DEVELOPING A TOOL FOR SETTING PRIORITIES IN THE MATERNAL HEALTH PLANNING PROCESS AT THE DISTRICT LEVEL IN CAMEROON

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A Thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

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DECLARATION

"I Declare that the thesis "Developing a tool for setting priorities in Maternal Health planning process at the district level in Cameroon" **Protocol N° 241/2012** that I hereby submit to the PhD in Public Health degree at the University of Pretoria, is my own work and has not previously been submitted by me for a degree at this or any other tertiary institution. All the sources used or quoted in this research study have been indicated and reflected"

____

Ebongué MBONDJI

Student number: 29639451

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Witness' Signature

____

Date signed

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DEDICATION

*I dedicate this work to all those wonderful individuals who devote their life to saving lives; to permanently remind them that "**Every maternal death is one death too many**". My earnest wish is that this study and the tool which it created will encourage you all to do a little bit more… To save another precious life!*

E. MBONDJI

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SUMMARY

In 2000, United Nations member states committed in the fifth Millennium Development Goal (MDG 5) to improve maternal health in order to combat poverty. Despite this strong commitment, the number of maternal deaths is still high in Sub-Saharan Africa. Monitoring indicators shows that Cameroon will not reach the 2015's target for MDG 5. The Demography Health Surveys conducted in Cameroon show an increasing maternal mortality since 1998 while several studies show that most of the maternal deaths are preventable and occur at peripheral level. In view of the age-old problem of limited clinical capacities at the peripheral level, the optimal and effective use of public health evidence to develop strong and efficient local reproductive/maternal health strategic plans, appears as a supplementary option to address maternal health issues.

The overall goal of this research was to develop a tool that will enable district managers to strengthen maternal health planning and practices in their district. We examined the barriers limiting the planning process at district level and we explored the opportunities to improve it.

Methodology:

A cross sectional, descriptive and process based research analysis was conducted through a literature review followed by interviews of stakeholders. A tool was then developed based on analysing the results from the interviews. The tool was reviewed during a national workshop by the relevant stakeholders involved in the policy and planning process in Cameroon, and tested by two district teams before its finalization.

Findings

The research revealed that the subject of maternal health is covered as a component of the reproductive health policy, which was developed with contributions from all the key stakeholders identified by the Ministry of Health. However, some limitations in the process tend to narrow the scope of the policy; the peripheral level had little involvement in the process and there

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was no national strategic and implementation plan; which explains the failure of the implementation of the policy by the peripheral level. Prioritization at the peripheral level is likely to be mostly influenced by the availability of funds. The planning at peripheral level is done by a district team, with very little support from the higher level or the local partners.

Outcome

The tool was developed in the form of an integrated matrix of priority activities, introducing the concept of "Package of Priority Activities" (PPA), and designed as a dynamic cross-table. The whole idea was to identify priority activities for each national health programme in a cross table, and see which under-resourced priority activity can be covered by similar or overlapping resourced programme's priority activity. The tool was tested by districts before its finalization.

Conclusion

The tool is designed to enable implementation of priority maternal health interventions. The tool should also contribute to improving the effectiveness of the integrated primary healthcare system, which is the ideal way to go in order to reduce the burden of maternal mortality in Sub-Saharan Africa.

Key Words:

Prioritization tool, planning at district level, integrated matrix of priorities, package of priority activities, maternal health, maternal health policy, policy development.

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My deepest gratitude goes to GOD.

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ACRONYMS

AGADJAS	Association 'Gaïnako Djamou' du Sahel (Association 'Gaïnako Djamou' of Sahel
AIDS	Acquire Immuno-Deficient Virus
ANC	Antenatal Care
ARV	Anti-Retro Viral (prophylaxis of mother and child, support
AWP	Annual Work Plans
BCC	Behaviour Change Communication
BUCREP	Bureau Central des Recensements et des Etudes de Population (Central Bureau of the Census and Population Studies*)*
CAMNAFAW	Cameroon National Planning Association for Family Welfare
CAPP	Centre d'Approvisionnement en Produits Pharmaceutiques (pharmaceutical supply centre)
CARMMA	Campagne d'Accélération de la Réduction de la Mortalité Maternelle en Afrique (Campaign on Accelerated Reduction of Maternal Mortality in Africa)
CDBPH	Centre for Development of Best Practice in Health
CENAME	Centrale Nationale d'Approvisionement en Médicaments (national supply center for drugs and essential medical consumables)
CHU	Centre Hospitalier Uniersitaire (Teaching Hospital)
CMA	Centre Médical d'Arrondissement (District Medical Centers)
CNPS	Caisse National de Prévoyance Sociale (National Social Insurance Fund)
COGE	Comité de Gestion (Management Committee)
COGEDI	Comité de Gestion du District (District Management Committee)
COSA	Comité de santé de l'aire de santé (Health area committee)
COSADI	Comité de Santé de District (District Health Committee)
CRVS	Civil Registration and Vital Statistics
CSI	Centre de Santé Intégré (Integrated health centers)
CUSS	Centre Universitaire des Sciences de la Santé (University Center for Health Sciences) now FMSB (faculty of Medicine and Biomedical Sciences – Faculté de Médecine et des Sciences Biomédicales)
CHW	Community Health Worker
DASP zones	Demonstration zones of public health actions
DH	District Hospital
DHS	District Health Service
DHS I to III	Demographic And Health Survey
DPM	Department of Pharmacy and Medicine
DSCE	Document de Stratégie pour la Croissance et l'Emploi

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	(Growth and Employment Strategy Paper)
DSF	Direction de La Santé Familiale (Department of Family Health)
EBHC	Evidence Based Health Care
EBM	Evidence Based Medicine
EBPH	Evidence Based Public Health
EONC	Essential Obstetric and Newborn Care
EPI	Expanded Programme of Immunization
FESADE	Femmes-Santé-Developpement en Afrique Sub-Saharienne (Women-Health-Development in Sub-Saharan Africa)
FP	Family Planning
GESP	Growth and Employment Strategy Paper
GIZ	Deutsche Gesellschaft für Internationalen Zusammenarbeit (German International Cooperation)
HC	Health Centre
HD	Health District
HDI	Human Development Index
HDT	Health District Team
HIA	Health Impact Assessments
HIPC	Heavily Indebted Poor Countries
HMIS	Health Management Information System
HR	Hôpital Regional (Regional Hospitals)
HSS	Health Sector Strategy
ICPD	International Conference On Population And Development
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illness
IMPM	Institut de Recherches Médicale et d'Etudes des Plantes Médicinales (Institute of Medical Research and Medicinal Plants Studies)
IPT	Intermittent Preventive Treatment
ITN	Insecticide Treated Nets
MCH	Mother and Child Health
MCAH	Health of the Mother, the Adolescent and the Children
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Surveys
MINJEC	Ministère de la Jeunesse et de l'Education Civique (Ministry of Youth Affairs and Civic Education)
MINPROFF	Ministère de la Promotion de la Femme et de la Famille (Ministry of Women's Empowerment and Family)
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Newborn Health
MoH	Ministry of Health
MVA	Manual Vacuum Aspiration

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NGO	Non-Governmental Organization
NHIS	National Health Information System
NHP	National Health Policy
NRHP	National Reproductive Health Program
OCALPAS	Organisation Camerounaise d'Appui à la Lutte contre la Pauvreté Au Sahel (Cameroonian Organisation in support to fight against poverty in the sahel)
OFSAD	Organisation des Femmes pour la Sécurité Alimentaire et le Développement au Cameroun (Organisation of women for food safety and the development of Cameroon).
PAP	Priority Action Plan
PDSD	Plan de Développement sanitaire du District de Santé (health district development plan)
PIAT	Policy Implementation Assessment Tool
Plantecam	Plantes Médicinales du Cameroun (Medicinal plants of Cameroon)
PMTCT	Prevention of Mother-To-Child Transmission
PNDS	Plan National de Développement Sanitaire (National Health Development Plan)
PNLMMI	Programme national multisectoriel de lutte contre la mortalité maternelle, néonatale et infanto-juvénile (National Multisectoral Program for Reduction of Maternal, Newborn and Child Mortality)
PPA	Package of Priority Activities
PRSP	Poverty Reduction Strategy Paper
PSPC	Priority Setting Process Checklist
PTA	Plan de Travail Annuel (Annual work plan)
RAIC	Rapid Assessment of Life-Saving Interventions and Commodities
ReoPHC	Reorientation of Primary Health Care
RéoSSP	Réorientation des Soins de Santé Primaires (Reorientation of Primary Health Care)
RESAEC	Réseau des Animateurs pour l'Education des Communautés (Network of community education's facilitators)
RMNCH	Reproductive, Maternal, Newborn And Child Health
RPSC	Regional pharmaceutical supply centre
SOCAPED	Société Camerounaise de Pédiatrie (Cameroonian Society of Pediatrics)
SOGOC	Société des Gynécologues et Obstétriciens du Cameroun (Society of Gynaecologists and Obstetricians of Cameroon)
SSS	Stratégie Sectorielle de Santé (Health Sector Srategy)
STI	Sexual Transmitted Infections
TBA	Traditional Birth Attendant
UN	United Nations
UNFPA	United Nations Fund for Population Activities

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UNICEF	United Nations of International Children's Emergency Fund
UP	University of Pretoria
USAID	United States Agency for International Development
WHO	World Health Organization
XAF	Central African CFA franc [CFA= 'Communauté Financière d'Afrique' (African Financial Community)]

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GENERAL INTRODUCTION

Each year more than half a million women die giving birth, about 3.2 million babies are stillborn and more than 4 million neonatal deaths occur in the world.[1] Most of these deaths are from causes related to their mother's health, including pregnancy and delivery.[2] Despite numerous global and regional resolutions and initiatives, the burden of mortality in developing countries still accounts for the great majority of maternal and neonatal deaths worldwide.[3]

The global campaign to reduce maternal mortality was launched in February 1987 with the Safe Motherhood initiative.[4] Subsequently, the International Conference on Population and Development (ICPD) held in Cairo in September 1994[5] fostered the need for improving access to quality maternal health services. Five years later, the United Nation's General Assembly in its resolution *A/RES/S-21/2* of 8 November 1999, adopted the key actions for the further implementation of the Programme of Action of the ICPD.[6]

Meanwhile, the World Health Organization (WHO) also recognized that reproductive health "implies the right of men and women to be informed of, and to have access to (1) safe, effective, affordable and acceptable methods of fertility regulation of their choice, (2) the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth, and (3) provide couples with the best chance of having a healthy infant".[7]

Finally, the United Nations Millennium Declaration, signed in September 2000, commits world leaders to combat poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women. That Millennium Declaration led to the eight Millennium Development Goals (MDGs) and its targets.

As the main achievement for poverty reduction, MDGs devotes 3 of its 8 cross-cutting goals directly to health. Two of them are specifically devoted to

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maternal and child health, namely MDG 4, “Reduce child mortality” and MDG 5, “Improve maternal health”.[8]

Global statistics however, reveal an unsatisfactory decline of the maternal mortality ratio by only 30 per 100 000 live births (from 480 to 450 deaths per 100 000 live births), between 1990 and 2005.[9] At the September 2010 High Level Meeting on the MDGs, world leaders expressed grave concerns over the slow progress in improving maternal and reproductive health and reducing maternal mortality in Sub-Saharan African countries.[10] That makes the achievement of target 5A of MDGs difficult as it is also one of the objectives for safe motherhood, namely: “*to reduce maternal mortality by 75% from 1990 to 2015*”. An attempt to explain this sluggish development includes:

- a lack of evidence on the relative effectiveness of safe motherhood interventions in terms of their impact on maternal and neonatal mortality,
- a failure to implement known effective practices and subsequently improve coverage and quality of maternal health services,[11]
- the scarcity of developing countries’ resources to attend to these problems, and
- the lack of information required to mobilize commitment to improving maternal health and effect policy making for this goal.[3]

Cameroon, as a member of the International Community, has adhered to the United Nation’s Millennium Development Goals (MDGs) and ratified international instruments on protection of children and women such as *inter alia,* (1) the Convention on the Rights of the Child, (2) the Convention on the Elimination of All Forms of Discrimination against Women, (3) the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa. Economically, the country has received some additional resources by reaching the completion point under the enhanced Heavily Indebted Poor Countries (HIPC) Initiative. These additional resources were redeployed to fight poverty, social exclusion and women and child vulnerability.[12] However, like most of the Sub-Saharan African countries, its maternal health indicators

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remain poor: Despite the progress in antenatal care coverage, with 85% of the population attending at least one visit during pregnancy in 2011,[13] the proportion of deliveries by a skilled attendant decreased from 83,4% in 2004 to 64% in 2011[13]. The Maternal Mortality Ratio (MMR) increased from 430 deaths per 100 000 live births in 1998 to 669 in 2004[14] and increased further to 782 deaths per 100 000 live births in 2011.[13] This is above the African region's average ratio of 620/100 000 live births (estimates).[15] Furthermore, women in Cameroon face a 1/25 lifetime risk of dying of maternal causes,[13] as compared to 1/22 in Sub-Saharan Africa and less than 1/6 000 in high-income countries.[16] Health indicators of Cameroon show that the country faces a crucial lack of skilled staff, especially in rural areas. A decrease is also observed in the accessibility to health care: household expenses for health dropped from 7,6% in 2001 to 3,9% in 2007 in the middle income population and from 4% to 3,3% in poor households.[12]

The vision of sexual and reproductive health for all people remains threatened by inequities:[16] Financial support for sexual and reproductive health has fallen far short of the targets set in Cairo,[17,18] while funding commitments have been hampered by competing priorities (primarily the dramatic increase in resources needed to combat HIV/AIDS). [16] Consequently, as reported by Bulatao et al (2002), although problems such as abortion complications, postpartum haemorrhage and obstructed labour are major causes of maternal death, less than 25% of health centres in 49 developing countries had the capacity to perform manual vacuum aspiration (MVA).[19] Most deaths of infants and their mothers thus occur among the poor and are often preventable through existing interventions and cost-effective and simple strategies.[20] Hence the importance of setting up the correct health strategy which is most suitable and effective to each set of circumstances in its context, in order to efficiently address and reduce the incidence of preventable maternal death through the strengthening of the system, especially at the peripheral level.

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The current research will seek to address the problem of maternal health in the Cameroon context, focusing on its organization at the national level and its management at the health district level, identifying eventual gaps, and suggesting a way to address it. The research will not address the issue of shortage and competence of clinical caregivers at the peripheral level whose the importance in addressing maternal health issues is fully acknowledged, but will rather focus on the maternal health policy and planning process. The first step will provide a descriptive analysis of the country context with its health system's structure and operation. This will be followed by a review of the existing literature on health strategy setting, through the policy and planning processes. Special emphasis will be placed on (i) related support materials and (ii) description of the existing maternal health policy and plans settings in Cameroon. Next, the detailed methodology of how the research was undertaken will be explained. Finally the findings will be presented and discussed, leading to proposed recommendations for improvement, including the development of a tool to guide district level manager.

Disclaimer

In Cameroon there is no policy and/or strategic document specific to maternal health, which is intrinsically linked to reproductive health. All the national strategic documents are talking of reproductive health, considering reproductive health as a package of which all the interventions lead to improvement of maternal health. This fusional link has led to both terms being invariably used in the context of Cameroon. Therefore, although this study focused on maternal health, both terms will sometimes be used interchangeably in this document.

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CHAPTER I:
THE CONTEXT

AN INTRODUCTION TO THE COUNTRY CONTEXT

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INTRODUCTION

The end of the 20th century and the beginning of the 21st century have been marked by the increased global awareness of the gap between the developing and the developed worlds. For the past twenty years, considerable commitments have been made by the world leaders to reduce that gap and pull developing countries towards a more sustainable development and life improvement of their populations. One of the major strategies to meet that objective has been the fight against poverty that detrimentally affects populations in developing countries. This strategy was set as the first Millennium Development Goal (MDG).[8]

Far beyond countries' economic growth, poverty will not be reduced unless it takes into account all the aspects of development, including innovation, equity, empowerment, education and health of the populations. The poverty reduction strategy then constitutes a strong basis for development of health programmes. Almost all the countries, including Cameroon, have adhered to this concept and have taken appropriate measures to implement the global strategy for poverty reduction.

