AGENDA FOR THE TRANSFORMATION OF THE CAMEROONIAN HEALTH SYSTEM:

TIME TO ACT

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REPUBLIC OF CAMEROON
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> We must, therefore, struggle for ever more effective and efficient health coverage. The health facilities available in this domain should serve the underprivileged segments of the population who are most economically weak. Accordingly, ongoing efforts are aimed not only at building more health centres and referral hospitals, but also providing, in these health centres and hospitals, more efficient, non-negotiable services without discrimination. We believe that this policy will resolutely lead to the setting-up of services that will constitute a true social security system.

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SUMMARY

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Introduction

According to the World Health Organisation, of which Cameroon is one of the Member States, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

Meanwhile, Health in the broad sense involves a health system, which is the set of organisations, institutions, resources and people whose main objective is to improve health. The result is a notion of a system and legal, regulatory and procedural interactions, which are open to a binding environment.

For several decades Cameroon, together with the international community, successively acceded in 1978 to the ALMA ATA DECLARATION on the primary health-care strategy, the strengthening of the strategy by defining three levels of the health pyramid (Lusaka Conference, 1985) and adopted the Bamako initiative on cost recovery, co-management and co-financing of health activities (Bamako Conference, 1987).

In 2000, Cameroon signed up to the 8 Millennium Development Goals. Thus, it drew up the Poverty Reduction Strategy Paper (PRSP, 2003) on the basis of which the health sector successively built the 2001-2010 Health Sector Strategy, then amended it to produce the 2009-2015 Health Sector Strategy. In the implementation of this strategy, the key link is the sustainable health district.

Access to quality basic social services for all

In 2009, the Cameroon Vision 2035, whose statement is "Cameroon: an emerging, democratic and united country in its diversity", is divided into four intermediate objectives: (i) poverty reduction; (2) attainment of the middle-income country stage; (iii) attainment of the Newly Industrialised Country stage; (iv) consolidation of the democratic process and national unity while respecting the diversity that characterises the country. In the health sector, the Vision is expressed by "access for all to quality basic social services", including health; in its socio-demographic domain, the health sector objectives aim to increase average life expectancy by improving living conditions through the generalisation of the offer and quality of services, increasing national solidarity and the social protection of vulnerable persons.

Following the Cameroon Vision 2035, the revision of the PRSP, the review of the sector strategies, participatory consultations and the review of surveys for the 2001-2008 period was started; this approach was materialised by the development of the Growth and Employment Strategy Paper (GESP, 2010) which is the first phase for the achievement of Vision 2035 and the basis for any action taken for the 2010-2020 period. While integrating the achievement of the Millennium Development Goals (MDG), one of the general objectives of the GESP is to reduce poverty to a level that is socially acceptable, and one of its specific objectives is: "Improve the offer and guarantee the access of the majority to quality health services."
The 2016-2027 Health Sector Strategy is anchored on

the health sector framework law, the Cameroon Vision 2035, the GESP and international guidelines including Sustainable Development Goals (SDGs). Its vision is "Cameroon, a country where access to quality health-care and services is ensured for all social strata by 2035, with the full participation of communities". This results in a strategic choice, which is to "Ensure equitable and universal access to basic health services and to priority quality specialised health care, with the full participation of the community and the involvement of other related sectors". Goal 3 of the SDG aims to ensure healthy lives and promote well-being for all at all ages. It aims to reduce maternal and child mortality, end epidemics linked to the main communicable diseases and reduce early mortality linked to non-communicable diseases, the reception capacity and accessibility of services for the population in general and the most disadvantaged in particular, resulting in access to universalhealth-careand services, the promotion of healthy behaviours and the development of health-promoting living environments.

Cameroon has 189 health districts, whose geographical delimitation should be done according to the administrative delimitation in force and may, as the need arises cover one or more neighbouring subdivisions according to the operational criteria of a health district. These criteria are demographic, socio-cultural, economic and technical, and even geographical accessibility. The country is divided administratively into 58 divisions, 360 subdivisions, and as a result, some health districts correspond to one or two administrative subdivisions, others straddle several subdivisions or even several divisions. The setting up of health districts often faces problems of administrative divisions based on political rather than technical considerations. A reflection is therefore necessary with stakeholders to reframe and adapt the total number of districts in order to strengthen their operational capacity.

In 2018, for a population estimated at 24,863,328 inhabitants, 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 extremes of 64,110 inhabitants (Centre Region excluding Yaoundé) and 183,483 inhabitants (Northern Region). The cities of Yaoundé and Douala have 510,681 and 348,098 inhabitants respectively per Health District. With 607 private and compliant health facilities, the country has 3,028 health facilities for a ratio of 8,217 inhabitants per facility. It is deplorable that there are more than 2,427 health facilities that do not comply with the regulations, and their regularisation process, as much as possible, is ongoing. Hence the need to undertake urgent actions with regard to the Non-compliant health facilities to reduce risks of poor quality service offer. The finality of this process is: "comply or close". Despite the gradual consolidation of the health map in recent years, aspects relating to curative care, institutional coordination, initial and continuing training, the distribution and availability of essential medicines and medical devices, and the organisation and management of the hospital system still need to be improved.

