Cameroon CTAP II - Country Specific Health Sector Accountability Report

CTAP
COVID-19 TRANSPARENCY & ACCOUNTABILITY IN AFRICA

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List of Acronyms

ANTIC	National Anti-Corruption Commission
CTAP	COVID-19 Transparency and Accountability in Africa Project
IMR	Infant Mortality Rate
MMR	Maternal Mortality Rate
MoPH	Ministry of Public Health
NASS	National Assembly
OGP	Open Government Partnership
T&A	Transparency and Accountability
U5MR	Under-5 Child Mortality Rate
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
ST/CP-SSS	Sectoral Secretariat dedicated to the health sector strategy
WHO	World Health Organisation

EXECUTIVE SUMMARY

Executive Summary

The study evaluates the political economy of healthcare delivery in Cameroon, highlighting its governance architecture and failures, the interests and incentives of stakeholders, financing and accountability patterns and gaps, systemic challenges, and snapshot of citizens' perception of healthcare access and quality. Commissioned under the COVID-19 Transparency and Accountability Project (CTAP). This was a mixed study with both empirical and secondary data use. Primary data collection involved Key Informant Interviews (KIIs) from 2 categories of respondents with Category 1 (Government and private healthcare stakeholders) and Category 2 (CSOs and community stakeholders).

The study finds that Cameroon national health system is based on a centralized organization offering a good opportunity to both an efficient control and a community contribution for health problems management. But beyond financial, personal and material difficulties, the system was not yet mature to face the brutality and the severity of COVID-19 pandemic.
Concerning the political economy of the health sector, persistent inadequacies in the management and treatment of personnel, inequalities and injustices that are sources of frustration, inadequacies in the tools and the quality and standardization of controls, interference, conflicts of interest and influence, lack of transparency in the definition and execution of expenditures, and excessive political interference in decisions are all ills that plague the health sector.

About the financing and fiscal management, the control institutions are trying to play their role as best they can, given the improvements and "small victories" often observed. The texts and protocols for procurement are there, but the lack of resources and corruption negatively influences procurement practices. Indeed, the control institutions, especially those of public finance, have no real power of sanction. And this is the problem. The real power of sanction seems to lie with politicians. It is worth noting that, the Chamber of Accounts was unable to publish the report on the management of COVID-19 funds. However, due to pressure from the Technical and Financial Partners, it was finally published. There are also bodies that fight against corruption and the staff representatives in the health facilities play an important role in reducing these practices.

With this study, we have seen that many people feel that health care personnel are not motivated, which deteriorates the quality of care. However, citizens feel that this right is not being adequately provided for. It also emerged that many citizens have a vision influenced by medical television series that show the ideal of health care provision in a highly developed context (which is unfortunately different from ours in the developing world), and on the other hand by ignorance of the realities of our health system in general and those of the health personnel in particular; this makes citizens extremely demanding and even violent towards the health personnel, which accentuates their demotivation and the deterioration of the quality of health services. When asked if they would be willing to hold those in charge accountable, almost half of them did not know that this was possible, 73% (48/65) said they would be willing to actively participate in health care decision-making if given the opportunity.

To improve the Cameroon's health sector accountability, shore up health financing and resourcing, as well as speed up universal health coverage, the study hazards multidimensional and coherent recommendations, and call to action points for the executive government, legislative government, private sector, civil society, medias and citizens in the last section.

SECTION 1: BACKGROUND AND METHODOLOGY

1.0 Background

The responses of African governments to COVID-19 were characterized by instances of mismanagement, waste, and blatant corruption. Issues such as unlawful procurement, political use of monetary and other relief, and the diversion of funds have led to a poor ability of many communities to deal with the hardship of the pandemic in economic and social isolation. This has further affected citizens' trust in government, reproduced social divisions, and increased inequality, leaving countries in a poor position to promote economic recovery. To address this, the COVID-19 Transparency and Accountability in Africa Project (CTAP) was commissioned as a civil society-led effort to empower citizen engagement and promote change in the ways that governments use public resources and increase the capacity of governments to meet people's needs.

Cameroon has 189 health districts whose geographical delimitation should be determined according to the administrative division in general.[1] These criteria are demographic, socio-cultural, economic, technical, and geographical accessibility. The country is divided administratively into 58 departments and 360 arrondissements, and therefore some health districts correspond to one or two administrative districts, others straddle several arrondissements or even several departments. The implementation of health districts frequently comes up against problems of administrative divisions based on political considerations. Reflection is necessary with the stakeholders to consider reducing the total number of districts in order to strengthen their operational capacity. **In 2018, for an estimated population of 24,863,328, Cameroon had 2,419 public health facilities with a ratio of 10,278 inhabitants per health facility. The average population per health district is 130,860 inhabitants, with an extreme of 64,110 inhabitants (Central Region without Yaoundé) and 183,483 inhabitants (North Region). The metropolises of Yaoundé and Douala have, respectively, 510,681 and 348,098 inhabitants per health district. With 607 private health facilities. The country has 3,028 health facilities for a ratio of 8,217 inhabitants per facility.** Despite the progressive densification of the health map in recent years, the aspects relating to care, institutional coordination, initial and continuous training, distribution training, distribution and availability of drugs and medical and availability of essential drugs and medical devices, as well as the organization of the hospital system and its management still need to be perfected.

CTAP is a collaboration between BudgIT, Connected Development (CODE), and Global Integrity, as well as partners in 7 African countries: Cameroon, Ghana, Kenya, Liberia, Malawi, Nigeria, and Sierra Leone. Under CTAP phase I (2020–2021), these partners used a combination of approaches to generate information on how COVID-19 funds were used by governments and leveraged that information to advocate and collaborate with governments to bring about change. Specifically, these partners advocated for accountability, open governance, strengthened civic awareness and ensured that governments use COVID-19 intervention funds transparently. In CTAP phase II, these partners will work with diverse stakeholders including government and communities to institute mechanisms for health sector accountability, foster effective & equitable COVID-19 vaccine distribution, and mount effective advocacies that mainstreams health sector's best practices in focal countries.

1.1. Purpose of assignment

Building on the achievements of CTAP phase I, the second phase of the project, amongst its interventions, seeks to evaluate Cameroon's healthcare system from the lenses of accountability, governance structures, political economy, fiscal management & financing, reforms, legislative oversight, and citizen engagement and access to healthcare. This study was carried out in Cameroon at both national and sub-national levels. This research study informs high-bandwidth, multidimensional, coherent recommendations based on its diverse findings, with specific call to action points for

1. Ministry of Public Health. (2020). Transformation agenda of the Cameroon's health care system time to act

various categories of stakeholders such as communities, government (executive and legislative), private sector, and civil society. These recommendations should further highlight possible and feasible interventions and advocacies that civil society can adopt for strategic accountability-related reforms in the health sector.

1.2. Research questions

1. What are the healthcare governance policies, structures, systems, and processes at the national and sub-national levels in Cameroon, including gaps, roles of stakeholders, and fields of cooperation and competition among critical actors?

2. What are the features and extent of reforms in Cameroon's health sector, including political economy analysis, as well as the nature and extent of corruption?

3. What is the role and impact of oversight institutions on health sector systemic efficiency, including the nature of procurement practices?

4. In what ways have healthcare financing and fiscal management at national and sub-national levels evolved, including the existing financing patterns, forms of expenditure, gaps, and issues of citizen participation and accountability?

5. What are citizens' perceptions and visions of healthcare access and quality of service in healthcare as a public good?

1.3. Methodology

1.3.1. Study design

This was a mixed study with both empirical and secondary data use. Primary data collection involved Key Informant Interviews (KIIs) from 2 categories of respondents.

a) Category 1 (Government and private healthcare stakeholders)

Interviews were focused on research questions 1–4 and data was collected from 19 respondents, including public sector personnel from the Ministry of Finance, Ministry of Economy and Territory Planification, Ministry of Public Health (at both central, intermediary and operational levels), private operators in the health sector, as well as technical and financial partners in the health sector.

b) Category 2 (CSOs and community stakeholders)

Data was collected from 65 respondents drawn from civil society organizations (CSOs) that work in the health sector and community leaders. Their interview focused on research questions 4 and 5. The community leaders included women and youth leaders from a few communities in the Centre, Littoral, and North regions, as well as Anglophone regions (South-West and Nord-West) in Cameroon.

1.3.2. Study Duration

The study was carried out from March to April 2022.

1.3.3. Data collection tools

The KII tools were used for this purpose.