While health is directly targeted in three MDGs (Goals 4, 5 and 6 Combat HIV/AIDS, malaria and other diseases), it is also featured in three other goals (Goal 1 – Eradicate poverty and hunger; Goal 7 – Ensure environmental sustainability; and Goal 8 – develop a global partnership for development), which makes it one of the key points for development. Developing efficient and sustainable health programmes and implementing them thus becomes a priority challenge for development. To be effective however, the health programme should be integrated in a whole national strategy; hence the importance of understanding the context surrounding it: the population; the social, political and administrative organization and the basic structure of the health system.

Cameroon is a complex country; in terms of its climate and geography, its sociocultural determinants, its economy and its health background. Each of these elements constitutes potential challenge to the efficient

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implementation of health programmes. This first chapter will introduce the context of Cameroon, including the structural and operational evolution of its health system, in order to understand the context surrounding the anchorage of the health system of Cameroon and its influence on the system. It will provide a description of the structural context of Cameroon, including the health sector, the reproductive health programme and its maternal health component.

A thorough review was conducted of existing relevant and validated documents collected through national departments concerned with each section. Some analytical comparison shows trends in the development characteristics of the country. The health system evolution, current structure and functioning, as well as its reproductive and maternal health components are described. Most of the documents consulted were national documents and written in French, as French is the predominant language in the country. The documents were then translated into English.

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I. Profile of Cameroon - *Structural & organizational characteristics*

I.1. Geographical Situation

Cameroon, a Central African country, is located in the bay of the Gulf of Guinea, just above the equator, covering an area of 475 440 square kilometres. The country extends from the Atlantic Ocean on its southwest border to Lake Chad on the northern border. Cameroon is bordered by Nigeria, Chad, Central African Republic, Congo, Gabon, and Equatorial Guinea. Cameroon is described as "Africa in miniature" because of its natural environment that exhibits almost all the major climates and vegetation of the continent, including mountains, deserts, rain forests, savannah grasslands and coastal areas.

I.2. Demographic Context

With an estimated annual population growth rate of 2.1% between 2010 and 2015, projections of the *Central Bureau of the Census and Population Studies* (BUCREP) of Cameroon estimates the population of Cameroon at about 21 143 237 inhabitants in 2013.[21] The density of the population is 38 inhabitants per square kilometre with 51% women and 49% men. The urban population is estimated at 52.7% in 2012[21] with a high concentration between Douala, the economic capital (1.6 million people), and Yaoundé, the capital city (about 1.4 million people). [22]

The population is predominantly young, which provides opportunities for health promotion among the active (15-49 years) and school (5-14 years) ranges of the population representing 60% and 28% of the total population respectively. The average household size is 5.5 persons; with 5.3 in Douala and Yaoundé, respectively the economic and the capital cities of the country, and 5.5 in rural areas. Life expectancy at birth is estimated at 53,9 years for men and 56,2 years for women.[23] Other indicators that give an idea of the fast growth of the population, including the birth activity of women, are the

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annual crude birth rate of 42 live births per 1 000 total population, the crude death rate at 11.4 deaths per 1 000 total population, and the total fertility rate 5,1.[13] This indicates an annual population growth rate of 30,6 per 1 000 or 646 975 in the next 12 months.

I.3. *Economic Profile*

Cameroon's economy, like that of many developing countries, is mainly oriented towards agriculture and primary industries. GDP per capita is estimated at US $ 1 489 in 2015.[24]

The efficient execution of macro-economic and structural reforms implemented by the government since 1996 with the support of its development partners culminated in Cameroon reaching the completion point of the enhanced Heavily Indebted Poor Countries (HIPC) Initiative process in 2006.[25] However, despite a sustained economic recovery, resulting in an estimated GDP growth of 4.9% in 2013[26] and 5,7% by December 2014;[27] the economic and financial situation is still too fragile to sustain the equitable development of all the social components, especially the most vulnerable.

On the human side, the Human Development Index (HDI) in 2013 is 0.504; ranking Cameroon at 152nd place in the world. The Human Poverty Index shows that 39,9% of people were affected by human poverty during the ten year period 2002-2012.[23] In 2007, 4 out of 10 people in Cameroon were still living below the annual income threshold of 269 443 XAF francs (about USD 1,5 per person per day or 22 453 XAF francs per month).[28] This is the threshold deemed necessary to enable an individual living in the capital city to afford a "minimum basket" of essential food and non-food expenditures, including health expenditures, education and housing.

Women have an important role to play in the basic economy: There is a high proportion of women in informal small business. They provide more than 90% of food production and are heavily involved in the manufacturing industries such as textiles, clothing.

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Figure1.1 Administrative map of Cameroon

AREA: 475 650 km^2 ; Population 21 143 237

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I.4. Socio-cultural profile

Cameroon is, by its geographical position, at the centre of the ancient migration patterns of Sudanese, Fulani and Bantu peoples. The result is that the country has more than 230 ethnic groups with different religions including a predominance of Muslims and Christians. There are about 270 local languages; but the official languages are French and English spoken respectively in 80% (8 regions including Littoral and Far North regions) and 20% (2 regions) of the country. As regards basic education, the adult literacy rate is 34.9% (41.7% for men, 27.3% for women).[25] Education is provided mainly in French or English depending of the Region.

– *Social Security*

There is not, strictly speaking, social security in Cameroon. However there is a health insurance of government civil servants (Decree N° 2000/692 of 13 September 2000)[i] provided by the state and covering accidents and occupational diseases. This protection extends to the employees' family.

There is another category of social protection especially for workers in the private sector, which is based on contributions of employers to the National Social Insurance Fund (CNPS). The CNPS provides: Family benefits, Old-age pensions, disability and death, and Allowances for accidents and occupational diseases.

The weaknesses of the social security system, coupled with lower revenue and higher prices, have had a negative impact on the behaviour in terms of demand for care. There is a tendency to resort to less expensive health care services / mechanisms that are of questionable quality. These include socio-traditional health, some charlatans who pose as health professionals, and dubious religious or faith-based practitioners.

[i] Decree No. 2000/692/PM of 13 September 2000 to lay down conditions for the enjoyment of the right to health of civil servants (Available in French from http://www.minfopra.gov.cm/spip.php?articles20 (Accessed 29/10/2015)

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The reform of the CNPS enabled it to increase the population coverage and to extend it to other groups of the population, particularly the poor (rural, informal), and to expand benefits (pension, health) through 'voluntary insurance'.[ii]

- *The female population*

The female population, the dominant gender (51%), plays a major role in the social development and the socio-economic life of the country. Distribution shows a disparity between rural and urban areas, with rural areas having a higher percentage of women. Despite the improvement in the living conditions of women and their increasing role in economic, political and social life of the country since independence, gender disparities remain. Having few women represented at the highest social and political level can partly explain the difficulty of effectively taking into account the specific needs of women in the development and implementation of social policies.[29] About 52% of poor household members are women, half being less than 15 years old. Furthermore, more than half the women of childbearing age are uneducated, while only 18% of women in rural areas have a secondary level education (Far North and North Regions are the most affected with respectively 14% and 22%).[26] There are fewer girls than expected in science and technical education areas; and there is a low representation of women (27%) who are permanently employed in business enterprises compared to men (73%)[30]. In addition, many other social and cultural barriers, psychological obstacles and legal loopholes hinder the full development of women.

I.5. Basic infrastructures

Like many of the developing countries, Cameroon faces limited access to basic services infrastructure. This has an inevitable influence on economic growth, trade and the fight against poverty; and thus has contributed to slow the progress towards achievement of MDGs.[31]

[ii] Decree No. 2014/2377 / PM of 13 August 2014. Available in French from http://www.cnps.cm/images/Decret_du_PM_sur_lassurance_volontaire.pdf (Accessed 29/10/2015)

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II. The Health Sector

Since the end of the 2000's, the country has defined new strategic orientations through the elaboration of its National Development Strategy for 2010-2035. This strategy reflects the long term development vision of Cameroon by 2035, also known under the label "*Vision 2035*". A first phase for the implementation of this strategy has been developed for 2010-2020 in the "Growth and Employment Strategy Paper" (GESP)[32] which serves as the reference framework for government action over that decade. This paper, which is one of the second-generation of Poverty Reduction Strategy Papers (PRSPs), identifies 7 development sectors including the "Health Sector".

The health sector is governed by a national policy implemented through a "Health Sector Strategy" (HSS – the original name in French is "Stratégie Sectorielle de Santé" (SSS))[41], which sets the priority actions for an adequate response of the health system. A chronological insight of how the health system was developed, frames the whole landscape for a better understanding of its organisation and functioning.

II.1. Evolution of the National Health System

The health system of Cameroon has evolved in four major steps[33]:

II.1.1. The colonial period.

This period is characterized by the practice of "mobile medicine" which is a mechanism of providing health care essentially through outreaches programmes,[34] free health care to a part of the population, the extension of the health network to rural areas, the medical and para-medical education, and the development of mobile vertical programs to fight local endemic diseases (trypanosomiasis, malaria).

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II.1.2. The post-independence period or phase of experimentation

The period is characterized by the extension of health care coverage to a network of hospitals and rural centres, the development of human resources for health by training of staff (establishment of the University Centre for Health Sciences (CUSS) in 1969), the intensification of research, the fight against endemic and epidemic diseases, and free health care.

The experience was carried through “demonstration zones of public health actions” (DASP zones) which aimed to complement or replace the mobile units in the delivery of basics health care. Health workers were asked to provide health coverage to their zone of action, by providing care at the health centre for the people of the ‘central area’, and by organizing field trips (outreach activities) for people from the peripheral zone (above 5 km from the centres).These DASP zones therefore allowed health care professionals to experiment with community health approaches that may provide technically sound healthcare to people, in harmony with their local realities. Another great innovation of this period was the creation of the Expanded Programme on Immunization (EPI) by WHO in 1974 and its application to Cameroon in 1976.

This period marks the development of a national health policy[iii] and can thus be considered as constituting the advent of public health and of community-based care in Cameroon.

II.1.3. The post Alma Ata period: Primary Health Care[35]

After the Alma Ata conference in 1978,[36] Cameroon adopted the implementation of primary health care in 1982, with the goal of providing essential health care of good quality, accessible to all members of the community and with their full participation. However, an evaluation conducted in 1988 showed many shortcomings, especially in relation to the quality of care, communities and organization of health services. To overcome this, the health authorities chose to reform the national health system under the name "Reorientation of Primary Health Care" (ReoPHC)

[iii] Decree No. 68/DF/419 of 15 October 1968

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which is not a new program, but a reorientation of the national system to the social objective “Health for All”.[iv]

II.1.4. Reorientation of Primary Health Care (ReoPHC)[37,38]

The ReoPHC process initiated by Cameroon is an outcome of the adherence to a series of initiatives taken by the African states subsequent to the failure of previous initiatives and a decline in their health systems. These consultations included the

1. Lusaka conference (1985), which recommends the organization of the health system at three levels:
   a. Strategic (Headquarters),
   b. Intermediate (provincial or regional services), and
   c. Operational (peripheral health services) ;
2. Inter-Regional Conference of WHO in Harare (August 1987) recommending the adoption of decentralised district health systems; and
3. Bamako conference (September 1987), through the "**Bamako Initiative**", which focused on
   a. maternal and child health,
   b. established cost recovery on essential medicines in public health facilities, and
   c. strengthening of community involvement.

This process led to the development in 1989 of health system reforms in Cameroon, which was officially adopted in 1992 through the declaration of the health sector policy. This was followed and supported by the national declaration of the implementation of "*Reorientation of primary health care*" in 1993.

The basic principles of the concept of ReoPHC are:

a) Community involvement through dialogue structures (health committee -COSA-, Provincial Special Fund for Health, Respective Management Committees);

[iv] “‘Health for All’ is a global health movement undertaken by the World Health Organization (WHO) means that resources for health are evenly distributed and that essential health care is accessible to everyone”. (source: MedicineNet.com, available from http://www.medicinenet.com/script/main/art.asp?articlekey=10708 accessed 30/10/2015)

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b) highlighting of the link between development and health; and
c) the respect for human rights.

Besides ReoPHC, the reform introduced, among other strategies:

a) Information, Education and Communication (IEC),
b) reproductive health, including mother and child health (MCH),
c) family planning (FP),
d) management of health, and
e) the health management information system (HMIS).

II.1.5. The post-2000 national health policy and the Health Sector Strategy (table 1.1).

To face the weaknesses identified in the health sector at the end of the 90's, especially the weakness of the health system and the health district to address the major health challenges, the government reacted by developing the Health Sector Strategy (HSS). The HSS is the national health policy to provide national strategic health directions through the development of priority programs to fight the major endemic diseases and upgrade the system. Initially developed for the period 2001-2010, these strategic directions were organized around eight (8) priority programmes including the Programme of Reproduction Health.

The HSS 2001-2010 was expected to allow the government to achieve, by 2010, its health main objectives which were:[39]

(i) to reduce by one third the morbidity and mortality of vulnerable groups including mothers, children and adolescents,

(ii) to ensure access to 90% of the population to a facility that provides the Minimum Package of Activities (MPA),

(iii) to ensure an efficient management of resources by 90% of health service and care facilities (public or private) of all levels of the pyramid, and

(iv) to implement the health related MDGs.

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"*During the mid-term evaluation of the 2001-2010 Health Sector Strategy, stakeholders expressed dissatisfaction and identified poor governance and weak health district development as major reasons for Cameroon being unable to achieve its health-related Millennium Development Goals*".[40] In 2009, the health sector strategy was revised and the period covered was extended to 2015, in order to align with the new "Growth and Employment Strategy Paper 2010-2020". The revised HSS (2001-2015) elevated the importance of strengthening the health system and particularly the role of the health district, with an emphasis on monitoring and evaluation of the outputs. It was thus articulated around five strategic orientations that should lead to the implementation of major health services interventions, which were categorized in <u>Four (4) national areas of intervention</u> supported by <u>21 classes of interventions</u>, <u>63 categories of interventions</u>, and <u>265 types of interventions</u>.[41] The four national areas of intervention are:

(i) Health of the Mother, the Adolescent and the Children (MCAH),
(ii) Disease Control,
(iii) Health Promotion, and
(iv) Health Districts Development.

In order operationalize the HSS and support its implementation, the country has developed a "National Plan for Health Development 2011-2015"[42] that constitutes the main source for the development of the MoH budget program, the Priority Action Plan (PAP), its annual Roadmap and the Annual Work Plans (AWP) at all levels of the health pyramid.

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Table 1.1: Chronology of the reference documents organizing the health sector in Cameroon after 2000

Year	Reference Document	Period covered	Comment
2000	Health Sector Strategy (HSS)	2001-2010	• Replace the National Health Policy • To align with the MDGs • To respond to the weakness of the health system and the health district in addressing the major health challenges • Created the "National Programme of Reproductive Health"
2009 (August)	Growth and Employment Strategy Paper (GESP)	2010-2020	• Second generation of "Poverty Reduction Strategy Paper" (PRSP) of Cameroon (1st generation in 2003). • Ten years implementation strategy of the development vision to be realized by 2035 • Reference document for the social and economic national policy, including HSS paper
2009	Health Sector Strategy Revised	2001-2015	Revision of the HSS (2001-2010) to: • Align on the GESP. • Address the slow progress in the attainment of MDGs • Emphasize of the health system strengthening and the development of the health district
2010	National Health Development Plan (NHDP)	2011-2015	• Implement the revised HSS • source for the development of the following guiding document at all levels of the health pyramid o MoH budget program, o Priority Action Plan (PAP), o Annual roadmap o Annual Work Plans (AWP)

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II.2. Organisation of the National Health System.

The health sector is divided into three subsectors:

– A public subsector; including all the health facilities that are under the control of the MoH, and facilities that are reporting to other government department such as defence and social affairs;

– A private subsector, that includes private non-for-profit health facilities, (religious groups, NGOs) and those for-profit;

– A subsector of traditional medicine, which is an ancestral component in the health sector. A department in charge of traditional medicine was created in MoH and research centres on medicinal plants operate in Cameroon (IMPM, Plantecam). However, the sector is still under-documented as for now there is no need for a legal authorization to practice traditional medicine.

The health sector is organized through the National Health System. As prescribed in the ReoPHC, the health system in Cameroon is of pyramidal type, organized into three levels including administrative, management, and care structures (Table 1.2 & Figure 1.2).