The 2019 report of the 2010-2018 development policy review made the following diagnosis regarding the health sector:

The central problem of the health system in Cameroon is its low capacity to contribute to the development of healthy and productive human capital.

These causes have been analysed as follows:

• Insufficient and inefficient use of financial resources allocated to health;
• The low use of operational procedures and protocols for diagnosis and hospital and community case management;
• People's lack of knowledge of the means / actions and benefits of disease prevention;
• Insufficient consideration of the social determinants of health in the provision of health-care services;
The full diagnosis of the review is provided in Annex 1.

The review notes that the main challenges facing the health sector are:
• Mobilising sufficient funding for the establishment of a national risk-sharing system;
• Facilitating access to health-care for vulnerable populations;
• Coordinating efforts between the Ministry of Public Health and partner ministries in charge of UHC.
• Operationalise decentralisation in health care;
Develop human resources in the field of health;
• Strengthen scientific research and innovation in the field of health;
• Strengthen the intersectoral consultation framework for promotion and prevention;
• Have a local medicine and vaccine manufacturing industry.

The problems identified relate to all pillars of the health system, including:

1. Care and service delivery (care/service packages at different levels; service delivery models; infrastructure; management; service quality and patient safety as well as demand for healthcare);

2. human resources in health care, (national policy and investment plan on human resources in health care; advocacy; norms, standards and data);

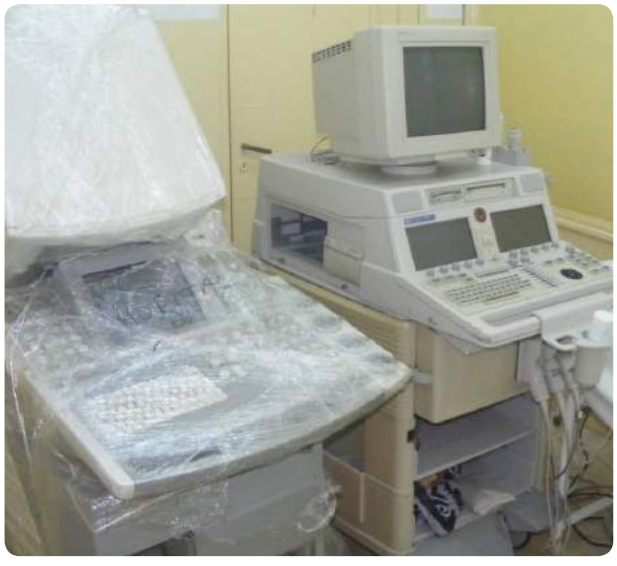
3. Health information (information and surveillance systems based on health facilities and population; global standards, tools);

4. Medical products (medicines, vaccines and technologies: standards, policies; reliable procurement; equitable access and quality);

5. Health financing (national health financing policy - revenue increase, pooling and management of resources, purchasing agreements; tools and data on health expenditure; costs);

6. Leadership and governance (health sector policies; harmonisation and alignment; surveillance and regulation). The diagnosis particularly highlights:
Unsatisfactory governance in health facilities;
Inequitable financial and geographical access to health-care for populations;
Human resource training not adapted to the needs of the sector;
Very unsatisfactory quality of care;
An ineffective system for the supply of essential medicines and medical devices;

"A vision focused on the six pillars of the public health system"



At the strategic level this diagnosis is based on the organisation of the health system in its entirety. The need to transform our health system is perceived both

by health professionals and beneficiary populations. Health professionals find it hard to reconcile on one hand the requirements of quality service, working conditions, including equipment, their socio-professional recognition and their careers, and on the other, the legitimate expectations of the population on the quality of care, and their satisfaction and financial and geographical accessibility of care. In both cases, health sector is the most concerned, hence a strong appeal to public authorities.

The transformation of the health system that I envisage, in consonance with the VISION of the President of the Republic, intends to be a transition from one form to another or give a different feel to the current system; it is to act in depth on the determinants of the poor performance of the Cameroonian health system to solve current problems sustainably, prepare a health system that will address the problems of the future effectively in a comprehensive approach involving all professionals, institutions and organisations working in the sector and communities. This transformation aims to improve all the components of the health system: access to care, quality of care, humanisation of care, prevention, financial and geographical accessibility, but also the transformation and modernisation of hospitals in Cameroon. Our health system must be questioned to meet current challenges and prepare the health system for tomorrow. Cameroon will have a population of 32 million in 2030 with obvious consequences on the capacity of the health system to offer adapted services. The reflection is also motivated by a concern to meet the challenges highlighted by the sector review during the 2010-2018 period and the need to improve the health system performance in order to contribute to the 2nd phase (2020-2030) of Cameroon's drive towards emergence and attaining SDGs in general and SDG 3 in particular.