1.3.4. Data collection procedures

Both primary and secondary data were collected for this study.

a. Primary data collection involved the interviewing of respondents at their work places or communities after securing an appointment with each of them. A written informed consent was then sought and the interview lasted about 30–45 minutes per person.

b. Secondary data collection involved literature review in academic journals, policy documents, books, newspapers, opinion pieces, and websites of key actors and government parastatals.

1.3.5. Procedure to ensure data quality

Before data collection, the KII tool was pretested among some personnel of the Ministry of Public Health and all the incoherencies were addressed.

The interviews were carried out by 3 field researchers who have mastered the tools to ensure accuracy and completeness of the data. Before leaving the site, the tools were proofread by enumerators to ensure coherency in the responses and the absence of missing data.

1.3.6. Data analysis

Microsoft Excel 2017 was used for data entry and analysis. Results were presented as tables and figures. Also, qualitative tools were used.

1.3.7. Impact of the study

Building on the achievements of CTAP phase I, the second phase of the project amongst its interventions sought to interrogate health sector accountability dynamics in Cameroon from the lenses of policy & reforms, political economy, management, corruption, legislative oversight, procurement, accountability, financing & expenditure, citizen engagement, access etc.

1.3.8. Ethical considerations

Some ethical considerations were: ensuring informed consent; protecting privacy, confidentiality, and anonymity of participants; ensuring cultural sensitivity; respecting the autonomy of participants; ensuring fair recruitment of participants (including women and socially excluded groups); and ensuring that the evaluation results do no harm to participants or their communities. During the inception phase, related risks and safeguard measures were also considered.

SECTION 2: HEALTH SECTOR OVERVIEW, GOVERNANCE AND STAKEHOLDERS

2.0 Health Care Governance Policies, Structures, Systems and Processes at the National, Regional and Peripheral Levels in Cameroon

The hospital-based malaria-specific mortality rate declined from 43% to 22.4% between 2008 and 2013, and the hospital-based HIV/AIDS prevalence declined from 5.5% to 4.3% between 2004 and 2011[2]. Similarly, infant and child mortality decreased significantly by 28%, from 144 to 103 under-five deaths per 1000 live births between 2004 and 2014. With regard to health promotion, the major achievement is the reduction of more than 50% of cases of undernourishment nationwide between 2001 and 2014.

While progress has been made in the area of communicable diseases, the same cannot be said for non-communicable diseases, where the burden of disease fell by only 4.3% between 2000 and 2010, with an upward trend since 2010. In addition, maternal mortality, which was supposed to be reduced by 2/3, has instead increased from 669 to 782 deaths per 100,000 live births between 2004 and 2011.
The Cameroon national health system is based on a centralized organization, which provides an excellent opportunity for both efficient control and community participation in health problem management. But beyond financial, personal, and material difficulties, the system was not yet mature to face the brutality and severity of the COVID-19 pandemic.

The national health system has been conceived on a community system based on a pyramidal shape with three levels of interventions:

a. At the base of the health pyramid is the peripheral level, with 191 health districts divided into 1829 health areas.

b. At the middle of the pyramid is the intermediary level, with 10 Regional Delegations of Public Health. Here, technical knowledge is acquired to transform national technologies into health programs to be applied at the district level.

c. At the top of the system, there are central services and structures of the Ministry of Public Health in charge of the elaboration of strategies of health policy defined by the Head of State.

Figure 1: *Organization of health system in Cameroon*

2. Ministry of Public Health. (2016). Sectoral Health Strategy 2016-2027

The system is really centralized and shows how it can be well controlled. This implies a good transparency and accountability policy can be well implemented and followed.

In fact, the health district is conceived as a basic structure intended to function as a local and autonomous health system, interacting with communities, providing first-level health services, and so on. It shows that all the systems are organized for a good frame, leading to the integration of health programs for good health care for communities, families, and individuals, since this is where all health care and activities are implemented and health problems are solved.

For a district to be operational, they are supposed to have health facilities responding to official norms and procedures, with enough well-qualified personnel that are able to realize the national health policy. The need for support from other sectors and community participation through its representatives, as well as constant capacitation, is necessary.

According to this system, communities are supposed to participate in health activities planning, implementation on the field, follow up and evaluation of development activities linked to the sector.

If well-educated, prepared, and trained communities, with enough human, material, and financial resources, had been up to the good implementation of national health policy as partners, then health care could be improved. But things are not often that way.

In fact, better system functioning required true community integration into the health system in order for them to act as equal partners in decision making and health district management, but unfortunately, this is proving to be one of the main governance weaknesses, leading to general mismanagement of many programs such as COVID-19.

Then, it seems difficult to reject the fact that the government is against transparency and does its best to keep corruption at bay through an uncertain management system.
The healthcare industry provides a variety of services to support the healthcare needs of a community or individual. A universally agreed-upon classification of sectors does not exist, but the key sectors of the healthcare industry can be broadly classified into four sectors namely: "Health care services and facilities", "Medical devices, equipment, and hospital supplies manufacturers", "Medical insurance, medical services and managed care" and "Pharmaceuticals & Related Segments". The policies used are those adopted by the government, i.e., the health system transformation agenda, the National Development Strategy 2020–2030, the health sector strategy 2020–2030, the health development plan, the monitoring and evaluation plan, various disease control strategies, and performance-based financing.

In general, when it comes to questions concerning transparency, accountability, and general improvement, which are generally related to privileged people in the system, it is clear that answers are also related to political considerations that make people afraid to comment. A doctor, formerly working in a general hospital in Bamenda, in a sociopolitical crisis for some years, recently confirmed that "under central support, the general hospital's directors rejected a centralized management through general computerization of all main offices of the hospital, refusing, for instance, the endowment of doctors' offices in the general hospital of the North West Region a few years ago." With the donation and technical assistance of an Atlanta institution, this project could have collected enough information on patients and health care to formalize the main central instructions for an efficient feedback system and management.

Accountability, like technical information, contributes to transparency and both lead to good governance. Then, good governance makes and gives way to better transparency through accountabilities and management tools, such as means of communication and organization, that individuals could not afford.
A health facility is actually like an enterprise. When each worker is conscious of the fact that a good yield of activities contributes to his own prosperity, he will invest more effort in better communication, leading to good service delivery.

In general, people spend a lot every day, even for little things in hospitals, and don't even know if there is any advantage, they can receive from health facilities; they spend a lot and pay all cash for their health.
During the hot period of the COVID-19 pandemic, many other services were even abandoned and the personnel were more focused on COVID patients, making ordinary care scarce and more costly. In other words, with the risks of contamination, people decided to run away from hospitals, further complicating the situation.

Table 1: *Organization and structures in health system*

Level	Administrative structures	Competencies	Health structures	Dialogue structures
Central	Minister's office, General Secretariat, Divisions and programs	Elaboration of concepts, policy and and strategies, Coordination, Regulation	General Hospitals, University Hospital and Centers, Central Hospitals, CENAME, CPC, CHRACERH, LANACOME, CIRCB, ONSP)	National Council of Health Hygiene and Social Social Affairs
Intermediary	10 Regional Delegations	Technical support to Health districts	Regional hospitals; Supply Pharmaceutical, Supply Centers, Regional Pharma-ceutical Supply Centers Regional Pharmaceutical Supply Centers	Regional Funds for health promotion
Peripheral	191 Health Districts	Program implementation	District Hospitals, Clinics; CMA; CSI,	COSADI; COGEDI COSA; COGE

Source: DHIS2, Ministry of Public Health, 2022

2.1 Gaps, Roles of Stakeholders, and Areas of Cooperation and Competition Among Critical Actors

Before the outbreak of the COVID-19 pandemic, the circuit of health care service was known, but generally, it is only at the end that the general cost of the care received is felt by the patient. In general, if the main cost of services is established as consultation fees, delivery fees, some specialties act or even official prices of drugs, it is difficult to establish a standard cost for many others, such as wound dressing, injections, fracture plastering, and so many others, depending on the location or even the quality of care. In some health facilities such as Laquintinie hospital, central hospital, or district hospitals, this could also depend on the team at work. Then, materials like masks were not common or even known by the public.

But with the pandemic, even in ordinary offices or shops, the wearing of masks became a condition to obtain a service, although there is no standard price for masks or even standard mask quality. If not some private donors, just few have been given to communities for free reason why it has been common to hear people saying that "members of the government should share vaccines among themselves as they have been doing with the COVID-19 gifts and even the government budget".

Despite its influence on the early development of the field, stakeholder theory is not widely used by strategic management scholars to explain competitive advantage. Using some of the central ideas of resource-based theory, we provide a fresh perspective on why firms that attend to the needs of a broad group of stakeholders may enjoy competitive advantages that are not available to other firms. The key is that these firms have a better understanding of their primary stakeholders' utility functions, which provides them with an enhanced ability to recognize value-creating opportunities. Value appropriation issues are also addressed.