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Table 1.2: Different levels of the Health System

LEVEL	ADMINISTRATIVE STRUCTURES	COMPETENCIES	CARE & DRUGS[v] STRUCTURES	STRUCTURES OF DIALOGUE
Central /National	Central Services of the Ministry of Health (MoH): –Office of the Minister of Health, –Secretariat General, –Departments and structures ranking as such	–Development of concepts, policies and strategies for the country –Coordination –Regulation	–Referral General hospitals –Central hospitals, –University Teaching Hospital (CHU). –Centre Pasteur –National Essential Drugs Procurement Centre (CENAME)	–Executive Boards –National Health, –Hygiene and Social Affairs Council
Intermediate	Regional delegations of health	–Technical support to health districts	–Regional hospitals and equivalent –Regional Pharmaceutical Supply Centre	–Regional Special Fund for Health Promotion
Peripheral	Health District services	Implementation of programmes in relation with the beneficiary communities.	–Districts Hospitals –Clinics –District Medical Centres –Integrated Health Centres	–COSADI –COGEDI –COSA –COGE

***Source:* Adapted from the conceptual framework of a health district (MoH, 1999)[43]**

[v] Reference throughout this document to drugs refers to legal drugs used as medication

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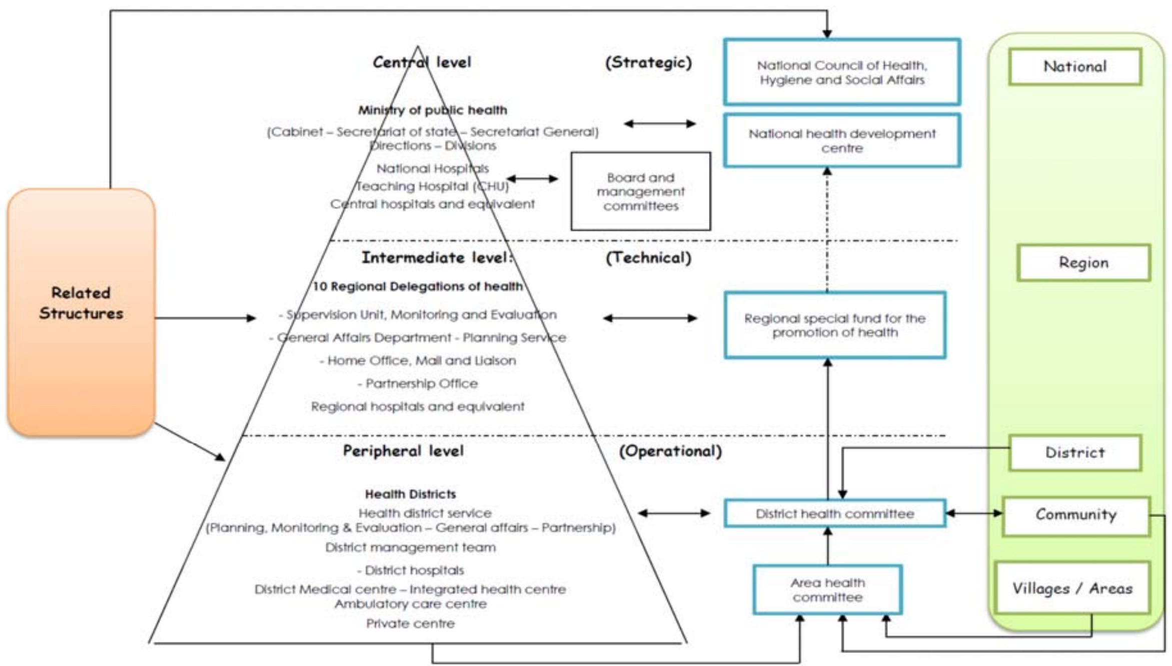
Figure 1.2: Different levels of the Health System



Source : Adapted from the conceptual framework of a health district viable (MoH, 1999)[43]

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a. The Central level is considered as the strategic level and is responsible for defining the country's health policy. This level is essentially composed of central services of the MoH and eventually from other related administrations through multi-sectoral collaboration. Health facilities belonging to this level, including research and care support centres like the Centre Pasteur of Cameroon, are responsible for training, research and providing tertiary and quaternary care.

b. The intermediate level, also considered as the technical support level, includes the ten Regional Delegations of MoH (DRSPs). This level is responsible for the planning and supervision of activities implemented by the lower level. Here, regional hospitals provide specialized care.

c. The peripheral level, which is the level of operationalization of programmes, is represented by the Health District Service. Health care facilities are responsible for basic integrated care. This level is the interface between health services and the communities.

***Drug distribution**:*

The structures for the implementation of the national pharmaceutical policy underlying the supply in essential medicines are the Directorate of Pharmacy and Medicine (DPM) at the central level, and the National Supply Centre for Drugs and Essential Medical Consumables (CENAME), as well as the Centre of supply of Essential Pharmaceuticals (CAPP) in what concerns the regional level. The "CENAME" refuels the "CAPP" at each level; they are responsible for meeting the needs of all community pharmacies.

II.3. Health System Resources

The hierarchical organization of health systems means the existence of, or the need for infrastructure, appropriate technical equipment and the corresponding personnel, at each level.

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– The staff,

The ‘health personnel availability’ indicator more than doubled in three years, going from 0,63 per 1 000 inhabitants in 2007 to 1,43 per 1 000 inhabitants in 2010 but it remains well below the international standard of 2,3 for 1 000 habitants.[44] The statistics of the Ministry of Health indicate that the total number of health professionals was 38 267 in 2011, with 25 183 belonging to the public sector and 13 084 to the private sector (Figure 1.3, Table 1.3). The distribution of health personnel between the 10 Regions of the country is unequal. Ratios vary from 0.17 doctors per 10 000 population in the Far North Region to 2.45 in the centre. Ratios for nurses vary from 0.31 per 10 000 population in the Southwest to 7.41 in the Centre;[45] these are well below the ratios recommended by WHO (23 physicians, nurses and midwives per 10 000 population).[46]

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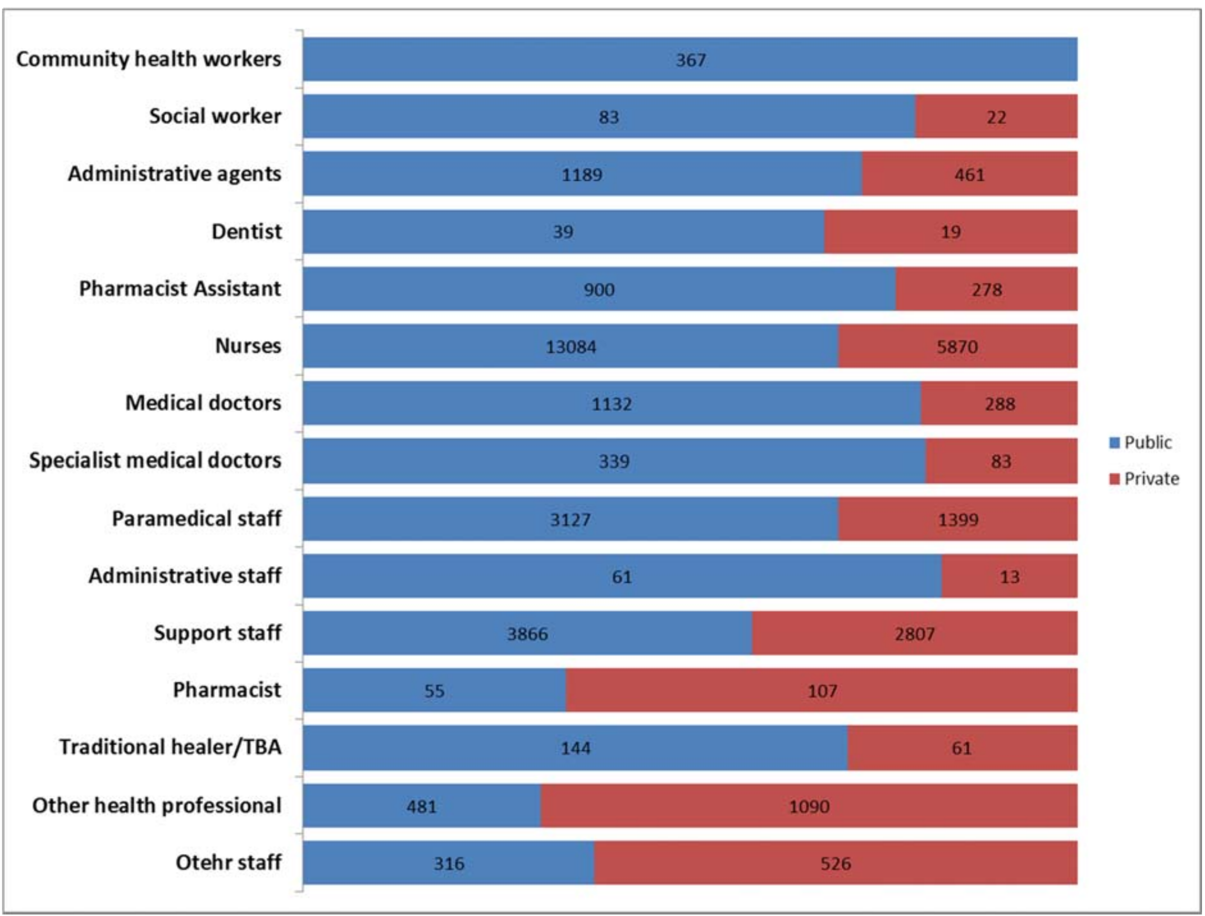
Figure 1.3 Number of health staff in the private and public sub-sectors in Cameroon



Source of data: Department of Human Resource, MoH Cameroon, 2011.[45]

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Table 1.3: Distribution of health staff across the regions

QUALIFICATION	REGIONS											TOTAL
	Adamawa	Centre	East	Far-North	Littoral	North	North-West	West	South	South-West	Foreigners	
Community health	3	26	27	131	6	11	47	97	11	8	0	**367**
Social worker	1	54	1	9	9	3	0	12	5	11	0	**105**
Administrative agents	46	715	56	68	186	57	183	129	64	146	0	**1650**
Dentists	4	22	0	4	17	1	2	3	3	2	0	**58**
Pharmacist Assistants	5	133	42	166	137	92	211	234	24	134	0	**1178**
Nurses	817	4512	874	1733	3276	965	1590	2599	781	1804	3	**18954**
Medical doctors	38	500	53	71	307	42	82	116	45	94	72	**1420**
Specialist medical doctors	16	192	5	10	127	3	9	26	11	16	7	**422**
Paramedical staff	176	1343	204	342	786	160	377	593	175	368	2	**4526**
Administrative staff	1	55	2	1	5	1	1	2	0	6	0	**74**
Support staff	77	1401	120	816	1534	227	844	726	100	828	0	**6673**
Pharmacists	7	38	4	12	40	8	2	26	4	21	0	**162**
Traditional healer/TBA	0	0	0	189	0	10	0	1	1	4	0	**205**
Other health professional	4	251	39	149	40	26	449	447	32	134	0	**1571**
Other	3	54	10	26	0	0	23	20	3	3	0	**142**
Total	**198**	**9 296**	**1 443**	**3 728**	**6 938**	**1 606**	**3 847**	**5 119**	**1 268**	**3 679**	**85**	**38 207**

Source: Department of Human Resource, MoH Cameroon, 2011.[45]

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– *The Infrastructures*

The many health facilities in the country are unevenly distributed between the regions, within the regions and even between urban and rural areas. There are 4 National Hospitals, 5 Reference hospitals, 11 Regional Hospitals (HR) or equivalent, 152 District Hospitals (HD) or equivalent, 185 District Medical Centres (CMA), and 1 819 Integrated Health Centres (CSI).

From the facilities listed above, the private subsector has 1 039 health facilities including 119 medical offices, 99 clinics and polyclinics, 5 Medical private faith based district Centres, 740 Integrated Health Centres and 76 Districts Hospitals. Many health facilities, mostly public, are old and need to be rehabilitated or demolished and rebuilt. As the sector does not have a national strategy for health technology, the resources allocated to this aspect are reduced, and structures are found with non-functional and obsolete equipment.

– *stakeholders of the health system* are represented by:

- The state: active as a regulator, funder, producer of care and support of the health sector. It is the second major funder (33%)[47] of the health sector after households.
- Households / Communities: leading funder of the health sector (52%)[47] through the cost recovery policy. Households constitute the "community", and thus, are expected to play an important role in defining, planning, implementing, then monitoring and evaluating health policies and programs through their organization into management committees or community development groups.
- The private sector: organized in the private for-profit sector mainly located in urban areas and the private not-for-profit sector that is mostly found in rural areas.
- External partners: represented by international organizations including UN agencies, international NGOs, bilateral partners, etcetera. They are, with the local councils and "private health

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insurances", the third major funder of the health sector with 14,4%.[47]

- Other stakeholders of the health system are Community Health Workers and Traditional Birth Attendants (TBA) who are mostly active in rural areas. The CHWs have more of an advisory role to play while TBAs are mostly acting as health providers. The importance of TBA is mostly driven by cultural beliefs.

II.4. The Health District

Cameroon has defined the Health District (HD) as "*a socio-economic entity performing health care services of good quality, accessible to all with the full participation of the beneficiaries*".[vi]

It is a geographical, administrative (district or county) and demographic (between 70 000 and 120 000 inhabitants) entity. The districts, in which health services are organized in a health system, are clearly defined, well-integrated into the local development committee, receiving technical and administrative support of the DRSP. It is the result of the decentralisation process under the health sector reform process, which recommends a transfer of competencies to decentralised authorities who will be responsible for the management[vii] and operation of health services.

The Health District consists of several health areas, each comprising 7000 to 12000 inhabitants and having one or more public or private basic health facility (health centre). These health centres constitute a network in which only one, the reference health centre, is responsible for each area. The network of basic health facilities is headed by a reference public or private health facility (District or borough hospital), a management team (district health service) and the structures of some partners. Structures of dialogue, community health workers, traditional birth attendants and to some extent traditional healers are also part of the health network of the health area.

[vi] Decree 95/013 of 7th February 1995 to lay down organization of basic health services in HDs
[vii] The HD fulfills three functions of management: Development Management (planning of public health and development activities); operational management (monitoring and evaluation of planned activities); and administrative functions (local management of human, material and financial resources).

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Cameroon has 185 health districts and about 1 400 health areas. The number and size of the health districts should allow more efficiency and effectiveness in the decentralisation process.

–The reforms envisage that **the Health Centre (HC)** should play a role of an interface between the community and health services, and serve as a place to provide:

- *Integrated care*: dealing with promotional, preventive, curative and, rehabilitative aspects.
- *Holistic care*: considering the human being in his biological, psychological and social entity; in other words taking into account a human being and his environment.
- *Continuous care:* providing care to the patient from the beginning to the end of his illness; having a system of tracking and recovery of patients (chronic cases, vaccination).
- *Defined care*: delivered to a population of which the number, the environment and socio-cultural aspects are well known by the practitioner.

At the health centre level, we should find a "*minimum package of activities*" which includes:

1. Health of the mother and child, including family planning
2. Curative care,
3. Chronic consultation (leprosy, tuberculosis, diabetes, hypertension)
4. Reference and counter-reference,
5. Health promotion.

The delivery of care by the staff of the health centre is defined through two types of strategies:

- *The fixed strategy*: the population residing within the 'central area' or within an hour walking distance from the centre, come to the centre to receive health care

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- *Advanced strategy*: the staff moves to provide preventive and MCH care to the population living beyond the 'central area'.

–**The District Hospital (DH) or the District Medical Centre** is expected to play the role of reference/counter reference for its health centre first; and secondly it refers, when necessary, some cases to the regional hospital from which it will also receive counter reference patients.

–**The District Health Service (DHS)** is the coordinating body for all the health facilities located in the district. It should manage:

1. The development of the health district action plan
2. The monitoring of implementation of this action plan
3. The supervision of health areas.

–**The staffing of the Health District** includes a chief of the health district service, the chief of the health office, chief of administrative and financial management office, the chief medical officer of the district hospital, the chief nurse of the district hospital, all the chief of health areas facilities.

The staffing may vary depending of the urban or rural location of the district: in rural areas, most of the health areas' facilities are managed by nurses or assistant nurses while in urban areas, there are more medical doctors in the health district staffing.