To achieve this, we must take a step forward: the patient must be at the centre of reflexions and future evolution more than ever. It is my slogan and my favourite topic that summarises my perception of "the humanisation of care".

The expectations of users of the system and health professionals are strong and require legitimately that a constructive and comprehensive action be considered tactfully and speedily, with the inclusion and participation of all. It is in this perspective that in parallel with the institutional work of my ministry in particular and Government work in general, I plan to organise a General Conference on Health in 2020. The latter will open with a white paper, focusing on the most relevant areas of intervention to reverse the trend sustainably.

The aim of this vast transformation is to focus on the 6 (six) pillars of our health system.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IMPROVE THE QUALITY OF RECEPTION AND CARE IN HEALTH FACILITIES

1.1. Quality of services, patient safety and user satisfaction

Current context

The delivery of care and services is the most perceptible and criticised area of action in our health system. It will depend on the institutionalisation of quality, hospital reform, health map and fight against illicit practices in the health sector.

The provision of quality health services is essential to achieve Universal Health Coverage (UHC). Measuring and improving access alone is not enough to ensure quality care for populations and monitor progress towards UHC.

The 2010-2018 development policy review attributes the poor performance of the Cameroonian health system to inefficiency and low quality of health care. The shortage of health resources is compounded by their unequal distribution across the country, which in particular results in the growth of an informal network that provides lower quality health-care with increased potential to compromise patient safety.

The persistence of high maternal and neonatal mortality, despite recent progress, can be attributed to poor quality care during pregnancy, childbirth and postpartum care.

Malaria is the most widespread endemic in Cameroon, responsible for 2.1 million confirmed cases and 3,263 deaths in health facilities in 2018, of which 61% among children ≤ 5 years. The WHO 2018 World Report estimates the number of cases of malaria to 7 million with nearly 7000 deaths throughout the country. The prevalence rate is estimated at 24% (EDS 2018); morbidity 25.9% (NMCP, 2018); the mortality at 14.6%, (NMCP, 2018); Malaria is a cause of the absence of workers in their place of work and students in schools.

According to available data, 134 million adverse events due to hazardous care occur in hospitals in low and middle-income countries each year, contributing to 2.6 million deaths.

Many medical practices and risks associated with health-care pose patient safety issues and significantly increase the consequences of unsafe care.

Envisaged Transformation

Quality as perceived by the patient must be our compass; it must be measurable and disseminated; the quality indicators will make it possible, at the end of consultations and regulatory acts, to move from a vague notion towards a certification system for our health facilities at least as concerns the interventions of the care package for Universal Health Coverage, and of the top 10 most common diseases in the country.

"Satisfaction of users and staff"

Systematic measurement of satisfaction should be mandatory for staff and users to ensure the quality of the service provided and working conditions.

The relevance of care, an essential element of the performance of our organisations, will lead our professionals to act only depending on the health status of the patient; To achieve this, the definition, or the adjustment of the set of essential services of health-care at all levels, the systematic dissemination of the care protocols and good practices, the application of standards and accreditation process for care services for different categories of health training facilities, will be a strategy that will be based on the contribution of learned societies, professional orders and institutions providing initial and continuing training.

As far as the reception system is concerned, it will be formalised by regulatory means with a specific content, processes and necessary resources.

A review of multiple quality of care improvement initiatives will be undertaken to identify key gaps to be addressed, combining current experiences in a coordinated and systematic effort to improve the quality of care across the health system.

Reach consensus on the approach to be used to improve the quality of care, create a culture change in the health system so that all service providers ensure a better quality of care, and agree on indicators to measure progress.

Efforts to improve the quality of care will be linked to existing national health priorities to help meet the most pressing demands of the population and ensure that quality improvement match these priorities.

Following the good news of the results of the 2018 Demographic and Health Survey (DHS), which sets the maternal mortality rate at 406 per 100,000 live births for the 2012-2018 period, a reduction of 48% from the 2004-2011 level, a special effort will be made to further reduce the maternal mortality rate in Cameroon to the target of 140 deaths per 100,000 live births by 2030 (target 3.1 of SDG 3).

Strong and concerted actions will be taken to reduce malaria-related morbidity and mortality through the implementation of universal health coverage and specific malaria control actions as described in the 2019-2023 Strategic Plan for Malaria Control.

Greater attention will be given to patient safety issues in line with the global action for patient safety adopted by the World Assembly in May 2019.

1.2. Hospital reform

Current context

Although this is an ongoing project, it can no longer be designed in isolation as it must be integrated into an overall process of transforming the health system. The current window of political opportunity points above all towards a revision of the framework law No. 96/03 of 4 January 1996 in the field of health; With the assistance of all state and non-state actors, public and private organisations, this courageous revision aims to revolutionise the public and private provision of our health system.

Envisaged Transformation

Improving access to public and private services through a hospital public service. The conditions for the participation of private health establishments in this hospital public service will be clearly defined by regulation.