There is also poor evaluation of health interventions and poor geographical distribution of resources. lack of equipment in health structures, poor working conditions, and

administrative red tape in the management of personnel. Lack of decentralization of activities; deficiencies in reference and counter reference systems; inadequacies in management codes and tools; inequity in the distribution of means, materials, and finances; inadequacies in personnel management; blatant injustice in the distribution of means and finances; irregularities in communication and control systems; centralization of management and decisions; excessive influence and interference in material, financial, and personnel management.

The shortcomings observed are felt at the level of the health financing pyramid, with financial and human resources being more concentrated at the central and regional levels. As far as cooperation is concerned, the shortcomings are noted to be multidisciplinarity in the financial and technical partners, with an absence or insufficiency in the traceability of financing and especially of the results obtained from these various contributions.

SECTION 3: POLITICAL ECONOMY OF THE HEALTH SECTOR

3.0 The Cameroonian health economy tested over time

According to the Abuja Declaration, countries were to allocate at least 15% of their annual budget to the improvement of their health systems. But it is difficult to make available resources to respond to some health challenges like malaria, HIV/AIDS, tuberculosis, etc., as well as for appropriate response to epidemics such as cholera, measles, and COVID-19. According to 1978 objectives of "health for all in 2000", the effectiveness of Primary Health care was related to a serious involvement of the community in health problem solutions; since the evidence was still the importance of community in health finance through the payment of heath care by families and their involvement in dialogue structures and social control. The truth is that since 1978 until this date, things have not improved. Although the Abuja Declaration looked like a revolution, meaning an upstanding in a crucial sector of development, it appears that after decades, it remains just a declaration, not a fundamental decision in a step toward health improvement in many countries. In Cameroon, for instance, the government has never come close to the 10% that is the continental average of allocation to health. The World Health Organization's report titled "Public Financing for Health in Africa from Abuja to SDGs" showed that Cameroon's health spending was 4% of the national budget. **According to a study reported by "Afrobarometer" in 2020, between 2016 and 2018, 27% of the population went without medical care many times, while a further 38% didn't get medical care even once. Close to 50% of the population that had contact with a public health facility had difficulties obtaining the care they needed. A World Bank study found that of the $61 per Cameroonian spent on healthcare in 2010, the government contributed only $17; that is, 28%, of which $8 was provided by international donors.**

According to Dr Kibu Odette, senior health policy analyst at the Nkafu Policy Institute, an independent think tank at the Denis and Lenora Foretia Foundation, the COVID-19 pandemic has greatly affected an already pressurized and weak healthcare sector. With 11 doctors per 100,000 of the population, less than 500 critical beds, and very few ventilators available to take care of COVID-19 patients, far below the recommendations of the WHO, Cameroon was not ready to face the COVID-19 pandemic.

3.1 Characteristics and extent of health sector reforms in Cameroon

Leadership and governance (health sector policies; harmonization and alignment; oversight and regulation) are characterized by unsatisfactory governance in health facilities; inequitable financial and geographic access to health care for the population; inadequate training of human resources to meet the needs of the sector; very unsatisfactory quality of care; and an inefficient supply system for essential drugs and medical devices. (Cameroon Health System Transformation Agenda, 2020)
Health sector reform has been described as "sustained, purposeful change to improve the efficiency, equity, and effectiveness of the health sector". There is no universal health-care reform package, but the most common elements include restructuring public-sector organizations, linking pay to performance, encouraging plurality and competition, funding through non-tax revenue, and expanding the consumer's role in the health-care system. The diversity of reforms makes it difficult to identify reforming and non-reforming countries, and most countries (industrialized and developing) have implemented some reforms. Usually, reform of the health sector goes hand in glove with a more general reform of public services called "New Public Management," a shift from direct service provision to delegation and oversight of public services.

There is also the progressive implementation of a universal health coverage system. Indeed, the establishment of a national system of

prepayment for health care and services is necessary in order to improve access to health care for all segments of the population, including the poorest. This system will be implemented on the principles of national solidarity, universality, compulsory membership and general responsibility of the State. With regard to the updating of the hospital reform, the texts governing the organization and operation of health facilities and which set the costs of health services and care are obsolete; it will therefore be necessary to update them. With a view to making the health districts viable, this reform will ultimately aim to ensure that hospitals have technical and financial management autonomy. In terms of governance and strategic steering, in accordance with the requirements of the planning guide in Cameroon, a technical monitoring committee will be created at the central level whose responsibility shall be technical pre-validation of proposals made by the Sectoral Secretariat dedicated to the health sector strategy (ST/CP-SSS). This committee will deal mainly with aspects that cut across the various ministerial departments and will facilitate the multisectoral mobilization of actors. However, these reforms do not have a huge impact. They often remain at the central level and do not extend to lower levels.

The current health system, faced with weaknesses in its six pillars (leadership and governance; human resources; health care provision; infrastructure; medicine and health technologies; financing; and health information system), is not able to sufficiently and effectively promote the health of populations or to ensure adequate and comprehensive management of illnesses. In practice, the weak capacity of the health system to respond effectively to the population's welfare needs is reflected in unsatisfactory health indicators, including high morbidity and mortality, increased health expenditure, and a declining workforce.

3.2 Overseas for medical care and brain drain

Medical evacuations outside the national territory are ordered by a joint decision of the Ministries of Finance and Health, after mandatory consultation of the National Health Council[3]. In February 2022, 1,168 medical evacuation files were received at the Ministry of Public Health, of which only 10 were processed favorably.

The political elite generally prefers to travel abroad for medical care. This is deplorable because the technical facilities of the referral hospitals are increasingly being improved. For an evacuation that costs millions of CFA francs, we can improve or create health facilities and offer better health conditions to the population. Moreover, the Minister of Health of Cameroon said at a session in the National Assembly[4]: "We have excellent technical platform and qualified personnel. We do not understand why we have to continue to evacuate our compatriots. We have nothing to envy others in terms of our technical platform or human resources. It seems that the elites do not trust the Cameroonian health system and do not put much effort into improving it, preferring to take advantage of more advanced systems.

Regarding the brain drain, the phenomenon is glaring. The health sector is the area most affected by the brain drain in Cameroon. In 2005, the OECD counted more than 57,050 international migrants of Cameroonian origin in Western countries, 42.3% of whom were highly qualified (OECD, 2006). Over the period 1995-2005, 46% of Cameroonian doctors and 19% of nurses migrated to OECD countries. According to the Cameroonian Medical Association, 4,200 doctors, mostly specialists, work abroad. According to the 2013 OECD report, the emigration rate of doctors and nurses trained in Cameroon is 48.6% and 18.9%, respectively. The loss of these health care workers undermines the capacity and quality of health services. This manifests itself in inadequate care and a lack of patient follow-up in both rural and urban areas. As the years go by, the phenomenon seems to worsen, with health professionals leaving at a younger and younger age. They deplore the difficult working conditions, uncertain career plans, and low salaries. For this reason, they prefer to look elsewhere for technical and financial partners or simply leave.

3. https://www.minsante.cm/site/?q=fr%2Fcontent%2Fproc%C3%A9dure-d%C3%A9vacuation-sanitaire
4. https://www.journalducameroun.com/cameroun-1168-dossiers-devacuation-sanitaires-ont-ete-deposes-au-minsante/

3.3 Political economy analysis and the nature and extent of corruption

Accountability remains a major issue in the health system at the national level, posing a significant barrier to all actors' ownership of HSS implementation. To date, several institutional mechanisms have been put in place so that the health authorities can report on the implementation of their activities (administrative performance reports). The establishment of exchange platforms (CNLS, COPIL and its branches, CCIA, coordination meetings, etc.) highlights the concern and the will of the public authorities to involve all the stakeholders in the implementation of the HSS and in decision-making. However, the lack of financial resources for the organization of coordination meetings, especially at the intermediate and peripheral levels, often limits their functionality The health sector shows a certain opacity and poor governance in the management of public funds. The latest report of the Chamber of Accounts of the Supreme Court is very evocative in this regard. A number of irregularities were noted in the procurement system, in the execution of contracts awarded and in the justification of funds used in the management of the COVID-19 crisis. This indicates a high level of corruption, coupled with impunity, as those responsible for this irregular management are still not worried.

Persistent inadequacies in the management and treatment of personnel, inequalities and injustices that are sources of frustration, inadequacies in the tools and the quality and standardization of controls, interference, conflicts of interest and influence, lack of transparency in the definition and execution of expenditures, and excessive political interference in decisions are all ills that plague the health sector.
Corruption seems to be deeply institutionalized and more of a norm than otherwise.