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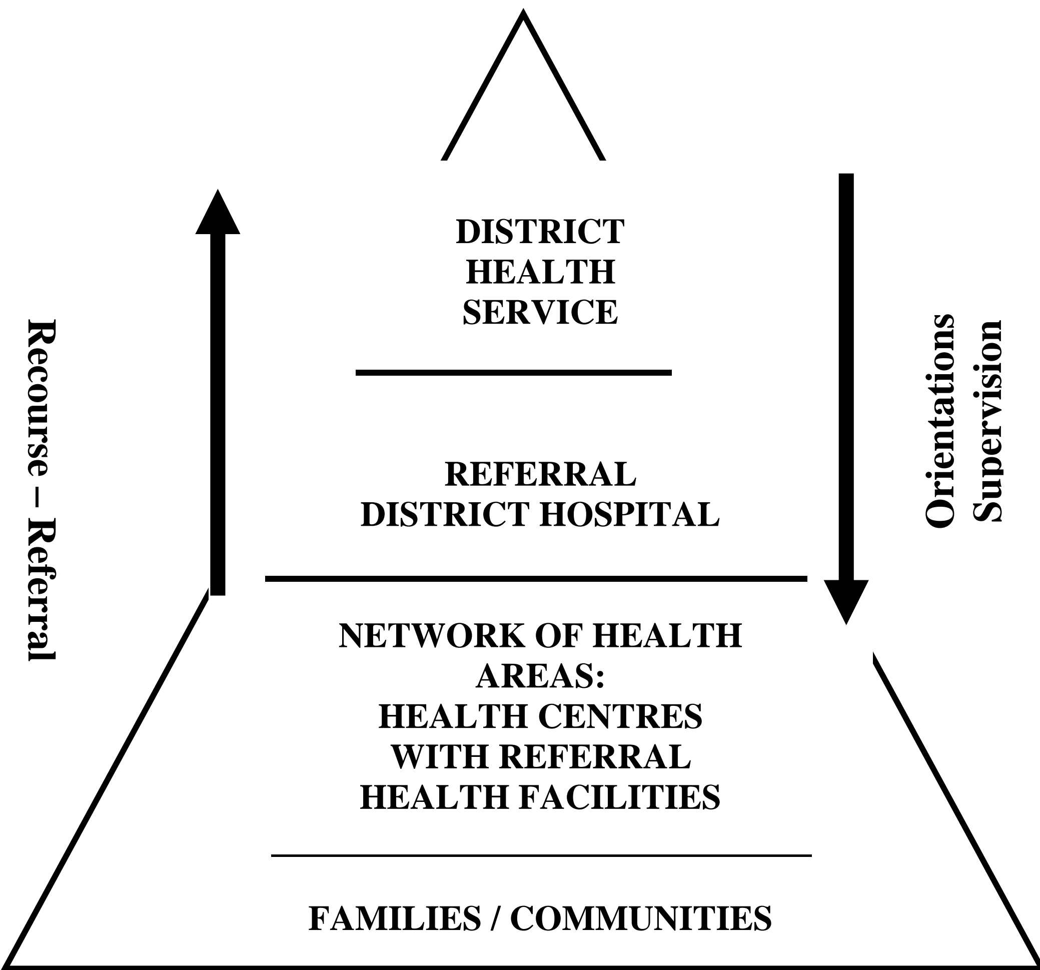
Figure 1.4 : Health District configuration



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The health district represents the level of the health system in which all health activities must be conducted, including those related to reproductive health. In fact, from the types of interventions of the health sector strategy, each level of the health pyramid should generate in its action plan, the activities corresponding to its primary missions. As the district is the operationalization level of the health sector strategy, this approach results in the *de facto* integration of the activities of all the interventions[41]. This must happen within a framework of multi-sectoral collaboration with the involvement of the various components of the district health system, the full participation of the community, and a constant support of intermediate and central levels (Figure 1.4 and 1.5).

Health Districts are still facing some major challenges. The reference/counter reference system used between the different levels of the pyramid is not well structured, and very few people are involved in its development. With respect to the quality of care, we note deterioration in the public sector's heritage, as well as qualitative and quantitative shortage of human resources. The primary health care facilities are underutilized, even in urban areas; this lead to a failure in the quality of health care, and justifies the underdevelopment of the referral/counter referral system and makes implementation of IEC at the peripheral health facilities, difficult.

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Figure 1.5 : Components of a Health District

REFERRAL HOSPITAL

HEALTH CENTRE

COMMUNITY DEVELOPMENT GROUPS

COMMUNITY HEALTH WORKER

HEALTH EDUCATION

FAMILY HEALTH

TRADITIONAL BIRTH ATTENDANTS

COMMUNITY ACTIONS

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III. The financing of Primary Health Care (PHC)

The reorientation of health care in Cameroon recommended the full participation of beneficiary communities in the financing of health activities and health development projects, leading to a PHC co-financing system between the community and the other stakeholders as described below and in Table 1.4:

III.1. Non-community based financing [about half of public funding] for health.[47]

The main sources of this funding are, the State's budget followed by foreign aid (bilateral and multi-lateral cooperation). The funding provided by the state primarily concerns investments such as the establishment of structures (buildings for HC) and heavy equipment; salaries, operating costs, training, initial provision of essential drugs.

The government's health expenditure for the past ten years has been an average of 4-5% of the national budget, with a maximum contribution of 7,9% in 2009,[47] very far from the 15% recommended by the "Abuja Declaration".[48]

III.2. Community based financing (costs recovery) [about half of health care financing] [47]

The sale of essential drugs, the payment for basic services (medical and surgical and others), at the health centre or district hospital by patients, generates funds that eventually should enable the facility, through decentralised management, to self-finance its functioning. The health facility could thus replenish products and small medical equipment. This operation has been made possible by a law that granted a special waiver to public health facilities in all financial matters.[viii] Until that time, Health Facilities were authorized to keep only 50% of their revenues; then a final act,[ix] followed by two implementing decrees,[x] and a finance law[xi] enabled them to keep their total revenues. [49]

[viii] Law N° 90/62 of 19 December 1990 – Cameroon
[ix] Final Act N° 92/001 of 3 August 1992
[x] Decrees N° 93/228/PM of 13th March 1993 and N° 93/229/PM of 15th March 1993

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Table 1.4: Sources of financing health activities at the different levels

No	Level	State sources	Community sources	Others
1	Functional Health Area	1. Government credits for running and investment 2. Parliamentary grant 3. Local Council financing	1. Payment of fees for services 2. Mutual Health Organisation (MHO) financing 3. Surplus from the Fund from sales of drugs 4. Semester assistance from the FUND 5. Project levies	Donations, gifts and contributions from NGOs and Associations
2	Non Functional Health Area (health area where there is no public health management structure	1. Investment credits when possible 2. Parliamentary grants 3. Local Council financing	1. Contributions especially in the form of project levies 2. Mutual Health financing 3. Donations from elites and development associations	Assistance from NGOs, Associations and friendly countries
3	District Health Service	Government Credits for operation and investment	1. 4% from Health Centres 2. 4% of 63% of revenue set aside of the District Hospital 3. District Health Committee Fund from NWPSFH 4. Supervision subsidy from	Assistance from NGOs Support from international organizations (WHO, UNICEF, GIZ, etc)
4	District Hospital	Government credits for running and investment Local Council financing	1. Surplus from the FUND from drug sales 2. Payment of fees for services 3. Mutual Health Financing (MHF) 4. Donations and gifts from the community.	Donations and gifts from NGOs, Associations, Foreign partners.

(Source: MoH Cameroon 2010)[49]

Regarding the reproductive health; 6,2% of the health budget is allocated to reproductive health.[47]

IV. The Reproductive Health National Policy

Maternal and child health (MCH), was already part of the specific objectives set out in the decree that lays down the structural organisation and organic functioning of health facilities in Cameroon.[xii] Since then, the

[xi] Finance law No 98/009 of 01/07/1998
[xii] Decree N°. 68/DF/419 of 15 October 1968, Art. 4

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RH national policy has evolved, to comply with the concept of reproductive health as defined by the ICPD[50] and includes men and adolescent health. The current national Reproductive Health Policy covers the period 2013-2020,[51] to align with the Growth and Employment Strategy Paper (DSCE) for which the timeframe extends to 2020.

Of the nine (9) reproductive health components recommended at the international level, this policy included the eight (8) components that were set as priorities in Cameroon, namely:

(i) Maternal and child health (safe motherhood, new-born care, abortion-related care, nutrition, Integrated Management of Childhood Illness -IMCI-),
(ii) Family planning (IEC and family planning services),
(iii) Fight against STI / AIDS,
(iv) Fight against childlessness/infertility and sexual dysfunction,
(v) Fight against harmful practices (excision, sexual and domestic violence, early marriage),
(vi) Adolescent health,
(vii) Fight against genital and breast cancers,
(viii) The management of reproductive health of the elderly (IEC, menopause / andropause, sexuality, cancer screening).

The ninth component at the international level, the one related to abortion, has not been selected as a priority at the national level. Despite the high rate of maternal mortality it causes, there is still a problem of legislation on abortion, which requires that all ethical aspects of law and socio-cultural habits be well explored before any regulatory decision is taken in this area.

The description of this policy also highlights some support components that are: (a) improving management of reproductive health programmes, especially supervision, monitoring & evaluation; (b) research and training in reproductive health.

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As described in the health sector strategy, maternal child and adolescent health is one of the four national programmes (area of intervention)[xiii] for health care and service delivery aiming to improve the well-being of individuals, families and communities living in Cameroon. The programme seeks to reduce maternal, neonatal and infant mortality and is organized around 3 main classes of interventions (sub-programmes) namely; (a) health of the mother, (b) health of the child and (c) health of the adolescent. These three classes of intervention are themselves divided into 13 categories of intervention leading to 54 types of interventions for this area. Activities for each type of intervention are decided by each level of the pyramid during the planning process. Regarding the health of the mother component, the medium term expected results are:

(i) improving quality of care provided to women who are pregnant and in postpartum,
(ii) increasing access to quality obstetrical and neonatal care,
(iii) increasing access to family planning services,
(iv) increasing screening and management of reproductive cancer,
(v) increasing screening and management of obstetrical fistula.[41]

Regarding woman's health two main subcomponents are considered. First is the 'safe motherhood' component, including preconception consultation, monitoring of pregnancy, management of labour and delivery, monitoring postpartum, post-abortion and postnatal; emergency obstetric care (1st, 2nd, and 3rd quarter). The second component is the Gynaecological Care that includes functional disorders, genital cancers, menopause, and management of sexual disorders.

IV.1. **Reproductive health indicators in Cameroon**

The health status of women is characterized by very high fertility and mortality rates with an estimated maternal mortality ratio of 782 deaths per 1 000 live births.[13] As with other countries in the continent and globally, the

[xiii] In some documents like the DSCE, "area of interventions" are sometimes referred as "programmes"

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direct causes of maternal mortality are bleedings, postpartum infections, eclampsia, and obstructed labour.[51] Abortions account for 13% of maternal deaths in health facilities and most of them are induced.[52] Coverage rates of ANC and delivery assisted by skilled health personnel are respectively 85% and 64%. The contraceptive prevalence remains low; only 16% of women use modern contraception methods.[13] In addition to all these facts and figures, both STIs and AIDS contribute to a high burden of morbidity.

Several retrospective studies, such as that of Mafany *et al.* (1990), undertaken in thirteen hospitals in the province of South-West Cameroon from 1982 to 1987,[53] under estimate maternal mortality compared with DHS III data. This is due to the fact that many maternal deaths occur outside of hospital units, and thus are not documented.

IV.2. **Maternal Health**

Maternal health, also referred to as health of the mother, and which will be the focus of this study, is one of the three subcomponents or classes of intervention of the area of interventions on health of the mother, the child and the adolescent. This area of intervention is the equivalent to the Reproductive Health Programme, and thus ruled by the Reproductive Health National Policy.

Maternal health in Cameroon is organized in 5 categories of interventions that are to be fulfilled by 24 types of interventions (services delivered) (Table 1.5).

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Table 1.5: Nomenclature of maternal health interventions (source HSS, MoH-Cameroon, 2010)[41]

Area of Intervention N° 2: Health of the mother, the child and the adolescent		
Class of intervention	*Category of Intervention*	*Types of Intervention in terms of service delivered*
Health of the mother	1. **Refocused antenatal care and postnatal care**	1.1. Antenatal care 1.2. Insecticide Treated Nets (ITN) 1.3. Prevention of Mother to Child Transmission (PMTCT) (Screening, ARV prophylaxis of mother and child, support) 1.4. Intermittent Preventive Treatment (IPT) of Malaria 1.5. Post-natal care 1.6. Post-abortion care 1.7. Screening and management of risks (cancer, obstetric fistulas, STIs, Pre-eclampsia, premature delivery threats, diabetes, sickle cell anaemia, asthma, epilepsy, behavioural disorders, etc.) 1.8. Anti-tetanus vaccination 1.9. micronutrient supplementation (iron, folic acid, calcium ...)
	2. **Deliveries and emergency obstetric and neonatal care**	2.1. Clean delivery and umbilical cord care (community activities, reorientation) 2.2. Basics emergency obstetric care 2.3. Comprehensive emergency obstetric care 2.4. Essential emergency obstetric care 2.5. Management of post-abortion 2.6. Screening and management of obstetric fistulas 2.7. Management of complications (premature rupture of membranes, dystocia, eclampsia, haemorrhage ...)
	3. **Family planning**	3.1. Counselling for the choice of the method 3.2. Provision of family planning services and management of side effects (complications) of contraceptive methods. 3.3. Family Planning in postpartum and post-abortion among adolescents
	4. Women consultations and early diagnosis of gynaecological cancers	4.1. Preventive consultation 4.2. Screening
	5. Mothers' consultation and early diagnosis of obstetrical fistulas.	5.1. Screening 5.2. Curative consultation and management

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In terms of human resources directly concerned by maternal health, there are only 131 midwives working in the country.[54] Gynaecologist-obstetricians number only 141, of which 87% are working in the two major cities of the country, Yaoundé and Douala; This is a heavily unbalanced ratio and explains the lack of skilled professionals for maternal care in the rest of the country, as well as the disparities in the maternal health indicators (Table 1.6).

Table 1.6: Disparities in maternal health indicators across the Regions of Cameroon

	Maternal Mortality Ratio (100.000 live births)	Percentage of deliveries assisted by skilled health personnel	Contraceptive Prevalence (All methods)	Percentage of adolescent (15-19) who has got at least one live birth.	Percentage of ANC provided by a skilled personnel	Unmet needs in FP among women aged 15-49 who are married
Far North	--	25,1	3.7	29.7	59,0	22,8
North	--	32,9	4.9	26.6	71,7	31,6
Adamawa	--	47.4	11.1	24.0	87,8	21,8
Centre	--	78,5 (93% in Yaoundé)	33.6	26.2	92,8	30,6
East	--	48,9	12.5	37.9	85,4	31,8
Littoral	--	94,2 (99% in Douala)	29.7	16.6	97,4	29,3
Nord-West	--	93,6	38.1	15.7	97,6	17,7
West	--	95,8	33.7	13.2	98,9	16,8
South	--	82,2	32.4	31.5	94,2	22,2
South-West	--	80,1	40.0	14.4	91,3	18,7
Cameroun	782	63.6	23.4	20.9	84,7	16,6

Source of data: DHS III[13]

An analysis of these disparities in the indicators of maternal health highlights a worrying maternal health situation in the Far North, while regions like Littoral, particularly its main city of Douala, are showing good indicators. Although deliveries assisted by skilled health personnel may require some significant resources, it is assumed that other indicators such as contraceptive prevalence, antenatal care, or promotion of health among

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the adolescents to avoid early pregnancies, can be addressed through less resource-demanding strategies. Such strategies should be considered in the national policy and taken into account in the planning and management of the health district.

The next chapter will review the literature around the policymaking at national level and the planning process at district level. The review is done in order to provide a better understanding of these processes and, at a later stage, see how they can lead to the improvement of the Cameroon planning in maternal health at the district level.

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CHAPTER II:
LITERATURE REVIEW

"The wellbeing of society depends on the good health of its older members in their later years. For policy-makers and individuals alike, this means planning for the future." (World Health Report, WHO, 1998)

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INTRODUCTION

Most of the African countries have opted for a decentralised health system. This implies a health system with three levels: Central, Intermediate and Peripheral/Districts, with similar levels for policy and/or planning development. While national health policies are made by the MoH, decentralisation requires districts to make planning decisions and to implement activities.[55] Similarly, the health system of Cameroon is divided into three levels, each of them having an administrative, a management and a health care structure. Like the other levels, the peripheral level has a health management service in charge of the development and the implementation of the district health plan.

