability. Community mobilisation, for example, has been shown to improve maternal and child health outcomes by doubling skilled birth attendance rates, and reducing neonatal mortality rates by one third.

Despite these benefits, there is a risk that community engagement may be seen as manipulative or tokenistic. It may be viewed by some as utilitarian – for example, its purpose might be seen as a way of assuring programme efficiency rather than as genuine engagement. This, in turn, could generate frustration among community actors if community choices are not supported by health professionals. Community engagement can be a long term endeavour and a time-consuming process. Even if communities are strongly supportive of capacity-building activities, district management teams may dislike the changes proposed during the engagement process if these alter the balance of power or require more work and investment and social accountability. Additional financial resources in a context of scarcity may also be needed to cover the costs of organising meetings, training workshops and consultative processes. There is tentative evidence that community engagement as part of a multifaceted approach to health promotion may have positive effects and could be cost-effective but there is no available evidence for the cost-effectiveness of specific engagement strategies, and therefore monitoring and evaluation is needed in order to learn from the processes chosen.

Option 2: Reinforcing leadership and management capacities in the district health services

Good leadership and management in health involves providing direction, gaining commitment from partners and staff, facilitating change, and achieving better services through the more efficient, creative and responsible deployment of people and resources. While leaders set the strategic vision and mobilise efforts towards realisation, good managers ensure that the organisation and utilisation of resources are effective, can achieve results and meet the specified objectives.

This second policy option, therefore, is to establish a programme for leadership and management capacity development and the implementation of a results-based management approach for the district health services and hospitals on a national scale. This option includes the adaptation of the Leadership, Management and Sustainability (LMS) programme developed by Management Sciences for Health; the organisation of training workshops and a mentoring scheme; and the provision of support mechanisms to foster results-based management practices at regional and district levels.

Evaluations of the LMS programme have concluded that improvements in health services are linked to improvements in leadership, management and governance. Before-and-after evaluations of LMS programmes without control groups have reported improved service delivery and quality of care but whether the observed effects were attributable only to the LMS was uncertain. Training workshops are potentially disruptive to routine district activities if they are time consuming or require long-term commitments. Similarly, while the majority of health professionals and community members who have benefited from LMS programmes were satisfied with them and integrated the principles they had learnt into their daily work, others expressed frustration that available local resources were insufficient to bring about changes in the working environment. Due to the paucity of evidence on the actual costs of LMS strategies, careful monitoring of expenditures is important.

Option 3: Updating the regulatory framework of health district governance

This option includes a participatory approach to revising and harmonising the fragmented framework in order to establish standard operating procedures (SOPs) for the management of district resources, the enforcement and measurement of accountability, and the selection and expansion of membership of governing bodies to include NGOs, CSOs, and CBAs. Such changes would help to reduce power imbalance, establish mechanisms and tools for participatory planning, budgeting, monitoring and evaluations, and fostering evidence -informed decision making. Ideally, the new framework would also clarify norms and procedures for community engagement, especially for consultative processes, indicate ways to provide access to health information, how to fight against corruption, manage conflicts of interests, and define reporting lines between municipal councils, governing bodies and the decentralised health administration.

The updated regulatory framework would aim at ensuring the full implementation of the principles and domains of good governance in the health sector as outlined in Table 1 [below]. SOPs to implement the decentralisation reform could potentially limit corruption and help improve health district performance to achieve Cameroon's MDGs.

While a new regulatory framework could provide fresh momentum for sustaining good governance, it also has the potential to be disruptive and may require a long transition period. This may therefore temporarily negatively impact on the performance of many districts. A process of revision and change is vulnerable to bureaucracy, the consultation processes may be slow, and

building expertise may be expensive. The publication and dissemination of job aids and tools, in-service training, and supportive implementation supervision may also be costly.