SECTION 4: LEGISLATIVE OVERSIGHT AND PROCUREMENT PRACTICES

4.0 Cartography of Institutions and Mechanisms on the Systemic Efficiency of the Health Sector

4.1 Legislative and Regulatory Framework

In the absence of an integrated public health code, numerous legal texts provide a framework for the main health functions and interventions. Several areas of public health do not yet have an appropriate legal framework: bioethics, the practice of traditional medicine and the development of alternative medicines, the provision of ambulatory health care, etc. **In addition, the pricing of medical procedures and care is governed in the public and private sub-sectors respectively by two decrees: Decree No. 63/DF/141 of April 24, 1963, fixing the rates for consultations, visits, deliveries, medical certificates and the value of the key letters of the nomenclature of professional acts for public health on the one hand, and Decree No. 62/DF/62 of March 1, 1962, fixing the rates for consultations, visits, deliveries, medical certificates and the value of the key letters of the nomenclature of professional acts for private medicine on the other. These legal instruments are mostly obsolete.** The organizational and structural mechanisms set up to manage legal problems in the health sector are available at the central level (Division of Legal Affairs and Litigation). The legal framework for interventions is also characterized by a multitude of regulatory acts with provisions that are sometimes competing, discordant and obsolete. This can be explained by;

a) failure of the health system actors to respect the process of developing legal instruments.

b) lack of knowledge of existing legal instruments.

4.2 Audits and Internal Controls

At the central level, the need for effective implementation of the regulatory, audit and control missions devolved by statute to the general inspectorates covering all aspects of the management of the sector is essential. Audit and control activities are limited by insufficient logistical and financial resources as well as a lack of implementation of the recommendations of inspection missions at all levels. Control brigades have been created in the Regional Public Health Delegations.

4.3 Accountability within the Government

At the national level, the government has adopted an anti-corruption strategy that is being implemented in all sectors. A roadmap based on the "PRECIS" approach (Prevention, Education, Conditions, Incentives, and Sanctions) has been developed by the Prime Minister's office to accelerate the implementation of anti-corruption strategies, with admissibility, transparency, consolidation of the rule of law, and decentralization as conditions for success. Civil society organizations have been involved through several initiatives such as CHOC (Changing Attitudes, Opposition to Corruption). In the same vein, local anti-corruption committees have been set up in public hospitals. Transparency and denunciation tools (complaint and suggestion boxes, etc.) have also been set up. Rapid Results Initiatives (RRI) to fight corruption have been implemented in hospitals. The milestones of these RRIs have been translated into measures to strengthen governance and secure hospital revenues and assets.

Moreover, reforms have been carried out, including the development of a Procurement Code in 2004, the creation of a Special Criminal Court, the establishment of a national coalition against corruption including members of civil

society, and more recently, the creation of a Ministry in charge of procurement and the national good governance program.
There are also institutions such as the National Anti-Corruption Commission (ANTIC) and the Audit Chamber of the Supreme Court that regulate financial transactions in the health sector.

4.4 Social control

Social control of health interventions, which is one of the modalities of community participation in the activities of the health system, remains "fairly weak". Dialogue structures that exist at all levels of the health pyramid should participate in the co-financing and co-management of health structures. However, most of them are not very functional.

4.5 Role and Impact of Oversight Institutions on the Systemic Efficiency of the Health Sector, Including the Nature of Procurement Practices

Corruption in the health sector also hinders the fight against HIV/AIDS and other diseases. Medicine shortages are often due to drug theft, causing interruptions in individual patients' treatment regimes. also limits the country's capacity to manage national and global health risks.
Several institutions have been set up in order to fight corruption effectively. These institutions must ensure that the clauses and commitments of the health sector are respected so that each project, donation, service, or agreement is respected by the individuals and is in line with the terms of reference.

There is also social control of health interventions, one of the modalities of which is community participation in the activities of the health system, but this remains "fairly weak." Dialogue structures actually exist at all levels of the health pyramid and should participate in the co-financing and co-management of health structures. However, most of them are not very functional.

The control institutions are trying to play their role as best they can, given the improvements and "small victories" often observed. The texts and protocols for procurement are there, but the lack of resources and corruption negatively influence procurement practices. Indeed, the control institutions, especially those of public finance, have no real power of sanction. And this is the problem. The real power of sanction seems to lie with politicians. It is worth noting that the Chamber of Accounts was unable to publish the report on the management of COVID-19 funds. However, due to pressure from the technical and financial partners, it was finally published.

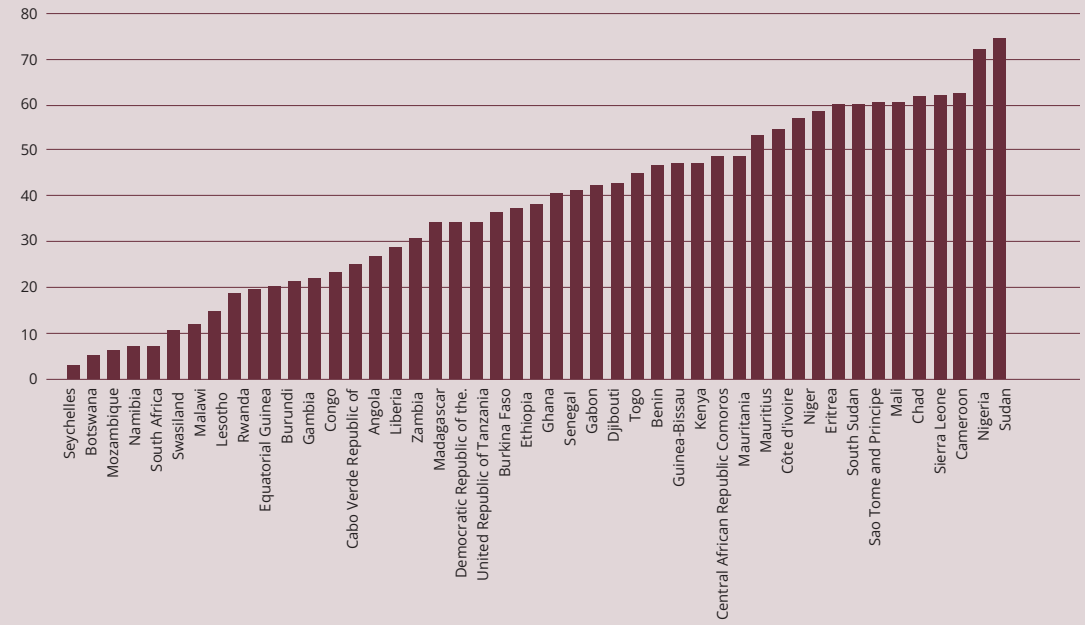
There are also bodies that fight against corruption, and the staff representatives in the health facilities play an important role in reducing these practices.

SECTION 5: FINANCING AND FISCAL MANAGEMENT

5.0 Health care financing and fiscal management at the national, regional, and peripheral levels

Cameroon adopted the 2001 Abuja Heads of State Declaration to allocate 15% of the annual national budget to the health sector. However, the budget allocated to the health sector has for decades hovered around 4–5% of the national budget. In addition, there are significant regional disparities in the per capita allocation of the national health budget. These disparities often affect regions that already face poverty and have health indicators below the national average, such as the Far North Region. Health statistics also reveal that Cameroonian households contribute about 70% of total national health expenditure in the form of out-of-pocket expenditures, compared to an average of 32% in the African region. WHO estimates that out of 100% of health expenditures, about 14% come from public financing, compared to an average of 47% in the African region.