As described in the general introduction, the main indicators of reproductive health are getting worse in Cameroon, which makes it a challenge for the country. Paradoxically, as one major concern of the MDGs, considerable evidence is produced by researchers, local and non-local organizations, aiming at reducing the burden of this public health issue. The literature reveals three major lessons: firstly, the positive impact on the health of the population of the use of evidence in decision or policy making. This is well demonstrated in health impact assessments (HIA), *"a data-driven approach that identifies the health consequences, positive or negative, of new policies, and develops practical strategies to enhance their health benefits and minimize adverse effects"*.[56] Secondly, it appears that bad maternal health indicators are more often at the peripheral level. In their survey, Bulatao *et al.* reveals that *"maternal health programme effort in developing countries is seriously deficient, particularly in rural areas"*.[19] In Cameroon, the worst indicators shown in Table 1.6 are in the Far North region, which is likely to be one of the less developed regions of the country together with North, Adamawa and East Regions. Finally, to expect positive outcomes from the implementation of national health priorities we need to have a strong policy underpinned by a plan that hinges on these relevant priorities. Prata *et al.* demonstrated that the most cost-effective interventions were family planning, safe abortion and antenatal care which, in general, do not receive enough resources. The

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authors then came to a conclusion that in order to achieve the expected 75% reduction in maternal mortality by 2015, programme planners will be required to make informed and evidence-based choices when allocating scarce resources.[3] In Senegal, data show that 57% of reproductive health expenditures are devoted to curative care and only 14% is allocated to prevention, while equipment and constructions represent about 25%.[57] An area that has received less attention but nonetheless contributes to the slow progress in achieving the health MDGs, is the analysis of how and why national health policies achieve less or differently from what is expected, or even fail.[58] Mba & Ongolo-Zogo analysed the reasons for Cameroon being unable to achieve its health-related Millennium Development Goals and identified poor governance and weak health district development as key factors.[40] They further reveal that "*Factors underlying this problem include the absence of standard operating procedures for district governing bodies and health services*"… "*In addition, mechanisms and tools to ensure the appropriate use of information for planning, sound social participation, and transparency and accountability have been inadequate*".

As we accelerate the process of decentralisation it is critical that managers and other stakeholders at district and sub-district levels have the necessary tools, as well as skills, to prioritise interventions, depending on the burden of disease, the needs of the population, and to match these against available resources. The current review thus aims to look deeper into the existing policy and planning mechanisms and tools in general in Cameroon, and eventually identify the gap that would help the most health districts managers and stakeholders to develop strong and efficient local strategic and action plans, that we believe can greatly contribute to reduce the burden of maternal health.

I. The policymaking process: a major role for evidence

Evidence in Health

Availability and accessibility of information is likely to appear as one of the greatest advances of the health systems' science for the past twenty years,

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probably driven by the increasing requirements for justification and accountability in health policy decisions and actions. Actually, a greater demand has been placed on decision-makers at all levels and in all fields to justify their decisions, in response to the dilemma between the scarcity of resources and the unlimited needs of the population.[59] Therefore, a need for evidence based prioritization of decisions for health actions is now becoming inevitable.

The use of evidence in health probably arose in the early 1990's with the development of the Evidence Based Medicine concept (EBM)[60] defined as *" the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research*";[61] However, this vision of EBM was restricted to scientific evidence and was essentially focused on the individual-clinical level. This reality exposed the need to broaden the scope of EBM to Evidence Based Health Care (EBHC) defined as "*the conscientious use of current best evidence in making decisions about the care of individual patients or the delivery of health services. Current best evidence is up-to-date information from relevant, valid research about the effects of different forms of health care, the potential for harm from exposure to particular agents, the accuracy of diagnostic tests, and the predictive power of prognostic factors*".[62] These definitions are strongly linked with scientific proof which has always depended on probabilities rather than absolute proof and are determined by observation and perception, both of which are open to misinterpretation and rebuttal.[63]

A third approach is "Evidence-based Policy and Practice" which "*explores the processes of systematically finding, appraising and using scientific research as the basis for developing sound practices. The knowledge gleaned from this research is used to develop policies and practices that improve health outcomes and performance as well as allowing for more efficient use of resources. Policy makers are also provided with a better understanding of the science, ensuring that policy decisions are based on the best information available"*.[64]

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As far as public health is concerned, evidence based policy or decision making must involve

- *Information* (meaningful collection of facts and data,[65] organized in order to create a message),
- *Scientific evidence* (scientific findings used to support or refute a theory or a viewpoint e.g. systematic reviews, expert opinions…-) and
- *Knowledge* (Information internalized by a human being) on top of EBHC.

This vision of evidence referred to as public health evidence, includes scientific evidence, local health information, expert opinion, experiences, values, available resources, local priorities, political considerations, time pressure and local contextual factors. This broader vision of evidence is what is used to justify Evidence Based Public Health (EBPH) which is defined as "*the development, implementation, and evaluation of effective programs and policies in public health through application of principles of scientific reasoning, including systematic uses of data and information systems, and appropriate use of behavioural science theory and program planning models*".[66] The EBPH utilizes "*the current best available evidence to make decisions in the public health service, and also to develop action plans, public health programs, and policies for addressing public health issues*".[67]

The health policymaking process

In order to have a better understanding and be able to analyse the maternal health policy and plans development, it is important to understand the policy making process in general and to understand how evidence contributes to building a policy and/or a plan. The health policy can be defined as a statement of a decision regarding a goal in health care and a plan for achieving that goal; e.g., to prevent an epidemic, a programme for inoculating a population is developed and implemented. In fact, health policy is a kind of action plan that steers the direction of a social (including economic, behavioural…), professional and often government response, to a health related issue. However, Policy-making is not just about a particular

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decision made at a certain time, it is also the continuous interaction among institutions (the structures and rules which guide the decision making process), interests (groups and individuals' interests) and ideas (evidence, knowledge and arguments).[68] Therefore, the policy process, most of the time, includes many other considerations like politics, interest and economics, that are mixed with evidence and knowledge to provide the final policy or decision. Health policies are then formed through the triangular inter-relationship of context, process and actors which represents the main elements to take into consideration in drafting the policy (Figure 2.1).[69,70]

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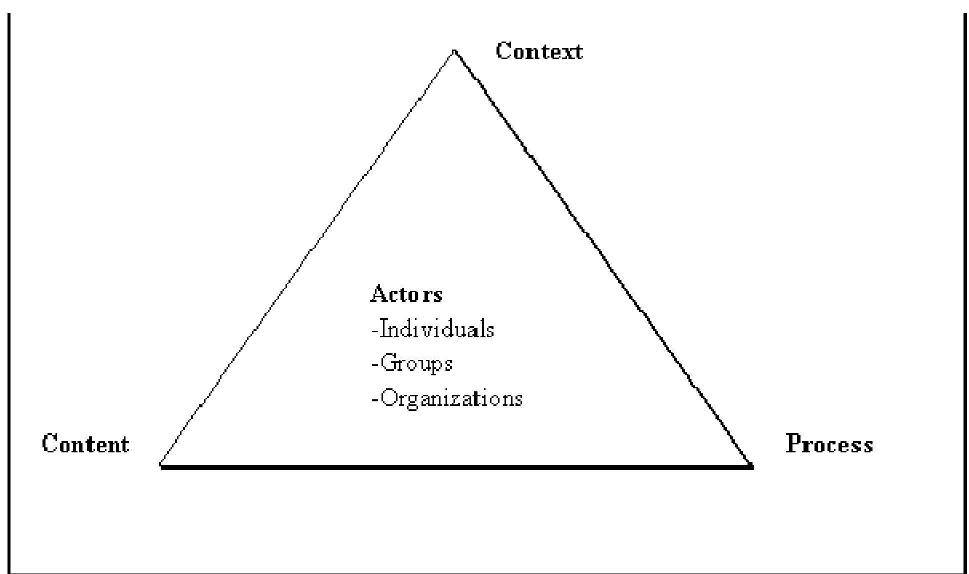
<u>Figure 2.1</u> : The Health Policy Triangle



Source Walt and Gilson, 1994 (in Buse et al, 2005)[69,70]

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Evidence-informed Policy

Policy formation varies according to the nature of the policy and the organizational structure in which it is made (actors, content, and context) but often includes assembling information/evidence, developing arguments, developing alternatives, and persuading others.[71] Thus, setting policies represents a compromise between the types of evidence the actors and the context. A representation of the Evidence-informed policy and decision cycle is presented in Figure 2.2.

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<u>Figure 2.2</u> : The Evidence-informed Policy & Decision Cycle

DATA

Data collection:
Routine registration;
Surveys; Censuses; &
Experimentation

Data processing
and analysis

Data
integration
and
interpretation

INFORMATION

Systematic
review of
available
information

Operational
studies to
assess
acceptability,
cost, feasbility,
etc..

EVIDENCE

Packaging the evidence:
Evidence
filtration and
amplification

Integration of
evidence with other
considerations

POLICY &
DECISION

Monitoring performance;
Forecasting trends; &
Evaluation of impact

Existing
Information
&
Experiential
Knowledge

Modified from these sources:
Don De Savigny & Fred Binka 2004;[72] APHSR & WHO 2007; Tugwell P et al 1985[73]

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As an important step for the policy making process, a decision analysis should be undertaken, aiming at providing policy makers with the insight into what variables and features of the problem should have a major impact on our decision[74]. Using evidence to set policies requires that we have weighed the benefits and risks of that policy: *"Policies should be based on the best available evidence. Doing nothing is also an active policy decision, and both action and inaction require justification"*.[75]

Considering the influence of policy on the health of the population, the World Health Organization (WHO) is of the view that using existing knowledge adapted to the local condition is particularly crucial in achieving the Millennium Development Goals (MDGs).[76] Realizing these goals in regards to health, requires actions through effective, efficient and equitable health care systems, which can only be reached if based on well informed policies. In these past approximately 15 years, health evidence has shown high interest and continues to offer solutions to health related issues toward better health for populations. It is now recognized that scientific knowledge actually plays a major role in addressing the diseases and conditions that afflict people, particularly in developing countries;[77] the issue remains the path to the implementation of evidence for action.[78] Addressing the dichotomy between evidence and policy-making or implementation is therefore of great importance to the efficient use of evidence to improve health policies and plans.

The concept of evidence based/informed policy is quite recent in Africa. Some scattered approaches have been developed to improve the interplay between research evidence and health policy, taking into account the complexity of policymaking in the African context. However, the interface between policymaking and research in low income countries is highly complex[79] especially when it comes to implementation. Production of evidence in such settings face a number of challenges such as under-investment, lack of human capacity, lack of public demand, inadequate utilization, and poor dissemination of evidence.[80] This can easily explain the inadequacy of the availability, quality and use of health information, research evidence and knowledge in the African Region.[81]

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Statements have been made by the ministers of health of the African region in 2008 through the Algiers Declaration[82] to reinforce health research systems, with emphasis on the harmonization for a joint strengthening of health information, research and knowledge management systems; and the use of evidence to improve health policies and actions.[83] One good opportunity for the use of evidence is the planning.

II. The planning process

Planning helps to determine where services are most needed and decide how best to move toward agreed upon goals.[84] It also consists of selecting the most important interventions to implement in the country, which interventions are meant to respond to problems that are identified based on evidence. Good planning demands the correct use of good evidence. As shown on the programme management cycle, Planning is the part of the programme management which consists of the strategic planning and the implementation planning. Most of the time, strategic planning is done at the central level for a 5 to 10 year period, while implementation or operational planning concerns the regional or peripheral levels that implements national strategies set by the strategic plan. Implementation or operational planning covers a shorter period, generally 1 to 3 years. (Figure 2.3).[85]

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Figure 2.3 : Programme Planning and Management Cycle

Evaluate programme
including coverage and health impact (e.g. using DHS, MICS surveys)
(every 5-10 years)

Develop strategic plan (every 5-10 years)
- ✓ Prepare for planning
- ✓ Do situation analysis
- ✓ Prioritize and package interventions
- ✓ Decide how to deliver interventions
- ✓ Select indicators and set targets for evaluation
- ✓ Write and disseminate plan
- ✓ Mobilize resources

Manage implementation (Ongoing)
- ✓ Advocate
- ✓ Mobilize resources
- ✓ Manage human, material and financial resources
- ✓ Manage supervision
- ✓ Monitor progress and use results

Prepare for the review of implementation status (every 1–2 years)

Develop implementation plan (every 1-2 years)
- ✓ Prepare for planning
- ✓ Review implementation status
- ✓ Decide on programme activities
- ✓ Plan monitoring of implementation of activities
- ✓ Plan for the next review of implementation status
- ✓ Write a workplan and budget

Source: Managing Programmes to Improve Child Health, Module 1. WHO, 2009[85]

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Strategic Planning is defined as a "*Systematic process of envisioning a desired future, and translating this into broadly defined or objectives and a sequence of steps to them*".[86] It considers priority challenges and defines strategies that take into account resource constraints. It also usually links with other stakeholders' agendas, in order to determine the direction and scope of the institution over the long term. The strategic plan does not stipulate the tasks and activities to implement the defined strategies. The implementation or operational planning thus appears as a more narrow process which follows the strategic planning as its logical step forward, and presents detailed information to direct the implementation of the strategies. In general, the operational plan provides the "What" (the strategies and tasks that must be undertaken), the "Who" (the persons who have responsibility of each of the strategies/tasks), the "When" (the timelines in which strategies/tasks must be completed) and the "How much" (the financial resources required to complete each strategy/task),[87] and the "How" (how the strategy/task will be implemented).

Planning models

In theory, three main models of planning are distinguished in the literature (Figures 2.4, 2.5 and 2.6).[88] The first model, the "*comprehensive rationalism*", combines "rationality" of a hierarchical series of steps towards the expected outcome and "comprehensiveness" of all possible actions in each step to achieve it. However, its implementation is limited by the fact that it is costly, and allocation of the scarce resources is usually a political decision; thus we have to deal with the challenge of the possible lack of political interest and commitment to implement health policies.[89] The second model, the "*incrementalism planning*" implies a movement which is determined by the political context, including not only ideology but also the different interest groups in society.[88] The third model, the "*mixed scanning*" refers to a deliberate decision to narrow down the area of manoeuvrability by focusing planning attention on selected areas of interest.[88] It includes adding a prioritization step to the comprehensive rationalism. This approach is less demanding than the

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full search of all options that comprehensive rationalism requires, and more "strategic" and innovative than incrementalism.[90]

Although the mixed scanning model seems much closer to the planning process in most of the African countries, it might not be feasible to use the three models described above in their pure forms. However, they each throw light on different ways of approaching planning which in practice can be combined in a balanced way according to the context to achieve the best health objectives.