The rights and obligations of patients and those of health institutions should be formalised through a Patient Charter, in order to create a common legal interface between these two (02) groups of actors in order to normalise their interaction sustainably.

The decompartmentalization of public and private offer will require a reduction of certain rigid provisions governing the exercise of the medical and medico-sanitary professions. As this legislation stands, there is no way to envisage effective integration of offer, including mobility of skills and highly skilled health personnel, or even their desired complementarity, between public and private sub-sectors. Dual practice regulatory mechanisms in the health sector should be considered.

The modernisation of the organisation and management of public health facilities will make it

possible to place them in their context, with the aim of placing the patient at the centre of attention. It goes without saying that I will pay close attention to the health workforce, with regard to working conditions and administrative and socio-economic recognition.

"Decompartmentalization of the public and private offer"

The inclusion of private offer in the hospital public service will be done in accordance with a general categorisation of health facilities that will take into account reference levels. In this perspective, it will be necessary to question the mechanisms for creating and opening up private health facilities in order to remove all the ambiguities by updating the roles of the professional orders and those of the supervisory authorities.

The introduction of the Health Facilities' Objectives and Performance Contracts aims to maintain a positive tension towards the achievement of specific management objectives, care and management activities.

The formalisation of the university hospital setting aims to make visible and understandable interactions between university teaching health facilities and training institutions on one hand, and teaching staff and non-teaching staff on the other. In this perspective, the concepts of hospital practitioners and intellectual services will have to be clarified with other administrations, in particular MINESUP, to contribute to the decompartmentalization of available highly qualified and experienced professionals in public and private offer.

The institutionalisation of traditional medicine to which 80% of the population resorts to. In accordance with the global strategic plan for the modernisation of traditional medicine, the focus will be on traditional medicine institutions, regulation, products and industry, teaching on it, its practitioners, practices and methods.

The integration of traditional medicine into primaryhealth-careand public health facilities will gradually continue with regulation, once the prerequisites in line with the global strategic plan have been met.

1.3. The health map

Current context

The health map must be the compass of our strategic planning. To do so, we must share our understanding of it as a territory, processes and resources.

The place of the health district as the operational level of the health pyramid must be more highly valued, as we are convinced that the performance of the health system at the national level depends on the effectiveness of the health district system. Health districts may not be able to fulfil their responsibilities due to varying leadership, planning, budgeting and management capacities.

Envisaged Transformation

We must redefine the criteria for the creation of health areas and health districts to bring services closer to the people. Finally, these entities which constitute the local health territory must, as far as possible, be closer to administrative constituencies.

Population is a fundamental element for a viable Health District. This population in terms of ratios requires that new standards be developed by distinguishing between urban, semi-urban and rural areas.

During planning and budgeting, ensure that adequate human and financial resources are available for the provision of care and services in a Health District. Depending on the size of the population, this offer must be adequate for 80% of health problems to be solved at the District level. It is also necessary to define the functionality of the health district and to strengthen the mechanisms for measuring its ability to provide essential services.

As for resources, a viable Health District requires that standards in human, material and technological resources should be set up. The mobilisation of financial resources at the level of the District is a concern which requires a sustainable solution, depending on the population size and this will also require the development of standards. The decentralisation of resources will have to continue according to budget allocations available, by granting the substantial share at the decentralised level.

Health infrastructure includes a set of intangible and logistical support subsystems necessary to facilitate service delivery. Four key areas of action are concerned, namely the standards, policies and

regulations, planning, and maintenance. Investments in health infrastructure in Cameroon will give priority to the following areas: physical infrastructure, Equipment and Supplies, transport and technological infrastructure. Urgent actions will be taken to accelerate the implementation of health infrastructure in order to contribute to the definition of a new health map, an important pillar of the universal health coverage. A special effort will be made to complete the various hospital sites under construction and their equipment in human and material resources.

"Comply or close"

Update and complete standards for laboratory, diagnosis and imaging technologies and medical supplies.

Once the health map has been standardised according to the criteria of population, process and territory, it cannot remain static. We will have to define together the periodicity of its revision to keep it efficient and realistic.

The fight against clandestine health facilities will continue with the support of administrative authorities and the effective participation of professional associations, in accordance with the provisions of Decree No. 063/CAB/PM/ of 19 July 2018 on the creation, organisation and functioning of the National Commission in charge of sanitising the health map.

MAKE PRODUCTION RELEVANT AND IMPROVE HUMAN RESOURCE MANAGEMENT FOR HEALTH

PILLAR II

Current Context

Despite all the efforts deployed to recruit new health workers, it is still hard to solve the problem of acute staff shortage. In Cameroon, the number of nurses, midwives, doctors, surgeons and hospital beds is lower than regional averages. The labour shortage in health is critical, especially in the remote areas. In spite of incentives put in place by authorities to attract health professionals to the remote regions, these remain highly concentrated in urban areas. There are almost three times as many staff (from doctors and nurses alike), in relation to the population, in the Centre than in the North. This inequality is particularly striking with regard to the distribution of physicians, with almost two thirds (64%) found in the Centre and Littoral regions, mainly in the cities of Yaounde and Douala.