Figure 2: *Percentage of total health expenditure coming directly from patients*

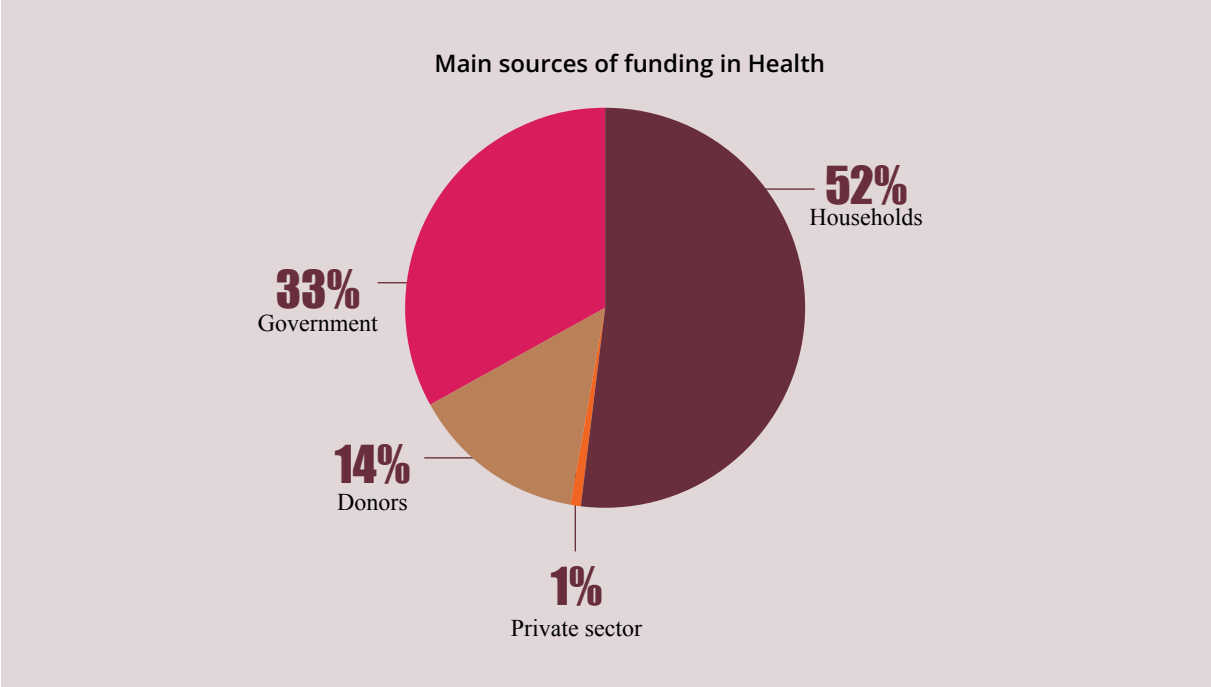


Source: National Health Accounts database, WHO 2013

Also, Cameroon does not have a national strategic plan for health financing. The various financing functions (resource collection, risk-sharing mechanisms, and procurement of health services) therefore do not follow a national logical framework. However, many programs and projects, such as the Comprehensive Multi-Year Plan, the Expanded Programme on Immunization, and the HIV/AIDS financing strategy, have developed financing strategies. According to the 2011 National Health Accounts, the total volume of health financing is 504 billion CFA francs, or 4% of GDP. The main sources of financing are households

(52%), the government (33%), donors (14%), and the private sector (1%). The mechanisms for mobilizing resources from both national and international sources are: the government budget; direct loans and grants; bond issues; loans from commercial banks; and innovative financing mechanisms (various taxes, etc.); innovative financing mechanisms (various specific taxes for health).

Figure 3: *Distribution of health financing in Cameroon by type of source*



Source: National health accounts

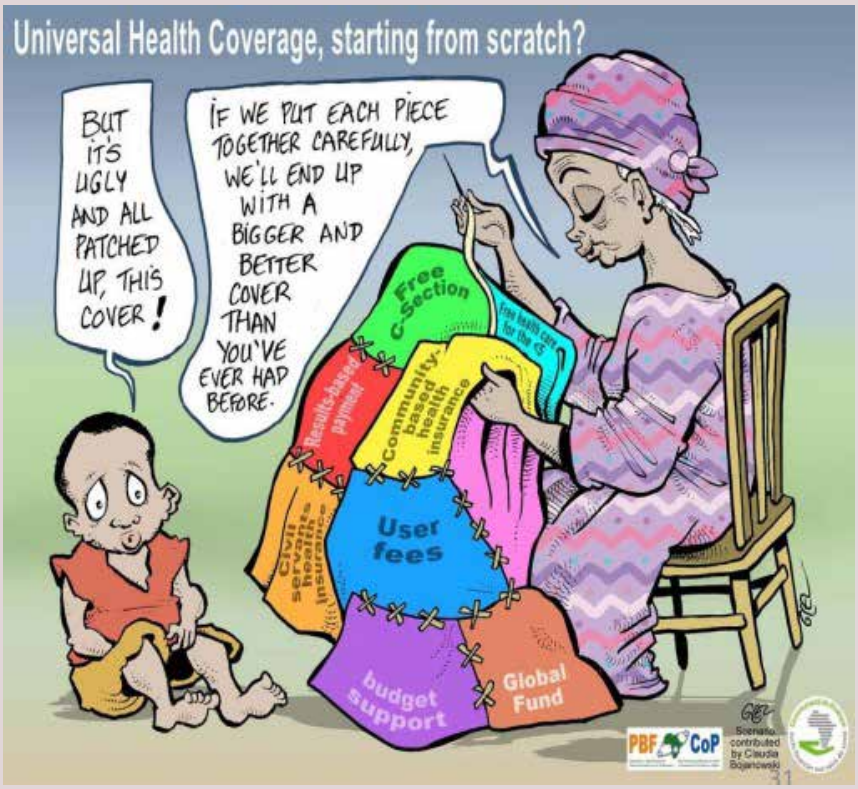
In 2014, 63% of external funding covered mainly communicable disease control (Malaria 51%, HIV/AIDS 12%, and Tuberculosis 0.3%), 27% was allocated to maternal and child health, and only 5% was allocated to system strengthening. It is important to collect and centralize information on funding from external partners, health facilities, and domestic off-budget sources in order to guide a future choice of strategy for pooling these resources. Almost 97% of household health expenditures are made up of direct payments at the point of contact with the health care system; only 3% of these expenditures go through risk pooling or third-party mechanisms.

In 2010, there were 158 mutual health insurance companies covering only 1.3% of the national population. In 2014, there were only 43 active mutuals covering 63,000 people, or 0.2% of the national population. Less than 7% of the Cameroonian population is covered by a prepaid and mutualized health care financing mechanism. Cameroon doesn't have a law-backed UHC scheme across the country and is domesticated at a subnational governance level.

However, after approximately three years of participatory reflection, the National Technical Group for Universal Health Coverage has defined the main basic elements for policy-making on the establishment of a universal health coverage system in Cameroon. The proposed set of elements is based on both lessons learned from international experiences in the field of universal health coverage but also, and above all, on the Cameroonian context[5].

5. https://www.minsante.cm/site/sites/default/files/Point%20CSU%20Conf%C3%A9rence%20Services%20Centraux%202018%20OK.pdf

Figure 4: *Universal Health Coverage Principles*



For several years, certain services and care have been offered free of charge to the population. These include: malaria treatment for children under 5 years and the dispensing of antiretroviral drugs for PLHIV, etc.

Results-based financing, whose objectives are to improve access to quality services and care, has been implemented in Cameroon since 2006. It shows that the system is efficient and equitable. Budget formulation is done vertically by following the strategic and operational plans of the different health programs. These plans are budgeted according to different methodologies, often based on centralized input planning and not on the real needs of the populations covered by the health structures. Budget formulation at the peripheral level is almost non-existent, although it should be the pillar of national budgeting, in a bottom-up logic.
The budget execution rate (commitment basis) was estimated at 88% in 2014.

Moreover, due to the lack of a system for collecting and analyzing financial information, calculating the execution rate is made difficult. Also, the cumbersome nature of public expenditure procedures does not guarantee visibility and predictability of the expenditure chain. Moreover, there is currently no information system and no real-time global monitoring of budget execution. It appears that the level of efficiency of health care spending is low. For example, in 2012, Cameroon spent $61 per capita and had results comparable to those of countries spending between $10 and $15 per capita.

In terms of specific funding for public health emergencies, in addition to funds from normal planning, it is possible to raise funds through another mechanism. Cameroon has developed and adopted a Multi-hazard Readiness and Response Plan for Public Health Emergencies which clearly defines the country's needs to effectively respond to a crisis such as COVID-19 over three years.

Table 2: *Budget Repartition on 3 years, Multi-hazard Readiness and Response Plan for Public Health Emergencies*

Unité d'activité	2022	2023	2024	Coût trienn at	Pourcentage
Aménagements	1,450,000,000	1,450,000,000	1,450,000,000	4,350,000,000	18%
Assistance Technique Nationale	296,302,000	213,575,000	213,575,000	723,452,000	3%
Contractualisation pour le transport et les instalations	660,000,000	85,000,000	540,000,000	1,285,000,000	5%
Enquêtes multisectorielles rapides	10,000,000	10,000,000	10,000,000	30,000,000	0%
Equipements et produits pharmaceutiques	2,598,000 ,000	2,550,000,000	2,298,000,000	7,446 ,00,000	31%
Maintenance du matériel et équipement	70,000 ,000	120,000,000	120,000,000	310,000,000	1%
Missions de supervision et de monitoring	185,350,000	93,200,000	71,000,000	349,550,000	1%
Production/dissemi-nation des documents	38,600,000	76,600,000	71,000,000	186,200,000	1%
Renforcement des capacités et élaboration des plans spécifiques	2,832,125,000	2,343,715,000	2,281,815,000	7,457,655,000	31%
Réunion de suivi	248,020,000	163,320,000	160,820,000	572,160,000	2%
Travaux de réhabili-tation et rénovations	500,000,000	500,000,000	500,000,000	1,500,000,000	6%
Total General	**8,888,397,000**	**7,605,410,000**	**7,716,210,000**	**24,210,017,000**	**100%**

Source: Multi-hazard Readiness and Response Plan for Public Health Emergencies.