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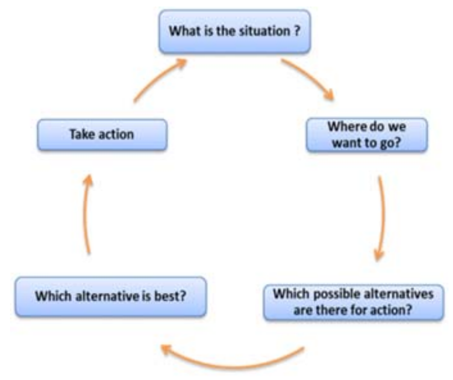

Figure 2.4 Steps in Rational Planning (source A Green, 2007)

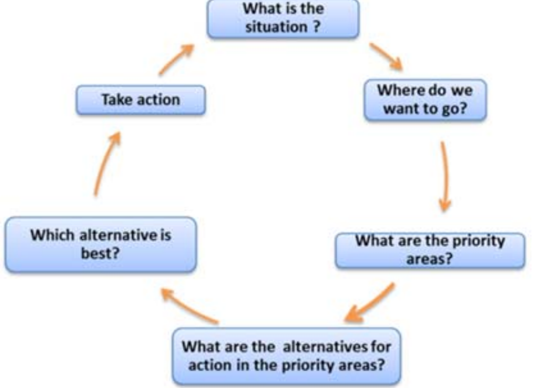

Figure 2.5 Mix scanning cycle (source A Green, 2007)

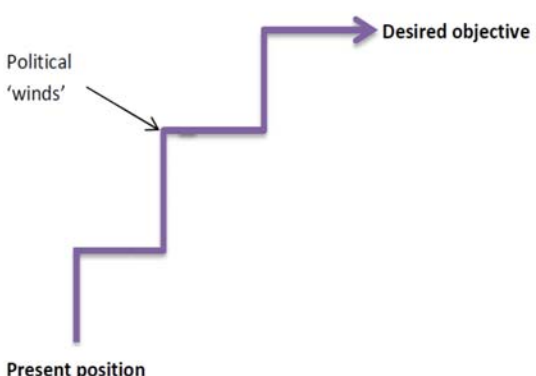

Figure 2.6 Diagrammatic representation of incrementalism. (source: A Green, 2007)

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II.1. Health planning

Health planning is defined as "*the orderly process of defining health problems, identifying unmet needs and surveying the resources to meet them, establishing priority goals that are realistic and feasible, and projecting administrative action, concerned not only with the adequacy, efficacy and efficiency of health services but also with those factors of ecology and of social and individual behaviour that affect the health of the individual and the community*".[91] Health planning thus takes into account not only the needs of the population and the resources available, but also the best means and methods to reach the goals set for providing the best health services possible. Unlike the traditional sector of industry, the health sector has a uniqueness that includes emotional dimensions characterized by (i) the fluctuations in demand and the exposure of health professionals to life-and-death situations; (ii) the complex relationships of many separate entities operating in a virtually uncoordinated manner and often at cross-purposes; (iii) the financial characteristics as the end user makes the consumption decision or may not pay for the service provided; and (iv) the diversity of functions performed by different entities (humanitarian, community services, health care, etcetera) while single entities such as a hospital, performs multiple functions simultaneously.[92]

Health planning comprises a range of activities that aim at improving health outcomes (health goals planning and population health planning), the efficiency of health services (health services planning) or both (health system planning, which includes both health service and population health planning)

The literature on national health policy planning reveals that there is often an interchangeable use of the terms national health "policy", "plan", "strategy" and "programme". There is a lack of consistency and consensus over the way the terms are used.[93] This interchangeable use of words could lead to confusion. The words have clearly different meanings and their correct use will

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add clarity to the purposes of each in the correct context. This will in turn lead to improved health care delivery and save lives.[xiv]

II.2. Planning at the district

a. The district "Health System":

As an entity of the national health system, the health district should be represented as a sub-system, thus should have a "district health system". A comprehensive definition of the district health system is given as a "*more or less self-contained segment of the national health system. It comprises first and foremost a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private, or traditional. A district health system, therefore, consists of a large variety of interrelated elements that contribute to health in homes, schools, work places, and communities, through the health and other related sectors. It includes self-care and all health care workers and facilities, up to and including the hospital at the first referral level and the appropriate laboratory, other diagnostic, and logistic support services. Its component elements need to be well coordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities*".[94]

The delimitation of districts in a self-entity means organization and management of its own system, not independently from the national system but as a "bottom up" input to it. Therefore, to contribute more efficiently to the implementation of national plans, it is further required for the district to develop 2 to 3 year health district plans to organize and deliver health services in the most effective way that contributes to the enhancement of health of the population in general. In some countries like South Africa, Cameroon, and

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[xiv] "Policy" – a course or principle of action proposed by an organisation / "Plan" – a detailed proposal for doing or achieving something / "Strategy" – a plan designed to achieve a particular long-term aim (Source: Oxford Concise English Dictionary)

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Tanzania, a guide has been developed to help managers for health district planning.[95,96,97] As a result of the requirement to develop their plan, "*districts now have more responsibility for setting their own priorities and managing their own budgets. Districts are therefore expected to be more accountable to their local populations for the quality of health services provided*".[55]

b. Planning tools

Because of the complexity of the planning exercise, and for the sake of harmonization and consistency of the response to public health issues across countries, several tools have been developed to guide health managers, especially those of the peripheral level, throughout the planning exercise.

- ***Review of existing planning tools***

A review of some health district planning tools developed to help health district planners in Sub-Saharan African countries, describe about ten main steps in the planning process (see table 2.1), representing a chronological suite of events to undertake, which are closely related:

Step 1: Situation Analysis is about gathering all the information available on the current health status, analyse the gaps and point out the issues. Generally the situation analysis includes the SWOT analysis (Strengths, Weaknesses, Opportunities and Threats).

Step 2: Listing the issues. It is a follow up of the situation analysis. It corresponds to an identification of problems and aims to index all the potential issues that are linked to the situation. At this stage all the problems and causes are pulled out from the situation analysis and critically examined. At this stage, a "problem tree" can be constructed with a set of assumptions on causes associated with the problem and its consequences.[98]

Step 3: Selection of priority problems concerns the choice of the issues that will be kept in the plan according to a range of criteria that refer to the magnitude and the feasibility of each problem.

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Step 4: Developing goals that will enable one to determine the activities to be carried out for implementation

Step 5: Develop strategies and set objectives that will be followed to achieve the goal

Step 6: Choose/decide activities. This refers to the selection of activities to reach the goals previously developed

Step 7: Estimates of resource needs correspond to the costing of the implementation of the selected priority activities.

Step 8: Develop an action/implementation plan to implement the decided activities that respond to the problem. An Action plan appears as a sequential representation of the different steps that will be undertaken to respond to each problem objective which leads to the defined goals. This step is critical as it will also determine the source of funding for different activities and enable the identification of sources that do not have funds.

Step 9: Develop a Monitoring and Evaluation (M&E) plan including relevant indicators. This plan will enable one to see if the elements implemented lead to the expected outcome. A follow up will allow detecting implementation's constraints and issues, including environmental matters, and adjusting at any time.

Step 10: Writing up and approval of the plan: This consists of finalizing the writing up and the review of the plan, taking into consideration the output of all the previous steps. The plan will then be approved and implemented.

A comparison of ten tools that are in use in sub-Saharan African countries showed that although they do not all have ten steps, they all approach planning in more or less the same chronological sequence, setting their priorities after the situation analysis, and ending with implementation and monitoring.

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Table 2.1: review of some existing health district planning tools/guidelines for Sub-Saharan Africa

Tool	Reference	Number of steps	Detailed Steps	Comments
District Planning tool for maternal and Newborn health strategy Implementation[5] [5]	WHO	10	1. Situation analysis 2. Analyse causes of identified MNH problems 3. Select priority problems 4. Setting goals 5. Develop strategies and set objectives 6. Select activities to strengthen MNH services 7. Resource needs estimate for MNH activities 8. MNH action plan 9. Monitoring and evaluation plan 10. MNH plan approval and advocacy	A tool developed specifically for maternal health planning, which follows the different steps of district health planning as described in the literature. Prioritization of problems here is done by weighting and ranking process, and refers more to the magnitude and feasibility of the problem.
Planning and Implementation of District Health Services[98]	WHO	10	1. Situation Analysis and problem Identification 2. Problem analysis and prioritization 3. Setting objectives and targets 4. Formulating (developing) Interventions 5. Determining resource requirements 6. Preparing the plan of action 7. Preparing the budget 8. Implementation 9. Monitoring and evaluation 10. District Health Plan write-up	A tool developed with the classical approach.
Planning of District Health Services[99]	Ministry of Health and Social Welfare (MoHSW) Tanzania	9	1. Situational Analysis 2. Problem identification 3. Prioritization 4. Objective formulation 5. Activity formulation 6. Resource Identification 7. Budgeting and costing 8. Monitoring 9. Evaluation	
Comprehensive Council Health Planning Guidelines[97]	MoH Tanzania	7	1. Situation Analysis 2. Review of resource availability from all sources 3. Health problems and priority setting 4. Objectives, targets and planned interventions 5. Plan of Action 6. Targets and monitoring performance indicators 7. Assumptions and risks	

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The Planning process – planning process toolkit[100]	Health System Intelligence Project (HSIP)	7	1. Surveying the environment 2. Setting directions 3. Problems and challenges 4. Range of solutions 5. Best solution(s) 6. Implementation 7. Evaluation	
Area planning tool[101]	Narcotics Anonymous	7	1. Gathering information 2. Listing the issues 3. Developing goals (*identify "what," not "how"*) 4. Prioritizing goals 5. Creating approaches 6. (actions to reach goals) 7. Prioritizing approaches 8. (a second look) 9. Developing an action plan	A community need-based tool that reflects the planning by the community for the community. This tool has the particularity to propose two different prioritization steps. One for goals, and one for the approaches (which can be seen here as "what should be undertaken to reach the priority goals". This second prioritization step is deliberate and decisive and is operated through ranking process again, although the difficulty of a numbering system at this stage is recognized in the tool.
Health Planning and Management for extensive health workers[102]	*Ethiopian Public Health Training Initiative (EPHTI)*	6	1. Situation Analysis 2. Analysing and selecting critical (priority) problems 3. setting objective and targets 4. Identifying potential obstacles 5. Designing the strategies 6. Writing up the plan	
Guidelines for District Health Planning and Reporting[95]	*National Department of Health (NDoH) South Africa*	5	1. Service platform planning 2. Problem analysis 3. Priority setting 4. Choosing service delivery mechanisms 5. Analysing the primary health care (PHC) package gap	
Guidelines for the Elaboration of Health District Development Plans[96]	MoH Cameroon	3	1. Situation Analysis 2. Intervention logical framework 3. Establishment of the budget	The first step, situation analysis, is a package of most of the intermediate steps described above that are undertaken between the situation analysis and the budgeting. More explanation is provided in the next paragraphs.

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- ***Setting priorities: a critical step***

Too often, health policy and strategic planning have envisaged unrealistic expansion of the publicly funded health care system. Eventually, the policy and planning document is seen as unfeasible and is finally ignored.[103] A major function of the planning process is therefore to determine the major needs, to devise suitable programmes for meeting them and to allocate resources accordingly.[88] It thus appears that there is a need to strategize with the resources available and within the country or area context, and to plan accordingly; in other words, to prioritize the components of the plan. Looking at its position in the planning process, "identifying/selecting priorities" appears as a key and very complex step. Upstream, the situation analysis highlights a number of problems that are listed and, because of a scarcity of resources, only few of them will be addressed in the plan. This in turn highlights the importance and necessity of being very strategic in the choice of priority problems as a range and variety of influential factors should be taken into consideration. Downstream the priority setting step, there are goals, objectives and activities that should be defined from the identified problems that have priority. It is therefore important to establish focus areas for the plan early in the planning process and to further set priorities with respect to goals, objectives, and implementation strategies. The guidelines for strategic health planning in developing countries developed by A. Green *et al.* (2002) recommends that we should consider a hierarchy of objectives which go from the general level to the very specific.[104] Priorities should then be set through a coherent and structured process in order to ensure of a positive outcome from the district plan.

II.3. Priority setting process

The literature distinguishes two major types of priority-setting processes in health:

"*priority setting for health research"* which consists of determining, weighting and ranking specific research topics and/or research questions, and

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"*priority setting for health service delivery*" which is about determining, weighting and ranking the interventions a health institution offers.[105]

The latest, which is also called "rationing" or intervention priority setting, is the one used in district health system planning, as it determines priority health care and services that are offered to the population. Whatever priority setting processes is considered, the overall aim is selecting priority problems based on clear criteria which lead to the goals, objectives and targets to be attained.

Prioritisation usually takes into account a wide range of criteria that can be grouped into two "major" criteria: the magnitude and the feasibility.

The magnitude certainly constitutes the first and most important criterion as it directly addresses the well-being of the population. In general, it refers to:

- ➔ The severity of the problem and its consequences (epidemic prone disease, incidence and/or prevalence of the problem, seriousness of its effects on health or to what extent it constitutes a danger for the life of the individual or the community);[98]
- ➔ The scope of the problem (proportion of population affected)

The feasibility mostly refers to the capacity to implement interventions, taking into account

- ➔ The means at our disposal such as financial, human, and material resources available;
- ➔ The environmental context such as socio-cultural, economic, geographical and political context; the timeliness and the level of development of the area. Criteria are selected to make sure the problems identified as serious public health concerns from their magnitude and can be addressed in a specific context and with the available resources.
- ➔ Challenges such as compliance with the national and international requirements, as well as the alignment within the global context
- ➔ The availability of valid and quality evidence/information/knowledge, including existence of a known intervention for the issue.

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Other criteria that may be considered include ***the impact*** that the plan can have on the problem (relevance of the proposed action/strategy/intervention)

With regard to the priorities set, there is now a need to appraise the best option for intervention.

II.4. Tools for priority settings

The health priority setting process is explained at great length in the literature and some tools are available. Two of the most common tools according to the literature are:

- **Priority Setting Process Checklist (PSPC)**.[106] This is a framework to prepare for priority setting using four priority setting methods (dotmocracy,[xv] paired comparisons, decision boxes, and grid analysis). It can be used to prepare for a priority-setting process, or as a reflection tool, after a priority-setting process is completed. The Priority Setting Process Checklist includes Data gathering, Meaningful stakeholder participation, Time (chronological and level of effort), Resources and Decision making.

- **Accountability and reasonableness framework**.[107]

The accountability and reasonableness framework proposed by Daniels and Sabin also described 4 steps in setting priorities:

- **Transparency:** Public visibility of the ethical framework/ principles/ rationale behind priorities
- **Relevancy:** Priorities should be set based on evidence, reasons and principles that fair-minded parties (including patients and clinicians) agree are relevant under the circumstances.
- **Appeal:** Opportunity to review decisions in light of new evidence/circumstances. Mechanism for challenge and dispute.
- **Enforcement:** Appropriate governance and accountability structures to ensure the above conditions are met.

[xv] " *Dotmocracy is an established facilitation method for collecting and prioritizing ideas among a large number of people. It is an equal opportunity & participatory group decision-making process. Participants write down ideas and apply dots under each idea to show which ones they prefer. The final result is a graph-like visual representation of the groups collective preferences.*" (http://www.kstoolkit.org/Dotmocracy accessed 30/10/2015)

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As one of the most critical steps in that process, especially in a scarce resource context, priority setting of identified issues is very lightly developed in the literature. However, in most cases the final priority process' action as described in the literature is to allocate a score to each problem in relation to its compliance with each criterion, then weight of the problems according to the goal set, and finally, the ranking is established based on the total score obtained for each problem.

In all the planning and priority setting tools that were reviewed, priority setting appears as a static activity (step) that occurs at a certain time of the process. However, setting priorities should be considered at each step of the planning process, from the identification of a problem to the selection of the relevant activities that will be implemented.

III. Review of the Reproductive health policy and plans in Cameroon

As recalled by WHO in its World Health Report 2000, countries should develop national policies and plans to strengthen their health systems. Moreover, decentralised decision-making on the details of service and intervention arrangements also requires investments in planning and management skills at all levels.[103] Like most of the countries, Cameroon has developed national health policies and plans to orientate the implementation of its national health areas of intervention. These policies and plans are inspired by and derived from the national health development plan, itself in line with the health sector strategy. At the lower level, strategic plans are developed by peripheral levels.

In the context of MDG framework, most of the countries with a high burden of maternal and new-born mortality and morbidity have developed national strategies / roadmaps towards reduction of maternal and newborn mortality and morbidity.[55] The review of existing documents at the national level revealed three major documents referring to the national policy in

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reproductive health before 2009, when the country developed the Growth and Employment Strategy Paper (GESP) 2010-2020[32] and requested the Health Sector Strategy and all derived policies, to align with it.

The first document covered the period before 2001, the "Norms and standards for reproductive health in Cameroon". This document was describing, in less than 15 pages, the norms and standards, as well as role and responsibilities for each level with regard to reproductive health service delivery in Cameroon.

In September 2000, the country developed a "Policy and Norms of reproductive health services" followed by a "Declaration of Reproductive Health National Policy 2001-2009"[108] released five months later in February 2001. The purpose of this September 2000 policy document was to align with the Health Sector Strategy 2001-2010 and to comply with the MDGs implementation requirements regarding reproductive health. The document defined the reproductive health national strategies, its financing, the implementation framework, and introduced the mother and child health related MDGs. In addition and to implement the policy document, a "Reproductive Health Strategic Plan"[109] was developed covering the period 2001-2009. These policies and plans were not implemented because they were seen as much too ambitious for a very limited funding.

In 2005, The National Reproductive Health Program (NRHP) 2005-2015 was set to address the alarming decline of reproductive indicators including maternal mortality. A "roadmap for reducing maternal and neonatal mortality from 2006 to 2015" was then developed, and gave the strategic orientation for the implementation of the programme.[110] The implementation of this roadmap also faced some challenges such as the lack of financing, monitoring and evaluation.

In 2009, the country undertook a series of updates of its reproductive health strategic documents to align them with the revised Health Sector Strategy 2001-2015 and the growth and employment strategy paper 2010-2020. The MoH then developed drafts of (i) a new national "policy of Reproduction Health Services", (ii) a document of norms of reproductive

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health services[111] and (iii) a strategic plan 2010-2015.[112] These drafts were neither finalised nor implemented.