It is necessary to adapt the training of health personnel and their deployment on the national territory to the needs of the populations. This will be done in consultation with initial and continuing training institutions and other stakeholders. The qualitative and quantitative production of human resources for health will require a multisectoral needs assessment, a continual updating of the active personnel file and consideration of potential human resources.

Envisaged transformation

2.1. Initial training

Without questioning the diploma, which is a presumption of competence, the profile of the general practitioner at the end of the training course should be questioned; it will be a question of formalising the practical aptitudes to expect from our young doctors upon graduation from school, with training institutions. It is desirable that assurances be given to us in the areas of maternal and child health and routine medical and surgical emergencies. This will only be possible with the support of trainers, professionals and learned societies.

2.2. Continuous Training

In view of the difficulties in significantly reducing regional disparities in specialised human resources,

mentoring and short-term capacity building of health personnel to provide expected care in remote areas is being considered. However, the involvement of training institutions must be permanent in order to increase the production of advanced skills in line with needs. Dialogue will be initiated with training institutions for an update of qualified human resources study programmes for health so that their training matches current service and emergency needs.

2.3. Health Human Resources Management

Retirement and salary levels are permanent demands that we are fully aware of. Annual, short and long-term planning and projection of human resources of health for current and emergency needs will be developed;

The retirement age of non-teaching health workers is a major concern, given the asymmetry in the ability to produce the number of staff that can replace retiring ones each year. It will be a question of introducing and maintaining advocacy with other administrations.

Wages, which depend on the country's macro-economy and financial sustainability, will nevertheless make a plea because the poor hygiene factors among health-care workers are partly at the root of several ethical and deontological abuses.

Incentive mechanisms are being developed and will be finalised from this year to celebrate the best staff in the form of Golden Palms. In the same vein, special provisions will be taken and maintained to support staff in remote areas. Ensure equitable recruitment and deployment of public health staff in routine and emergency. Develop retention strategies and labour market analysis.
Finally, an Internal Transfer Committee will continue to analyse the appropriateness of transfers based on profiles and duration at the position.


PHILIPS

“RETIREMENT AND WAGES” SYSTEM

PILLAR III

Current Context

Cameroon, like most countries in the African region, suffers from a weak "data culture" at all levels of the health pyramid and at all stages of the data cycle (Collection, Validation, Storage, Analysis, Use, Dissemination). Indeed, health system actors (technicians, managers, decision-makers) do not pay enough attention to the use of factual information/ bases for decision-making.

However, efforts have been made to improve routine data collection in recent years in Cameroon, in particular by scaling up the DHIS2 (District Health Information Software), which now gives a completeness rate of more than about 75%, although only 60% of health facilities have received formal training on the use of the DHIS2 tool.

Indeed, more than in the past, data are needed for performance measurement, improved programmatic decisions and improved patient care. The Health Information System (HIS) is populated by several types of sources (survey data, censuses, vital statistics data, patient data in health facilities, data community, data from surveillance, etc.). The country presents a birth registration rate of 60% (MICS, 2014) and a lack of reliable information on deaths and causes of death: these two indicators show that there is a real gap in terms of civil status statistics (CVRS) in Cameroon. However, in terms of organisational structure a specialised structure (National Civil Status Office - BUNEC) was established to coordinate actions around this and it is within this framework that a civil status strategic plan has been developed.

In addition, the country has data for 70% of the indicators for monitoring Sustainable Development Goals (SDOs). Remember that a well-functioning health information system has three main attributes:

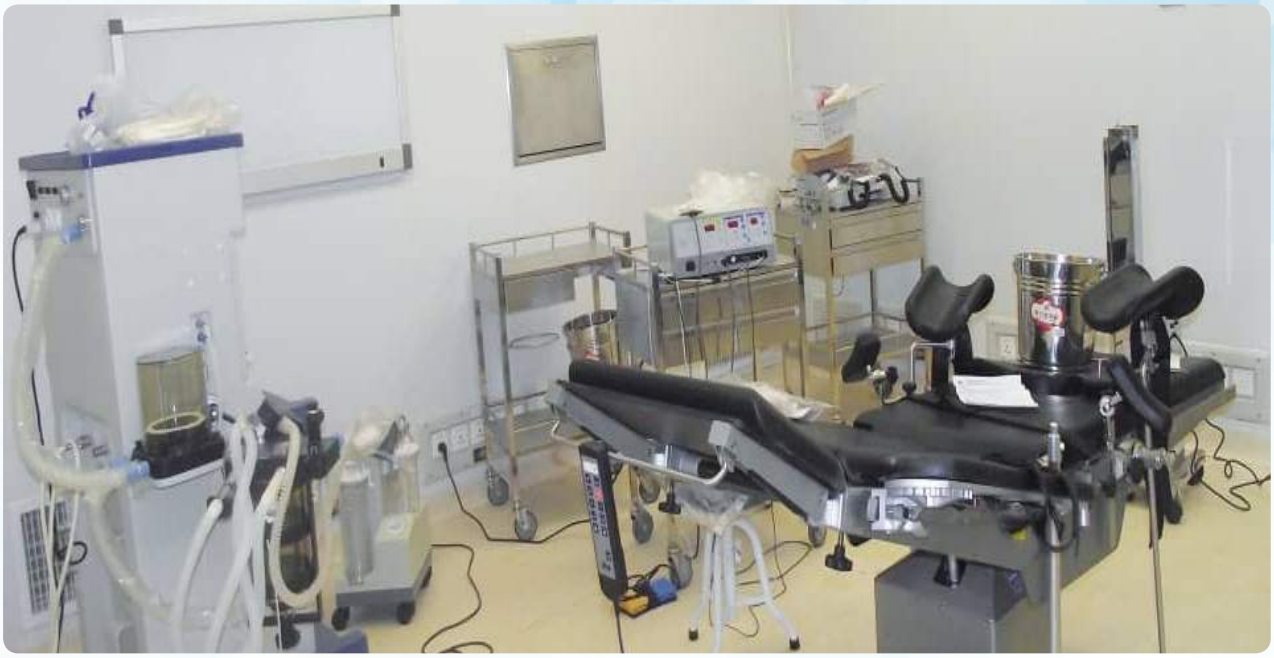
1. Data generation at the individual, facility and population level from multiple sources;
2. Ability to detect, investigate, communicate and contain events that threaten public health security at the place where they occur and as soon as they occur;
3. Ability to summarise information and apply this knowledge. A good health information system improves the demand, supply and use of data - in clinical management, financing, planning and implementation.

Envisaged Transformation

Like the health map, the health information system (HIS) is one of the essential resources for planning, decision-making and monitoring and evaluation of health interventions. It is also through health information that we are aware of the elements of the health map, and therefore it is an essential resource for the health system. It is to be deplored that this pillar is compartmentalised into various priority programmes.

I therefore envisage the integration of all sources of health information into a single system for the production, processing and dissemination of health data;

Strengthen the governance of the Health Information System: the strengthening of the HIS requires an enabling environment and strong collaboration between the health sector and other sectors, including Information and Communication Technologies (ICT), in the public and private sectors; The setting up of a national digital health committee and development of the HIS would be an opportunity to build on, validate and disseminate the National Strategic Health Plan for production, processing and popularisation of health data and develop its implementation plan.



Investing in data sources and capacity: These investments will strengthen HIS governance, the digital health architecture, and data standards - enabling interoperability and improving health information system skills and capacity to use health statistics and data;

Align technical and financial partners that support health information systems: development partners and national institutions should align their investments. Monitoring, evaluation and accountability should be integrated into a plan, budget and monitoring and evaluation framework for the health sector aligned with the SDGs;

Health Information for Informed Decision-making

Fostering a "structured" use of Digital: Innovation in ICT can help to improve the availability, comprehensiveness, speed, quality and use of data for health decision-making, including the improvement of patient service provision. However, for "Digital" tools to be effective, they must be based on optimised processes because the technology is only the container of the content which is the data that will be transformed into information and then into knowledge.

Strengthen accountability and results reporting: frameworks and mechanisms for transparent monitoring (at all levels) and analysis of key indicators (for the UHC: population coverage, service coverage, financial protection, morbidity and mortality, etc.), as well as feedback mechanisms for action, should be strengthened/institutionalised.

MEDICAL PRODUCTS

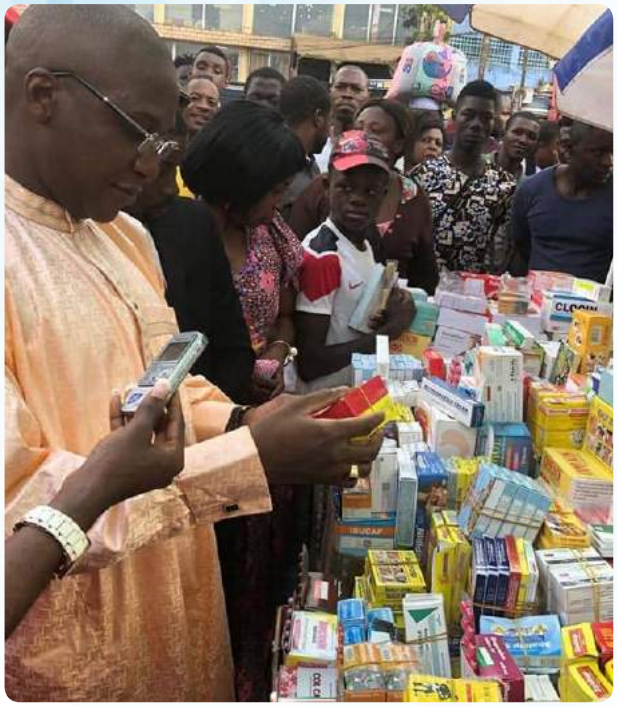
PILLAR IV

Current context

Medical products are medicines, vaccines, consumables and essential medical devices including technology. It goes without saying that these are essential inputs for the delivery of quality care and services. However, one deplores a multitude of stakeholders in both the central and peripheral level, with the result being the inefficiency of the supply system. To inflect this dissatisfaction, the revision of the framework law in the field of health will be an opportunity to redress these deficiencies.