Implementation considerations

Option 1

Barriers could include insufficient or unclear political and administrative will, rampant poverty, insufficient public financial resources for health, the increasing privatization of health services, low salaries that result in low staff motivation, imbalances in power, and specific socio-cultural values that may make it difficult for people to work together or question local administration. At an organisational level, impediments may include top down approaches that often ignore local input, lengthy bureaucratic procedures for establishing regulations or enforcing the law and guidelines, inappropriate or unfair selection of community representatives, poor managerial and organisational infrastructure, and the scarcity of resources. At an individual level, progress may be limited by stakeholder interests and resistance to change mainly amongst bureaucrats, a lack of knowledge and skills among district managers and community representatives on how to engage into fair and transparent processes, elitism or poor public health literacy, high opportunity costs and time disincentives for community participants, health worker hostility towards community participants, and the misuse of power which could hamper involvement in decision making and accountability.

Strategies: Although there is an absence of systematic reviews of effects, reviews of qualitative studies suggest that those strategies that are respectful of local cultures and indigenous systems of knowledge are more likely to be effective, especially if community representatives are selected from local opinion leaders and existing bodies – such as community based associations, nongovernmental organizations and authorities, or community networks and constituencies shaped by historical contexts and local values. Participatory approaches – such as building on local consultation processes, group dialogue, collective action, advocacy and leadership training, organisational development, and the transfer of power to participants – can potentially raise community awareness and help to build the capacity of citizens and officials to improve accountability. These approaches can be applied to planning, education and training, budgeting, monitoring and evaluation. Sound advocacy strategies towards municipal authorities can help to mobilise additional financial resources. Multi-faceted information, education and communication campaigns effectively raise awareness and sensitise citizens and stakeholders on matters related to health governance and development.

Option 2

Barriers: The adaptation, initiation and scale-up of a programme require time. The scarcity of skilled human resources to facilitate training workshops, mentor and supervise the results-based management programme may also be an obstacle to implementation. Scarcity of financial resources may restrict the organisation of training sessions, attempts to scale-up a programme or sustain the implementation of nationwide change. Actors may resist the implementation of change or lack the capacity to undertake the work needed to bring about change after training.

Strategies: Ensuring that the LMS tools are suited to local contexts is achievable with the assistance of medical and nursing schools or NGOs working in capacity development. Staged capacity-building approaches can potentially facilitate efforts to scale-up programmes, while resource mobilisation throughout the health pyramid can also sustain programmes. A sound

monitoring and evaluation framework would allow 'learning through doing'. Joint training workshops and mentoring programmes for health professionals and community actors potentially facilitate change and implementation.

Option 3

Barriers: Collaboration between Ministries in charge of health, decentralisation, finances and administrative reform could be impacted by difficulties associated with overlapping authority, by bureaucracy, bureaucratic turn-over, or a lack of resources and skills for consultative approaches and informed decision making. Some actors may benefit from current arrangements and therefore oppose reform. In such instances a lack of adequate participatory skills or unfamiliarity with particular approaches may jeopardise the process.

Strategies: Participatory approaches include the establishment of an inter-Ministerial task force to steer through new or revised processes, and the organisation of consultative meetings throughout the health pyramid with key stakeholders to evaluate the current situation and suggest improvements. Both of these approaches are likely to create conditions for the stronger ownership of the new framework amongst stakeholders.

Table 1. Corrective actions to the current framework

Principles and domains	Actions needed
Strategic vision	No action needed
Participation and consensus orientation	Provide fair administrative mechanisms for the selection of community representatives (including community-structured bodies), for evidence-informed decision making within district governing bodies and for access to information and democratic stakeholder consultation
Rule of law	Establish SOPs for inspections, supervision, sanctions and rewards
Transparency	Set conditions for open access to health information including the monitoring of performance. Stipulate conditions for the management of conflicts of interests
Responsiveness	Set conditions for participatory planning, monitoring and evaluation, but also for the fair selection of interventions which respect the values and preferences of beneficiaries
Equity and inclusiveness	Provide administrative mechanisms to mainstream equity and fairness while selecting community representatives, consulting the community, allocating resources, and selecting health interventions
Effectiveness and efficiency	Set guiding principles for evidence-informed priority setting, planning and management to ensure the appropriate use of resources in a context of scarcity
Accountability	Establish SOPs for the clear delineation of roles, responsibilities and lines of accountability both in district governing bodies and in management teams
Intelligence and information	Establish SOPs for evidence-informed decision making, standards for data collection, analysis and information sharing
Ethics	Establish professional ethics committee for both civil servants and health professionals