In 2010, in order to fill the gap due to the absence of "implementable" national strategic document and despite the existence of the Roadmap 2006-2015, the country developed its "CARMMA[xvi] strategic plan", covering the period from 2011 to 2013.[113]

In 2013, in order to handover the CARMMA strategic plan which was coming to its end, the country developed the "National Policy for Reproductive Health", covering the period 2013-2020. The development of a strategic plan was initiated in 2015, but it is still not finalized.

Further to the development of a reproductive health policy and plan documents by the central level, the peripheral level had elaborated a strategic or action plan to implement the national priority strategies. At the peripheral level, maternal health is also fully included in reproductive health which is an integrated part of the district plan. During the current review, two types of plans were found to belong to the districts: A district strategic plan (health district development plans) covering a three year period starting from 2009, which was not renewed after 2012, and an annual work plan which is likely to be the main implementation reference document at the peripheral level.

III.1. The planning and prioritization processes at the peripheral level in Cameroon

III.1.1. The health district development plan

As mentioned in table 2.1, a guideline for elaboration of health district development plans was developed to help district managers to develop their strategic plans. The first step of this guideline refers to the "situation analysis" and includes a "stock-take" section which gives a full description of the context and a "diagnostic" section which analyses the functioning of the

[xvi] The Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA) is an AUC initiative that was officially launched in May 2009 with the aim of intensifying the implementation of the Maputo Plan of Action for the reduction of maternal mortality in the Africa region. (http://africa.unfpa.org/public/site/africa/pid/8804) visited 14/11/2014

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system, identifies strengths, weaknesses (problems), and possible solutions, and establishes priorities. In general, the main steps of the planning process described in the literature are taken into account in this first step. Identification of strengths and weaknesses describes what exists and lists the issues, providing probable causes and proposing a range of solutions. Prioritization mostly concerns categories of interventions. Priorities are selected from solutions that were proposed to address the category's issue, through a traditional ranking process. This ranking process takes into account technical and operational feasibility and acceptability by the community, with a particular attention on opportunities and threats. It is not clear whether the strengths are effectively taken into account in the prioritization process, as the analysis of strengths comes after the selection of priorities.

The second step of the guideline referred to as "Intervention logical framework" provides elements of the implementation plan with the detail of activities.. This step reveals that prioritization here concerns 16 (for the HD) to 17 (HDS, IHC/CMA) tracer interventions selected at the central level, out of the 78 categories of interventions defined by the country. These tracer interventions are analysed to produce corresponding outputs and activities of the concerned class of intervention. There is no specific guidance on prioritization for implementation's interventions and the link with the first step is not very clear. The third and final step described in the guideline, the Budgeting, describes norms and standards for intervention at the district level.

In general, Development objectives and strategies for the district health plans are set in the national HSS, and only operational objectives are formulated at the district level, based on expected outcomes for each type of intervention as set in the national guide (see Annexure 1 & 2). From the guideline, it is likely that district managers have a little flexibility in the choice of their strategic priorities and just take care of operationalization. Their only action thus appears to be on activities, for which they don't have any proper guidance to prioritize.

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Health activities and resources at district level are co-managed by dialogue structures representing a balanced partnership between the state (represented by the health staff) and the community. Following the 2009 SQI guide for district management teams referred to earlier, another guide was developed in 2010 to guide dialogue structures (health staff and community representatives at district level) in the management of health activities and resources. This 2010 guide describe the management cycle at district level as including three major phases: *planning, implementation and evaluation* (PIE).[49] While the planning phase consists of identifying problems, searching for resources and clear budgeting, the implementation phase gives directions on the execution of the plan, the monitoring of activities, and the control of level of realization and supervision. The evaluation phase is more a continuous event which regularly measures what has been realized against what was planned.

In the context of health sector strategic plans and the National Health Development plans using SQI, all health units and health system levels (health area, health district and regional delegation) have an obligation to plan for the Minimum Package of Activity (MPA) and Complementary Package of Activities (CPA) in their annual work plans and strategic development plans. This is done to complete the process and ensure viability of the district plans and attainment of the strategic development goals.

III.2. The plan of action (adapted from the guide for dialogue structures delivering Primary Health Care in Cameroon). [49]

In the Cameroon guide, 'health plan' is defined as a course of action to be followed by the dialogue structures in order to achieve the objectives set. It is developed based on one budgetary or financial year (January to December) and involves (i) *planning, (ii) implementation (execution), (iii) monitoring, (iv) evaluation and (v) reprogramming*. The plan of action is based on identified priorities and related needs of the community, taking into consideration the availability and efficient use of resources. The factors that are considered for prioritization are:

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- The Severity/danger to individuals and the community. Does the condition threaten life, cause major suffering, decrease the ability to lead a normal life, reduce productivity, and cause deaths?
- The Amenability to intervention (vulnerability). If a problem is not amenable to intervention because of technological requirements and other factors, it makes little sense to include it in the list of those targeted for action.
- The Cost of intervention: If the cost of solving a problem is too high then it will not be a priority.

The plan of action includes the health needs according to priorities; objectives to achieve, and indicators to measure achievements, as well as the global cost.

Setting an Action plan at the Health Area

At the level of the Health Area the plan of action is made by the Management Committee of the Health Area. A copy is forwarded to the District Chief of Service of Public Health. At the level of the Health Area the plan of action is initiated by the Health Centre Management team, presented to the Management Committee for study and modification by including other community felt needs. The Management Committee then submits the plan to the General Assembly for deliberation and approval. A copy is forwarded to the District Chief of Service of Public Health. At the Health District level the district plan of action is initiated by the District Management team, finalised by the District Management Committee and submitted to the General Assembly of the District Health Committee for approval. A copy is forwarded to the Regional Delegation of Public Health.

The Work Plan

In order to monitor and control the implementation of activities, the work plan should be developed in a six months or one year basis. This work plan proposes a list of activities or interventions and tasks that will be

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implemented during the period covered, to achieve the objectives of priority needs established in the plan of action. It takes into account eliminating non-working days; duplication of efforts; determining the most appropriate dates for carrying out of activities, etcetera. It includes:

1. Date of execution of activities
2. List of activities
3. Place of execution of activities
4. Person responsible
5. Cost
6. Sources of finances

Should it be necessary, activities not executed in one semester/year can be included in the next action plan. It is recommended by the country that the work plan is initiated at all levels by the technical staff and presented to the Management Committee for study and submission to Health Area Committee and District Health Committee respectively, for approval. The production of the district plans will take into consideration the plans of the Health Areas while the regional plans will be based on the District Health plans. This procedure develops integrated and harmonised plans.

From experiences in Sub-Saharan African countries, it was noted that strategic choices in policy making /planning are sometimes in contrast with the reality in the field. Considering the peripheral/district level, most of the time they are requested to identify their priorities from the national strategic health plan to build their local health plan. There is a concern whether strategic plans developed at the peripheral level effectively address their local priorities, or if they are just aligned on national, international or global priorities and standards.

Despite the fact that all the planning steps are followed, some policies are simply not reflecting or addressing accurately the local priorities. The planning guidelines for a health district level of Cameroon described almost all the major planning steps listed earlier and its priority intervention was provided by the central level through a predefined table (Annexure 1 & 2).

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However, the guideline was meant to cover a period ending in 2012 and was not updated to allow the development of further plans. As a matter of fact, there has not been any further health district strategic plan developed after 2012. However, districts continued to develop district annual work plans. A quick review of the annual work plan developed by two districts, showed very few activities planned for maternal health which is certainly a major national issue, given the national MMR. Knowing that the highest burden of MM is at the peripheral level, it seemed like district level priorities in maternal health, which are included in the national priorities, are not always tackled by their work plan. Priority tends to be given to activities pertaining to areas or programmes for which funds are available, like immunization, HIV/AIDS and malaria.

Challenges remain. A key problem lies with inherited inefficiencies and inequities in resource allocation, which make it difficult to improve access and quality in some areas. Solving these problems requires careful identification of challenges and priorities at the district level, as well as good planning and implementation.[95]

As regards the literature related to the planning process in Cameroon, there is at present no planning tool or guide to develop planning. Despite the existence of a national policy on reproductive health that includes maternal health orientations, to date there is no national strategic plan on maternal health which can help district managers with developing their plan and with which they can align their plan.

By analysing the steps of the planning process as described earlier in this literature review, priority setting appears as a cross cutting activity which can be considered at all steps of the process. Thus priority setting should not be considered only at the step following the listing of issues but throughout the process. As many strategies can lead to the defined goal, they should also be prioritized. Similarly, as many Objectives can justify a strategy, they should be prioritized, much the same as activities that are selected to develop the action plan. Furthermore, the action plan developed appears to be the final step of the planning process leading to implementation by the district level. It can

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therefore be considered as the most critical and practical step for the contribution of the district level to the implementation of the national priorities. A thorough research in the literature does not propose a clear and proper tool which would provide insight to the setting of priorities, or an appraisal of systems of prioritization of activities, that can be used by planners at the district level to overcome issues like scarce resource allocation, for a better and realistic plan of action. The lack of such a tool gave the impetus for the current research. The detailed methodology is described in the next chapter.

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CHAPTER III:

METHODOLOGY

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I. Goal and Objectives

1. Goal

The overall goal of this research was to build a tool for selecting and implementing maternal health priority activities. This tool would enable district managers to optimize the management of available resources to strengthen maternal health planning and practices, in order to respond more effectively to local maternal health problems, and thus reduce the burden of maternal health issues in their district.

2. Objectives:

The objective was to examine the barriers limiting the implementation of maternal health priority activities, and the opportunities for action to decrease the gap between national reproductive health policy and plans and a district plan of action as regards maternal health. The main expectation was to create a tool to help district managers in the planning exercise by identifying the different steps and elements to be considered for setting priorities in planning maternal health priority activities at the district level in the Cameroon context.

Specifically, the context of the policy-setting process in maternal health at the national level and of the planning process at the peripheral level in Cameroon, were described and analysed, taking into account:

- *The factors influencing it, that can be classified as*
    - Internal factors: social, political, economic, cultural.
    - External factors: National and International requirements, global partnership context.
    - Scientific factors: validity of evidence/information/knowledge.
- *The stakeholders involved* in the process: civil society, community, professionals, researchers, funders, and politicians.
- *The process itself*

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II. Work design and Methods:

The work was intended as a cross-sectional, descriptive and designed-based research

a. Study design

The research was divided into four main steps that are (1) the analysis of the situation, (2) the development of the prioritization tool and (3) the review and testing of the tool by district planning teams assisted by some regional and national stakeholders, and (4) finalization of the tool.

Practically, a two parts descriptive analysis was conducted using qualitative criteria to describe the process and to capture the views of decision makers: the first part was a documentary review and the second was interviews with stakeholders. A tool for setting and implementing priority activities in maternal health planning at the peripheral level was developed based on the analysis of results from the descriptive analysis. The usability, handiness and relevance of that tool were reviewed by stakeholders active in reproductive health in Cameroon, and tested by two district teams during a national workshop for an eventual further implementation by the Ministry of Health.

b. Study Settings

After a brief analysis of the content of reproductive health policies and plans at the central, intermediate and peripheral level and the link with global/regional orientations, a description was made of the planning process at the peripheral level (Health District). Further on, gaps and challenges were identified from interviews and observations, particularly as regards the priority settings step of the health district planning process. Mechanisms address these gaps and challenges were proposed for discussion. Reports from these discussions were compared with the description from interviews and the outcome was used to build the tool.

The work was performed in two districts, the District of Nylon in the Littoral region and the district of Maroua Rural in the far North region. The two districts were selected by a ranking process as described in the

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paragraph on “sampling methods”. Where community representatives were active, they were associated with other stakeholders involved in the planning process of the health district.

- **Phase I: Analysis of the situation**

After a thorough description and analysis of the health policy, planning environment and settings provided by a review of the literature, the bottlenecks and gaps were identified. The challenges for an effective planning process that takes into account major issues of maternal health at the district level in Cameroon were examined.

- **Documents analysis and literature review**

An analytical review of existing documents related to reproductive health policies and plans for the past 10 years was undertaken (national policies and plans are usually developed for a maximum period of 10 years). This analytical review was conducted from the global level to the peripheral level, with a particular interest on the two selected districts of the research (Figure 3.1 shows the three different levels). The document analysis was conducted based on the existing evidence on policymaking and planning processes, including available tools and methodologies. This analysis enabled me to identify the driving elements of the policies and gave an idea of the policymaking and planning process. The expected outcome of the document analysis was to provide an overview of existing policies and plans, and the guides and/or frameworks for their development.

The document analysis included Global/Regional strategic documents in maternal health (WHO, IMF, World Bank, and others), as well as relevant national reference documents that are relevant to organization and management of maternal health in Cameroon. These included the Growth and Employment Strategy Paper, the Health Sector Strategy (the national Health Policy reference document), the National Health Development Plan, the national and infra-national reproductive health policies and plans since 1990s. We also reviewed official texts/notes/laws; reports of activity; policy briefs; national and infra-national planning guidelines and research reports.

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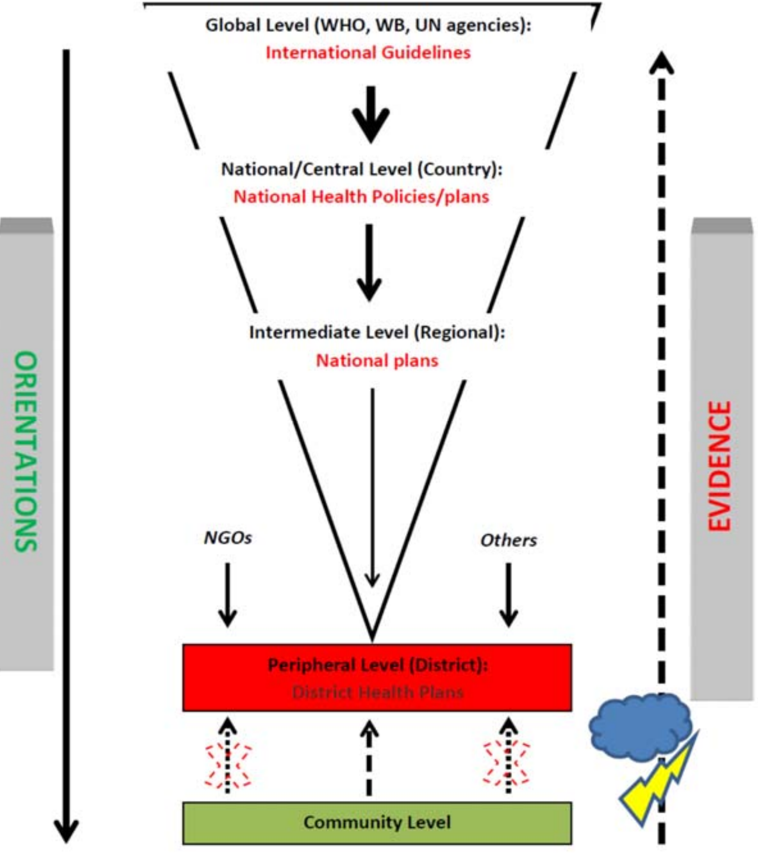
Figure 3.1: A model of application of policies/guidelines and use of Evidence



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Key Informant Interviews

One-on-one interviews of all the actors involved in maternal health policy setting and planning were conducted at both the National and the Health District levels. Two types of persons were individually interviewed: "*primary key informants*" referred to as all individuals who have primary responsibility for management of maternal health at central, intermediate and peripheral levels of the health system, who are involved in elaboration of maternal health strategic documents; and "*other stakeholders*" representing interested parties involved in the policy formulation at national level and in the planning process at the district level. Stakeholders or "interested parties" in this process are actors (persons or organizations) who have a particular interest in the maternal health policy/plan that is being formulated.

Analyses from phase I provided a thorough description of the current processes of setting maternal health policies at the national level and planning at the district level, including the methods for selection of priorities to be addressed. This Phase allowed us to determine how maternal health policies and plans are made in Cameroon and to identify the potential bottlenecks and gaps/missing points in the process.