The pharmaceutical sector in Cameroon is governed by Law No. 90/035 of 10 August 1990 on the establishment and exercise of the profession of pharmacist. This law is obsolete.

CENAME provides the 10 Regional Health Promotion Funds (RHPF), which in turn provide on-site supply and supervision of pharmacies in public health facilities. CENAME and most of the Regional Health Promotion Funds are facing huge stock-outs and material difficulties in meeting drug needs.



Financial access to quality medicines remains a major concern for most of our citizens. Drug costs are estimated to play a large role in household health-care spending.

The local production of quality medicines remains embryonic and non-competitive. Local manufacturing units cover fewer than 5% of national needs.
LANACOME, which is in the process of applying for WHO accreditation, is the main body for quality control of medicines in Cameroon.
"Combating street drugs"
[Picture]

Inspections and controls of pharmaceutical services are insufficient due to the lack of logistics, equipment and qualified financial and human resources to cover the national territory.

The drug surveillance system (pharmacovigilance) is inadequate, and this contributes to the scourge of antimicrobial resistance. It is noted that the Extended Programme on Immunisation makes reports for adverse reactions following vaccination (MAPI).

Concerning the fight against illegal practices: The most prominent are street drugs, clandestine health facilities. Counterfeit medicines and illicit drug trafficking account for at least 30% of the pharmaceutical market. A multisectoral national plan to combat drugs and illicit trafficking in pharmaceuticals has been developed.
Hospital pharmacy is experiencing dysfunctions in its organisation and functioning due to the lack of qualified pharmacists in many district hospitals.

Traditional medicine is practised in an uncontrolled way. A code of ethics for traditional medicine practitioners and a draft text on the use of traditional and complementary medicines have been developed.

The availability of quality blood products remains rare in Cameroon. The country needs about 400,000

secure blood bags per year for medical and surgical care of patients. Barely 20% of these needs are covered (about 90,000 bags per year). Moreover, in the 20%, only two percent come from voluntary donors. The absence or inadequacy of safe blood products contributes significantly to maternal mortality (bleeding complications), to many deaths of under 5 children due to anaemia. It is responsible for the insufficiency in the management of surgical cases and patients with chronic diseases whose treatment depends on blood products such as the haemodialysed and haemophiliacs. Finally, it is responsible for the inadequacy in the immediate care of victims of disasters, injured persons on the highway, victims of terrorist attacks, etc.

Envisaged transformation

Review the laws establishing the practice and organisation of the profession of pharmacist;

The need to strengthen the drug supply chain. Support the development of a national strategic plan for the pharmaceutical supply chain;
Supply chain and local pharmaceutical industry
Strengthen the role of the National Essential Drugs Procurement Centre (CENAME) in the direct supply of pharmacies in health facilities;

Revise import/export channels to designate entry points for drugs and medical devices and ensure robust and more effective control measures;

Strengthen drug registration and post-market surveillance. Organise and support the training of a group of local evaluators on the approval/registration process;

Provide the necessary support to improve the performance and pre-qualification process of LANACOME by WHO;

Strengthen the implementation of the multisectoral national plan to combat counterfeit medicines and trafficking in illicit pharmaceuticals, 2019-2020. The fight against street drugs and counterfeit drugs wherever they are will be the subject of a multisectoral emergency plan to be implemented, with the full involvement of all stakeholders. The availability and affordability of quality medicines is one of the key conditions for success in this fight;

Need to improve good practices in the hospital pharmacy sector and the quality of services: development of norms, standards and procedures for universal health coverage;

Support local production of medicines and create mechanisms to motivate better quality;

Support the establishment of the National Medicines Agency;

Accelerate efforts to strengthen the blood transfusion system, amongst others through the implementation of the project under BID credit to make quality blood products available. This project, whose grant of around CFAF 18 billion was approved in July 2018 was to transform the current system based on donations from replacement/families into a regular blood donation system, which is voluntary and unpaid, and which I the way of ensuring an adequate supply of safe blood and blood products.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HEALTH FINANCING

PILLAR V

Current context

One of the main challenges of Cameroon's health system is its low capacity to respond satisfactorily and equitably to the social and health needs of the entire population without impoverishing it. Indeed, less than 7% of the Cameroonian population is covered by prepayment and pooling of the health-care financing mechanism, the only reassuring alternative to excessive spending onhealth-caredue to diseases and unfortunate consequences thereof.