5.1 Issues of citizen participation and accountability

In 1993, Cameroon adopted the Reorientation of Primary Health Care (RPHC) policy that emerged from the Bamako Initiative. This policy is characterized by the development of "dialogue structures" and is based on three essential principles:

co-financing, co-management, and community participation. Community action to date has been expressed through

a) Participation of populations in the financing of health care,

b) Participation of community representatives in co-management,

c) Advocacy, communication and social mobilization actions by civil society organizations

d) Services of community health workers

e) Community initiatives for health promotion

As far as civil society is concerned, more than 160 non-governmental organizations and associations are formally involved in the activities of the Ministry of Public Health (Letters of Agreement for Collaboration, Framework Agreements, Implementation Contracts, and Frameworks of Obligations and Means). Several

public administrations are working to strengthen community action. A Guide to Interventions under Community Directives, developed in 2012, was updated in 2019 by MINSANTE.

A major internal challenge in public participation is inadequate financial resources and human resources involving the public in decision-making is time-consuming and costly in terms of money and energy.

External factors include citizens' lack of interest in public matters; thus, the questions to be answered are how to motivate them, stimulate their interests, and obtain meaningful inputs. For example, encouraging the public to participate in public issues related to their daily lives or offering rewards for participation are possible solutions. Access to information is also a problem.

Actually, citizens cannot really access health sector budgets in Cameroon at different tiers of government. Citizens are not automatically invited to budget public hearings. A processus exists for Cameroon as a member of the OGP, which would impact T&A in health spending. ADISI Cameroon[6], which is an important civil society actor, works on it with the executive government. We don't have a freedom of information law in Cameroon for citizens to readily access data from government MDAs. Is post-bid evaluation data in the public domain? Civil society cannot participate in health sector bid evaluation and contract award ceremonies by several health sector national and subnational parastatals. Communities cannot influence the nature of projects in the health sector budget based on their needs and priorities. Sometimes, needs assessment leading to projects' inclusion in the budget is done to avoid incongruity between what communities wanted and what was proposed. But the best practices are observed in projects financed by the Global Fund to fight AIDS, tuberculosis, and malaria. There are civil society coalitions that ensure effective citizen participation in the decision-making process and contribute to Global Fund policies and practices in order to influence them to continuously meet the needs of people.

5.2 Existing financing models, forms of spending, gaps: the COVID-19 experience

In order to facilitate the accountability of public funds allocated to the response of the COVID-19, and in accordance with the requirements of the code of transparency and good governance, the authorities have chosen not to create a specific public structure as has been the case in some countries, but to lead the response strategy through the ministerial departments involved within the framework of the current organization of government work and the budgetary mechanisms provided for by the law. This steering has two dimensions: a strategic dimension and an operational dimension.

At the strategic level, the Prime Minister, Head of Government, coordinates the response under the authority of the President of the Republic. This is reflected in the weekly cabinet meetings devoted to COVID-19 with the heads of the ministerial departments involved in monitoring and implementation of defined actions and, if necessary, to readjust the strategy's requirements.

At the operational level, the action plans are developed and implemented by the heads of the ministerial departments and institutions that benefit from the resources of the COVID-19 fund, who are required to produce a quarterly activity report. The Minister of Finance, the principal authorizing officer of CAS COVID-19, ensures the control of the eligibility and regularity of expenditures and makes the payments. He also prepares the execution report on COVID-19 expenditures at the end of the budget year.

The mechanism put in place by the government consisted of (i) a collective budget and the opening of a special allocation account; (ii) the signing of the decree on the endowment of the Special National Solidarity Fund for the Fight against the Coronavirus and its economic and social repercussions; (iii) the development of specific management rules applicable to the said Fund; and (iv) the development of the infrastructural and technical mechanism for the management of the COVID-19 CAS.

6. https://adisicameroun.org/

***Table 3:** COVID-19 execution budget*

RUBRIQUES	PREVISION (*)	REALISATIONS	
		MONTANT (*)	TAUX
Prélèvement du Budget Général (y compris les appuis budgétaires)	137,00	153,30	111,51%
Fonds de concours	43,00	8,59	19,98%
Banque Mondiale	22,00	0,00	0,00%
Union Européenne	2,00	0,00	0,00%
Agence Française de Développement	6,50	5,29	81,38%
Partenariat Mondiale pour l'Education	9,00	0,00	0,00%
Autres (Personnes physiques et morales)	3,50	3,30	94,29%
TOTAL	180,00	161,89	89,93%

(*) En milliards

Source: Special national solidarity fund for the fight against the coronavirus and its economic and social repercussions

As part of the fight against COVID-19 and its health and social repercussions, several international financial institutions and development partners, including the IMF, the World Bank, BDEAC, and the European Union, have activated instruments to help countries cope with the negative consequences of the pandemic on their economies.

Cameroon has benefited from CFAF 222.4 billion from the IMF, paid in two (02) respective instalments; CFAF 135.6 billion in May 2020 and CFAF 86.78 billion in October 2020, under the Rapid Credit Facility. On the other hand, the expected contributions from the World Bank (CFAF 22 billion), BDEAC (CFAF 15 billion), the Global Partnership for Education (CFAF 9 billion), and the European Union (CFAF 2 billion) have not yet been received. However, BDEAC has granted a donation of CFAF 500 million.

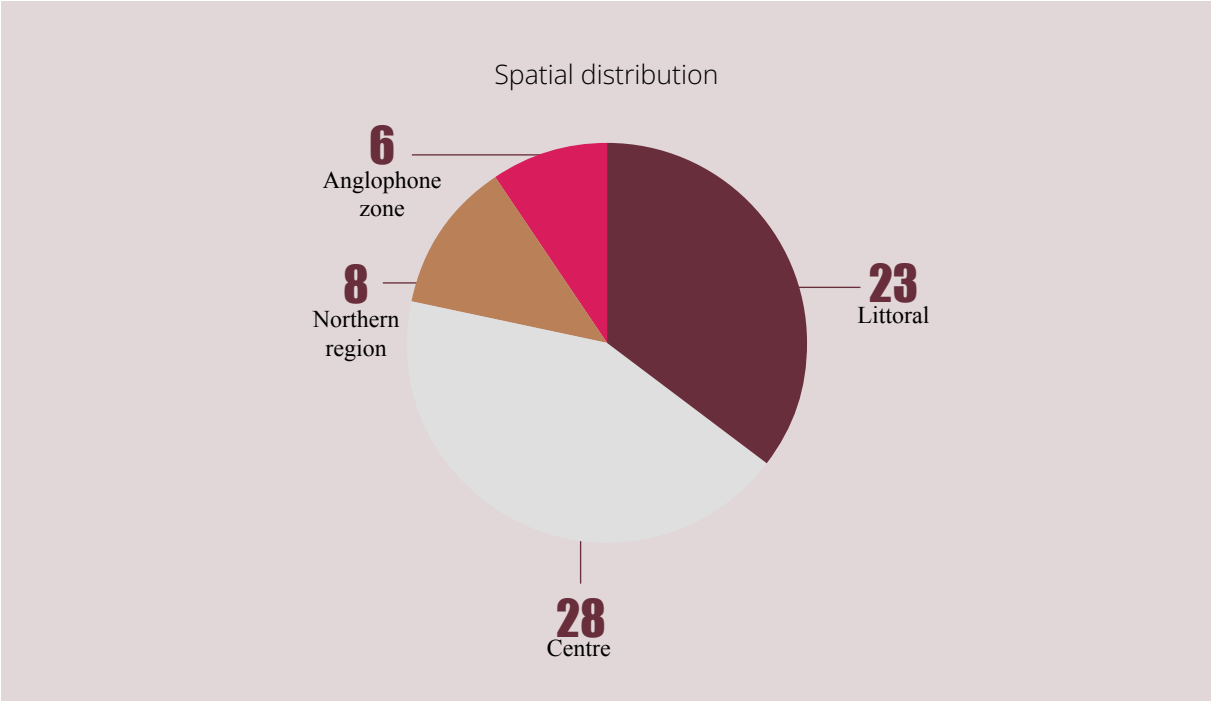
SECTION 6: CITIZENS VOICES ON HEALTHCARE ACCESS, QUALITY AND VISION

6.0 Characteristics of Interviewees

We interviewed 65 citizens as follows:

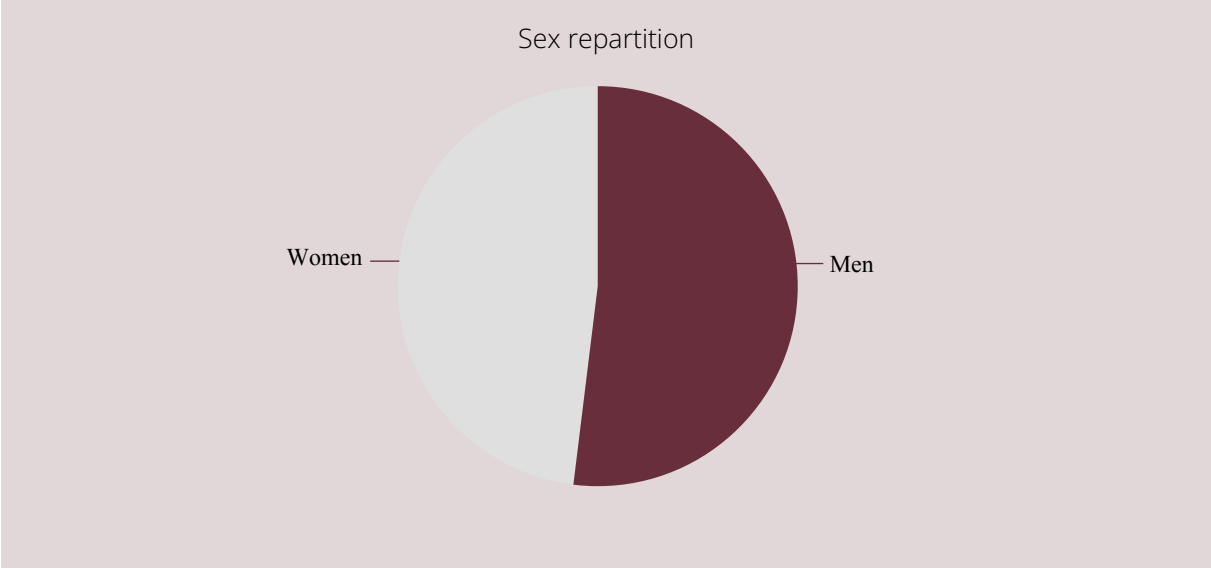
a) By place of residence

Figure 5: *Spatial distribution*



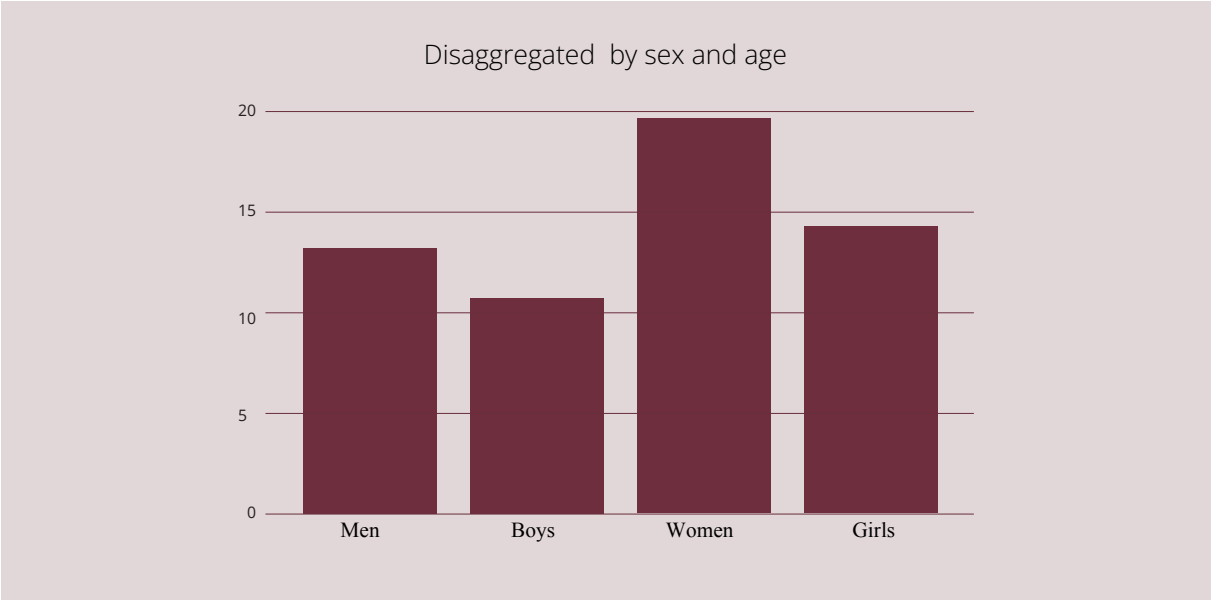
b) By gender

Figure 6: *Sex repartition*



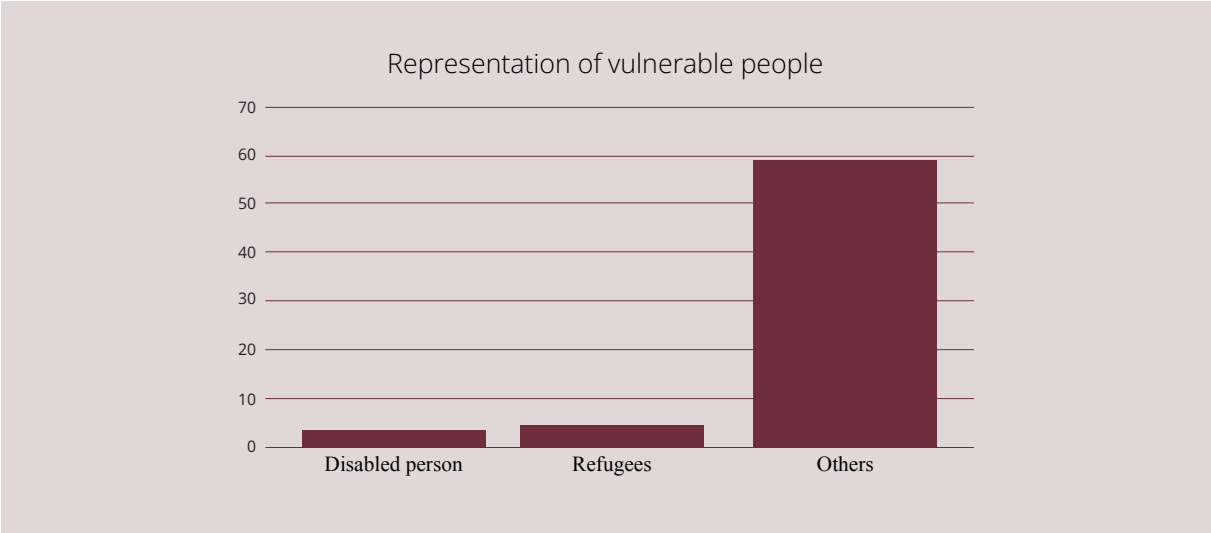
c) We also disaggregated by male/female/boy/girl

Figure 7: *Sex and Age repartition*



d) Among the interviewees, there were vulnerable groups represented

Figure 8: *Representation of vulnerable people*



e) Distribution by financial income

26/65 had an income below the minimum wage in Cameroon of 37,000 CFA francs, and 30 had an income between 37,000 and 100,000 CFA francs. 9 had an income of over 100,000 CFA francs.

6.2 Citizens' Knowledge, Attitudes and Practices

Of the respondents, only 53% (35/65) said they had easy access to health care. 92% (60/65) were in favor of setting up a health insurance system to benefit vulnerable groups. 92% said they had already used traditional health care systems, although 49% used the public system on a regular basis.

The citizens' perceptions of the health care system were also analyzed. "My family and I have a very negative perception about public services in health facilities." "Said one young man." Many people think that in order to get good service, you have to bribe the health personnel in the public sector or go to the private sector and spend more money.