The country has subscribed to Sustainable Development Goals (SDG) whose objective 3 is to enable all to live in good health and promote the well-being of all at all ages. Target 3.8 of Objective 3 of the SDGs calls on countries to ensure universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. This target is at the basis for the realisation of all the health targets and SDG 3.

The 2016-2027 Health Sector Strategy gives priority to the Government of Cameroon's efforts to achieve Universal Health Coverage. Through it, the country undertakes to: (i) ensure optimal, equitable and sustainable financing of its health system (ii) put in place mechanisms and means to provide the population with protection against the financial risks associated with disease and health expenditures, and (iii) make the governance of its health system credible.

Cameroon has undertaken ambitious health system reforms that should lead to the gradual implementation of universal health coverage (UHC).

However, the architecture of the sector's current financing of health requires a profound transformation to achieve the ambitious objectives expressed. Cameroon has adopted the Abuja Heads of State Declaration of 2001, to allocate 15% of national budget to the Health sector. However, the budget allocated to health has been fluctuating for decades around 4-5% of the national budget. In addition, significant disparities are recorded in terms of allocations from the national budget of health per capita. They often affect regions whose poverty and health indicators are 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 direct spending, as opposed to an average rate of 32% in the African region.

WHO estimates that out of 100% of health expenditure, about 14% comes from public funding, compared to an average of 47% in the African region. This situation is likely to constitute a major obstacle to the achievement of universal health coverage and the Sustainable Development Goal No. 3.

Envisaged transformation

We expect to improve the financing of the sector through

identifying the different funding destinations for health in the different administrations and organisations involved in the sector.

building the capacities of actors at all levels on budget preparation, implementation and control techniques, on the one hand, and on advocacy methodology on the other.

the leadership of the Ministry of Public Health must allocate resources to services that optimise results, including giving priority to primary health-care and programmes that have not yet achieved their objectives, such as maternal and child health.

We intend to implement Universal Health Coverage in Cameroon from January 2020, despite the constraints of the current technical platforms. Our strategy aims to:

Start the management of pathologies in the initial care basket, in categories 4 to 6 health facilities that are currently functional. The conditions for their accreditation are defined, and will allow the

formalisation of those that will be selected. At the same time, we are currently engaged in the progressive upgrading of these technical platforms to accredit a sufficient number of starts.

Define a clear strategy for pricing services taking into account public health benefits and affordability (free services, cost sharing and cost recovery).

The financing of the request must be governed by Universal Health Coverage to cover the preventive, curative, and promotional and rehabilitation services included in thehealth-carebasket.

Develop a strategy to facilitate domestic revenue generation.

Organise evidence-based advocacy to increase domestic revenue for health in a sustainable way through the use of innovative financing.

Establish a mandatory prepayment mechanism for health expenditures to minimise direct payments to households.

Develop instruments (policies, laws and/or regulations) for effective and equitable sharing and management of health funds.

The health-care basket and services covered by Universal Health Coverage for the benefit of affiliates will be governed and periodically reviewed by regulation.

Conduct an equity assessment of access to and use of health services to better identify services and populations associated with greater inequity.

Strengthen the control and regulation of service delivery

Periodically review all essential health-care with a view to gradually expanding the range of care that can be provided at an affordable cost. (Principle of progressiveness which leads the health system towards universality.)

Finally, at the normative level, we will rely on the revision of the framework law, the preliminary draft law and the regulatory texts of the UHC, including the creation, organisation and functioning of its management body.

LEADERSHIP AND GOVERNANCE

PILLAR VI

Current context

The field of health governance provides a vast set of interventions in all the areas for the development of policies, standards, regulations and guidelines to guide the use of resources and the functioning of health systems. The main areas of focus on health governance are: the structure and the organisational systems, operational management and accountability, policies, regulatory standards and legal instruments, partnerships and intersectoral commitments.

Overall, it is my responsibility to note that the health sector's benchmark legislation and regulations are out of phase with the context and performance requirements of the day.

Envisaged transformation

First, the revision of the framework law No. 96/03 of 4 January 1996 is an opportunity to update most of the regulatory texts in the sector.

The Ministry of Public Health is involved, under the supervision of MINFOPRA/SPRA, in the revision of the organisational chart of the Ministry of Public Health. This 2013 organisation chart is not in line with the implementation of Operational Programmes in accordance with the principles of programme budgeting. This observation requires a revision of the organisation chart of the Ministry of Public Health.

Align the regulatory framework with the needs of the sector for service delivery at all levels of the health system.

Define and harmonise the responsibilities of actors at all levels of the health system.

Develop mechanisms to build capacity and knowledge of legal and regulatory requirements at all levels.

Develop and implement an accreditation mechanism for health facilities.

Align the mandates and capacities of professional associations with the legal and professional requirements of the health sector.

Establish mechanisms to involve all stakeholders in the health sector and other sectors and coordinate their actions.

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