A teacher interviewed explains: "There are a number of health challenges that Cameroon is faced with: inadequate approaches to meeting healthcare needs evident in the demographic indicators; brain drain of its health workers that disproportionately affects healthcare; inability to sustain health technology transfer (especially after the withdrawal of potential sponsors); and the emergence of chronic or new diseases. All of these challenges have caused citizens to distrust the health service and sometimes give preference to buying medication on the roadside or doing homemade remedies.

Many people have a negative perception of the public health system as a result of the staff's casualness, negligence, and contempt for citizens. They are accused of providing poor quality care. This can be explained by the fact that a few days ago, a family accused the health staff of having facilitated the death of their child by leaving the tourniquet on after the treatment.

"Healthcare is too expensive in Cameroon," said the father. Indeed, policies have been put in place to reduce the cost of health care, including free treatment of malaria for children under five, and free HIV and AIDS care. But this is only a small part of what is needed. Health care costs a lot of money, especially in remote areas. People with low incomes are also unable to access quality care.

"Access to health care remains a problem for citizens, as they pay for their own care in most cases."

Many people feel that healthcare personnel are not motivated, which deteriorates the quality of care. Health is a public and collective good. It is a right. However, citizens feel that this right is not being adequately provided for.

It also emerged that many citizens have a vision influenced by medical television series that show the “ideal of health care provision” (highly qualified personnel, high quality technical facilities, accessibility of care for all) in a highly developed context, which is unfortunately different from ours in the developing world; and on the other hand, by ignorance of the realities of our health system in general and those of the health personnel in particular; this makes citizens extremely demanding and even violent towards the health personnel, which accentuates their demotivation and the deterioration of quality of health services.

When asked if they would be willing to hold those in charge accountable, almost half of them did not know that this was possible. 73% (48/65) said they would be willing to actively participate in health care decision-making if given the opportunity.

SECTION 7: CONCLUSION AND ROUTE TO REFORMS

7.0 Recommendations and Call to Action For Government and Civil Society

The health sector cannot be optimal without clear, robust, and sustainable mechanisms to ensure transparency and accountability. This will improve the efficiency of the management and information systems, with the direct impact of improving health care.
We therefore propose the following recommendations.

7.1 To the executive government

a) Put in place an integrated e-governance system, a vector of democracy, making public and accessible to all, the results of management as well as all information related to the management of funds.

b) Organize and facilitate decentralization so that health is at the heart of everyone's concerns and is made more accessible. The process has been underway for several years but has been slow to become operational, although it would facilitate the management of health issues.

c) Strengthen the capacities of all actors involved in the health sector on a regular basis and popularize the laws and standards in force.

d) Use new information and communication technologies to improve the financial and health management systems and thus facilitate the traceability of finances.

e) Renew, readapt or update management tools on a regular basis to reduce automation, which is a source of control and opens the door to various accommodations, falsifications, and manipulations.

f) We must give more power to the Court of Audit. Not only the power to control, but also to publish its reports freely and to sanction all infringements of public wealth, specifically in the health sector. Procurement procedures must be transparent, and each program manager must report monthly. Allocated funds should be published along with performance contracts.

g) Sanction failures and malpractice in the health sector without double standards.

h) Put in place a reliable system to ensure the recruitment of dedicated, passionate, honest, and hard-working staff to serve the health of the population, to promote competence, to manage careers effectively, and to improve the working conditions of staff.

i) Strengthen innovative strategies such as the Performance-Based Financing (PBF) strategy, which aims to contribute to the improvement of the health status of the population by offering accessible, equitable, and good-quality services.

j) Effectively implement Universal Health Coverage, which promotes essential health care accessible to all at a lower cost.

k) Put competent people in the positions they deserve.

l) Involve the CSO and media at every level of management. Data on the management of health funds should be made available on the MOH website.

m) Carry out regular evaluations, in particular: regular institutional diagnosis of structures; evaluation of interventions; analysis of beneficiary satisfaction; CAP, acceptance, and service consumption surveys; analysis of the demand for services by users.

n) Make the peripheral level operational in the management of finances and other health problems.

o) Free the operational level from administrative dependencies and cash flows.

p) Strengthen mechanisms for citizen participation, particularly in the management of public funds and special projects such as water supply, distribution of mosquito nets, disinfectants, etc.

7.2 Legislative government

a) Adopt the law on full and free access to health management information and data.

b) Promote the improvement of the working conditions and salary of the health personnel, which is the first source of weakening of the personnel, opening the road to corruption.

c) Adopt the e-governance law for transparent and participatory access to the management of public affairs.

d) Strengthen the penalty for embezzlement and corruption.

e) Increase the budget allocated to health. For example, the budget allocated to the Ministry of Health has been reduced from 213.651 billion CFA francs in 2020 to 197.121 billion CFA francs in 2021. This is a clear decrease at a time when the country is facing many challenges, such as COVID-19.

f) Giving greater emphasis to risk forecasting and reactivity to the occurrence of major health events/epidemics, disasters and their management.

7.3 To the private sector

a) Increase capital investment in the health sector.

b) Strengthen collaboration and involvement in the management of private partnership activities and finances.

c) Encourage the systematization of computerized management systems to facilitate the traceability of finances.

d) Accompany the public sector in actions to improve the health system and guarantee transparency in these activities.

e) Propose digital solutions and ensure that human beings have less and less direct contact with money. In Senegal, with the advent of digitalization of services in some health facilities, corruption has been reduced.

f) Promote public-in which all stakeholders are brought on board.

7.4 To civil society/media

Civil society and citizens should also continue to leverage the Freedom of Information (FOI) Act to access public information and keep mounting pressure on government institutions to release official data locked away from citizens' scrutiny and utilisation for engagement. The civil society sector should continue to simplify budget and fiscal data for citizens to easily understand. Such simplified information should be disseminated using electronic media such as Facebook, Twitter, Instagram, and WhatsApp platforms, as well as through the radio to elicit effective public oversight by the citizenry.

Advocacy is also required for the establishment and effective implementation of M&E frameworks for effective oversight of government health projects and budget implementation at all levels of government. Such M & E systems within health facilities are also required for the procurement of drugs, supplies, and medical equipment.

Civil society also need to:

a) Form a unit to be stronger and propose concrete actions in the health sector.

b) Civil society must be represented more at the level of the boards of directors of programs and health facilities.

c) Inform and educate the population on their crucial role in the health system as stakeholders and on the importance of the community's contribution to health.

d) Ensure citizen participation in the health sector and inform them about the community's financial contributions.

e) Advocate for the dissemination of real-time data by the government.

f) Carry out reports, surveys, and investigations to shed light on the scourges and vices in the health sector.

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Annexe

KII Tool

As part of a study being conducted by the COVID-19 TRANSPARENCY AND ACCOUNTABILITY PROJECT, PHASE II (CTAP) in several African countries, namely Cameroon, Kenya, Malawi, Nigeria, and Zimbabwe, on accountability in the health sector in Cameroon, we would like you to take 5 minutes to fill out this questionnaire.

This questionnaire is anonymous and voluntary. Please respond with examples if possible. Thank you very much.

Summary: The COVID-19 Transparency and Accountability in Africa Project (CTAP) is a civil society initiative to strengthen citizen engagement, promote change in the way governments use public resources, and increase the capacity of governments to respond to the needs of the people. CTAP is a collaboration between BudgIT, Connected Development (CODE), Global Integrity, and partners in seven African countries: Cameroon, Ghana, Kenya, Liberia, Malawi, Nigeria and Sierra Leone. As part of CTAP Phase I (2020 - 2021), these partners used a combination of approaches to generate information on how COVID-19 funds were being used by governments and leveraged this information to advocate and collaborate with governments to effect change. Specifically, these partners advocated for accountability, open governance, increased civic awareness, and ensured that governments used COVID-19 intervention funds in a transparent manner.

a) Gender

b) Age

c) Occupation

d) Position

e) Structure

f) Region of origin

g) Nature of residence

h) What are the health care governance policies, structures, systems and processes at the national, regional and peripheral levels in Cameroon?

i) What are the gaps, roles of stakeholders, and areas of cooperation and competition among critical actors?

j) What are the characteristics and extent of health sector reforms in Cameroon?

k) What is the political economy analysis and the nature and extent of corruption?

l) What is the role and impact of oversight institutions on the systemic efficiency of the health sector, including the nature of procurement practices?

m) How have health care financing and fiscal management at the national, regional, and peripheral levels evolved?

n) What are the existing financing models, forms of spending, gaps, and issues of citizen participation and accountability?

o) What are citizens' perceptions and views of access to care and the quality of health services as a public good?

p) What recommendations can you make to improve accountability and transparency in the health sector in Cameroon?

q) Your e-mail address (optional) if you would like to receive a copy of the final report.


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