- **Phase II: development of a tool for identifying priorities in the planning process at the health district level**

As an outcome from phase I, all the factors that are likely to influence and orient the priority settings during the planning process were identified, and the level of use of evidence in setting priorities was assessed. Based on the preceding, a tool for setting priorities in planning for maternal health activities at the health district level, using a balanced combination of evidence, external influential factors (financial, social, environment, politics, etcetera), and existing opportunities, was developed. This tool establishes a framework that provides a step by step guidance to the best identification possible of maternal health priority activities to be addressed in the health district plan of action, taking into consideration existing opportunities, evidence and other influential factors such as those mentioned above.

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- **Phase III: Finalization and adoption of the tool.**

Further to its development, the tool was reviewed by Maternal and Neonatal Health (MNH) and policy development national experts; then tested with health district teams, and finalized. A three day national review and testing workshop with stakeholders involved in any policy / planning process at national, regional and district levels was organized in Yaoundé from 3rd to 5th February 2015 for feedback of findings, presentation, review, and testing of the tool. Discussions were organized in working groups around the structure and the usefulness of the tool. The tool was tested by the two districts surveyed in a one day planning session and feedbacks and discussion followed in a plenary to ensure comprehension, ease of usage, and efficiency. Any incomprehension or other issue revealed by the test led to discussions and revisions of the tool until the tool was successfully accepted and fully understood by the users.

The expected outcome of this step was for us to get the feedback from stakeholders on the worth and the applicability of the tool; to finalize it accordingly, and to propose its adoption at the national level.

c. *The Sample:*

Two types of samples were considered: the sample of key informants (actors involved in the process) and the sample of districts.

→ Key Informants.

As described in phase I above, two types of key informants were identified for the national and district levels: the primary key informants and the other stakeholders.

- Primary key Informants:

- All the primary key informants concerned with maternal health policy setting/ planning were included in the survey. These include:

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- The head of the reproductive health programme (or unit in charge of the development of the reproductive health policy and planning development) at the Ministry of Health;
- Collaborators of the head of the reproductive health programme that are involved in the policymaking and planning process at the central level;
- The Regional Health manager,
- The District Health care manager
- The District Health service manager.

- <u>The Stakeholders</u>

Priority stakeholders from all categories were involved in the study. Categories of stakeholders included international, national, political, public/civil society, non-governmental organization (NGO), commercial/private, users, community, etc. Prioritization of stakeholders is described in the next section on sampling methods.

→ Health Districts

Two districts were sampled out the 183 districts existing in Cameroon: one from the top ranked districts and one from the bottom. The ranking process is described in the next section on sampling methods. Key informants from the two districts were surveyed.

The number of districts was influenced by the logistical limitation for the research, but the outcome could be scaled up by the MoH to a larger sample at a further stage.

d. *Sampling Methods*

→ Key Informants:

At the central level:

– No sampling was made for *Primary Key Informants* as they were all contacted to be part of the survey. However, regarding the *close collaborators*

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of the head of Reproductive Health department, a purposive sample was built through a "snowballing" process: the head of Reproductive Health department (or the highest coordinator of Reproductive Health) at the Ministry of Health provided us with a list of all his close collaborators involved in the reproductive health policy and planning at the national level. They were contacted for the interview.

– Regarding the selection of stakeholders at the national level, two steps were observed:

1st step: Identification of all the potential stakeholders who might have knowledge of or insight into reproductive/maternal health management in the country and have been involved in a national process for the elaboration of reproductive health strategic documents. A list of stakeholders was then built from:

(a) the review of existing information on the maternal health related official documents of the country, and

(b) the list of all the participants who attended the most recent national workshops for the elaboration of the current leading reproductive health strategic documents.

These strategic documents are

(i) "Reproductive Health National Policy 2013-2020",[52]

(ii) the "strategic plan for the implementation of the CARMMA 2011-2013" and

(iii) the "Roadmap for the reduction of maternal and neonatal mortality in Cameroon 2006-2015".

A non-exhaustive list of stakeholders was then built from the compilation of the different available lists of participants for the preceding year. Fortunately, the new policy had just been developed.

2nd step: from the first step, a restricted list of priority stakeholders at the national level was established. This list was built in consultation with the director of reproductive health and the chief of maternal health services who are the lead for all activities related policy and planning development for maternal health at the national level. They have extensive knowledge of the maternal health sector in Cameroon, its actors, and the influence of each of

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them on the reproductive health area in the country. Identified Stakeholders were classified according to its category as defined above.

At the district level, all key informants were selected for the survey. For the stakeholders, a purposive sample was built through a "snowballing" sampling process: a request was made to the district primary key informants to list the names of all the other stakeholders involved in the planning process at the district level. All of them became part of the sample.

→ Health District

For logistical limitations, two of the 183 health districts with different profiles were sampled by a ranking process, using the following range of criteria specific to Maternal Health (taken from the list of MDG5's indicators)[8]:

(i) *Maternal Mortality Ratio (MMR),*
(ii) *Antenatal care coverage (ANC),*
(iii) *Proportion of births attended by skilled health personnel,*
(iv) *Adolescent birth rate,*
(v) *Unmet need for family planning, and*
(vi) *Contraceptive prevalence rate.*

Districts were weighted according prioritization criteria set by the country to weight for maternal health burden as shown in table 3.1. The most recent official Indicator data was requested from the department of reproductive health of the Ministry of Health of Cameroon. When needed, missing data was sought from the latest country statistics documents (annual statistical reports). Other national documents were also consulted. The Ranking reference table for selection is provided in annexure 3. Taking into account the limited accessibility of some districts as well as the time and financial constraints, a convenient choice of one of the top-ranked health districts and one of the bottom-ranked districts was considered for the study.

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Table 3.1: prioritization criteria set by the country to weight for maternal health burden

Criteria of prioritization	Relative weighting of the criteria	Scoring scheme per criteria	
FAMILY PLANNING	10		
Contraceptive Prevalence	10	The scores are attributed proportionally to the performance as compared to the ideal of 100%, with a maximum of 10 points for the highest performance of 100%. Any performance above 100% gets the maximum score of 10 points.	Performance/100*10
ANTENATAL CONSULTATIONS	20		
ATT 2 (p 100 Live birth)	5	The scores are attributed proportionally to the performance as compared to the ideal of 100%, with a maximum of 5 points for the highest performance of 100%. Any performance above 100% gets the maximum score of 5 points.	Performance/100*5
At least one ANC1, by qualified staff (p 100 Live birth)	5	The scores are attributed proportionally to the performance as compared to the ideal of 100%, with a maximum of 5 points for the highest performance of 100%. Any performance above 100% gets the maximum score of 5 points.	Performance/100*5
4 ANC at least (p 100 Live birth	5	The scores are attributed proportionally to the performance as compared to the ideal of 100%, with a maximum of 5 points for the highest performance of 100%. Any performance above 100% gets the maximum score of 5 points.	Performance/100*5
Continuation rate in ANC	5	The scores are attributed proportionally to the performance as compared to the ideal of 100%, with a maximum of 5 points for the highest performance of 100%. Any performance above 100% gets the maximum score of 5 points.	Performance/100*5
DELIVERIES	25		
Assisted deliveries (p 100 Live birth)	15	The scores are attributed proportionally to the performance as compared to the ideal of 100%, with a maximum of 15 points for the highest performance of 100%. Any performance above 100% gets the maximum score of 15 points.	Performance/100*15
Caesarean section (p 100 Live birth	10	The scores are attributed proportionally to the performance as compared to the lower limit of the national norm of 5%, with a maximum of 10 points for the highest performance of 100%. Any performance above 5% gets the maximum score of 10 points. So long as it is not above the upper limit of the national norm of 20%	Performance/norm of 5*10
PERINATAL DEATHS	30		
maternal deaths (p 100 000 Live birth)	15	The scores attributed are proportional to the difference between district performance and the national rate of 699/100000 live births as compared to the latter with a maximum of 15 points for the lowest. Any negative performance (rate above 699/100000 gets 0 score	= (699-performance)*15 / 699
Neonatal deaths (p 1 000 Live birth)	15	The scores attributed are proportional to the difference between district performance and the national rate of 29/1000 live births as compared to the latter with a maximum of 15 points for the lowest. Any negative performance (rate above 29/1000 gets 0 score	= (29-performance)*15 / 29
Total	85		

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e. *Data collection and questionnaires*

a. The collection process

A letter was addressed to the Ministry of Public Health of Cameroon with the protocol and research tool to introduce the research and to seek authorization to undertake it. The request was forwarded to the reproductive health unit who provided us with the authorization to conduct the research, upon clearance by the national ethics committee. Once granted, the authorization was shared with authorities at the central, regional, district and community levels of the research targeted areas with the work programme for the visit to their places. To access the districts, authorizations were granted by the head of the regional delegation of health to which the each district belongs. Further down, health districts managers delivered authorizations to us to conduct the research at the health areas level.

Information was gathered through interviews of key informants and other stakeholders involved in the policymaking/planning process. Interviews were conducted by the principal investigator and recorded in a tape record upon consent of the interviewee, obtained beforehand through a signed informed consent form (*see Annexure 2*). The answers to the very few closed ended questions (mostly introduction of the interviewee) were marked directly on the questionnaire by the investigator.

Interview methods were "one-on-one" and "unstructured" interviews which allowed the investigator to interview one person at the time, following a standard set of questions, but gave a large scope to the investigator to dig more into some of the respondent's answers. Cameroon is a bilingual country with almost 80% francophone people; thus the interviews were conducted mostly in French and translated into English by the investigator. Information collected from interviews was then extracted from tape records and analysed under some corresponding predefined topics.

b. The questionnaire

The Questionnaire for the interview was adapted from the Policy Implementation Assessment Tool (PIAT) developed by USAID/Health Policy Initiative, combined with other relevant tools used in various related

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studies;[58,114] all adapted to the Cameroon context (*Annexure* 4). It had open ended questions to get a thorough description of the policymaking and planning process and some closed ended questions to evaluate the self-appreciation and vision of interviewees of the current process. Regarding the survey at the peripheral level, the questionnaire placed particular emphasis on the priority setting phase of the planning process.

The questionnaire outlined five dimensions that may influence policy formulation and the Implementation planning process:

I. Basic Information about the Policymaker

II. The Policy, Its Formulation, and Dissemination

a. Identification of stakeholders involved in the policy formulation process (who is involved? who decides who is involved? What are the involvement criteria? Is there any stakeholder's analysis prior to the planning?) -– Stakeholders analysis guideline).

b. Level of involvement and influence of each stakeholder

c. Policy setting (National) and planning (District) processes

→ How are problems and issues defined and constructed?

→ How are they chosen for political and policy agenda?

→ How priority options emerge?

→ How and why governments act or do not act

→ What are the effects of government policy?[79]

d. Factors influencing maternal health policy/plan (driven factors): what are the major factors, elements, indicators and references taken into consideration in policy formulation; what are the primary points of interest.

e. Place of research findings, National Health Information System (NHIS) and other existing knowledge in the policy setting/planning process

f. Sources of information used to set policies

g. Validation of information/knowledge included in the policies (including validity of the validation) (who validates information/knowledge)

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III. Social, political, and economic context
IV. Leadership and governance
V. Implementation
    a. Stakeholder involvement in policy implementation
    b. Implementation planning and resource mobilization

In addition to those five dimensions, the questionnaire for district planning assessment put a particular accent on a sixth dimension: Criteria for selecting priority problems describing and explaining the setting of priorities in maternal health planning process at the district level.

Regarding the working group discussions during the review and finalization process, discussions were led by the principal investigator as facilitator, focusing on:

i. The feedback from participants as regards the findings
ii. Propositions for improvement (to optimize the use of evidence, context and individual factors in setting priorities)
iii. The way forward

f. *Pilot study*

We conducted a pilot study to test our data collection tools on a sample of participants with the similar characteristics with our sample. They were two key officials from the reproductive health unit of the MoH, the regional focal person of one region, and one district health manager from a mid-level performing health district. The pilot was preceded by a half day meeting with stakeholders to explain to them the interview's questionnaire and to receive their inputs. After the pilot survey, the questionnaire was revised and finalized by the principal investigator and ready for use.

g. *Local partner*

An agreement was concluded with a local research institution, the Centre for Development of Best Practice in Health (CDBPH) based in Yaoundé, to benefit from the working environment resources, their strong

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experience in the health system of Cameroon and their solid network of Cameroonian health workers. Researchers from the centre were briefed on the research during a 2 days training workshop. They were able to contribute to discussions and assist in the logistical organization of the workshop.

h. *Quality assurance plan*

The information gathered with the participants was crossed-check with reference documents when available, or with the findings of the document/literature review. When discrepancies were observed, we either went back to the interviewee for clarifications or classified it as 'unknown' answer.

i. *Analytical strategy*

Almost all the data were qualitative. Once collected, answers were transcribed under each question of the questionnaire as shown in annexure 5, then transferred into an Excel file (template available upon request). The data and inputs were checked and clarifications were sought when needed. An example of comment noted to seek clarification is showed in page 9 of annexure 5. Subsequent to this step, answers were grouped under some themes/topics for analysis and discussion.

III. Ethical and Legal considerations

1. Approval of the study by the relevant departments

- *Cameroon:*

Ethical approval was obtained from the national ethics committee of Cameroon, and administrative approvals were obtained from the department of reproductive health for the central level, and the regional delegation of public health for each of the regions surveyed. (*Annexure 6*)

- *University of Pretoria:*

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The protocol obtained approval for both the Ethics Committee and the Academic Advisory Committee *(Annexure 7)*

2. Consent

An Informed consent form (*Annexure 8*) was shown to and discussed with the interviewee, and signed before the beginning of the interview. This form included information about the research and was accompanied by the official approval letter from the director of reproductive health.

3. Privacy of information/confidentiality

Privacy of information and confidentiality was guaranteed to the interviewee in the informed consent form. Furthermore, a special mention was specified in the brief to every researcher involved in the survey, about the respect of the privacy of information and confidentiality of people with whom they may have been in contact during this study.

4. Conflict of interest & responsibilities of staff and/or investigators (Contributors and authorship)

All the persons who participated to this survey had their roles, responsibilities, and rights clearly explained and specified. Responsibilities of staff were aligned with the current rules and regulations in force at University of Pretoria (UP).

IV. Budget/ Resources

The research was almost fully self-funded by the principal investigator (PI) (travels, field activities, material, logic, etc.). The only external funds came from the World Health Organization's Country Office in Cameroon who provided 70% of the funds needed to organize the review and testing workshop, the 30% remaining being funded by the PI. Detailed budget is shown in the *annexure 9*.

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Apart from the UP premises, the CDBPH provided material support through the use of their offices, the secretariat, for some printing, scanning, and access to internet; and their library which offers important national information and documents.

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CHAPTER IV:
FINDINGS

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<u>Summary:</u>

Findings indicate the existence of a reproductive health policy 2001-2009 as well as a strategic plan covering the same period, that were never implemented. Later, the country developed the "roadmap for the reduction of maternal and neonatal mortality in Cameroon" covering the period 2006-2015[110]. This roadmap was only partly implemented and led to development in 2009 of a new reproductive health policy and a new strategic plan for 2010-2015, which were never disseminated nor implemented, because of financial constraints. To compensate for the weak implementation of the reproductive health roadmap, Cameroon developed, in 2010, a strategic plan in the form of its "Campaign on Accelerated Reduction of Maternal Mortality in Africa" (CARMMA) which took into account some elements of the roadmap. The CARMMA strategic plan covered the period 2011- 2013. In 2012 however, the country developed a new reproductive health policy 2013-2020 to align with the NHDP and the HSS, but they did not simultaneously develop a new strategic plan. It appears therefore that the implementation of reproductive health strategies is still ruled by the CARMMA strategic plan which was due in 2013. This multitude of overlapping documents of policies, plans and strategies has contributed to the confusion and delayed implementation of maternal health priorities. It also created discrepancies in the implementation of any plan by the different levels, as it weakened the lower level which did not have clear and updated orientations for their planning in maternal health.

As described in the literature review, Reproductive Health policy is developed at the central level. The peripheral level is expected to develop a district strategic/action plan, based on the policy, as the platform to implement national priorities. Maternal health is linked to reproductive health, which is an integral part of the district action plan, together with other programmes. The findings showed that district action plans are more likely to be driven by a national framework and do not take into account all the elements of their

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local context. On the other hand, tools to guide the elaboration of district health development plans which existed for the district level, were found to be sometimes not well known or understood by targeted users. Currently, there is no district planning tool at the peripheral level. Planning is now left to the discretion of district managers, without any supervision or support from higher levels. The process of developing plans as described by the district level is not comprehensive or inclusive of local aspects, issues and opportunities; it just attempts to respond to national priorities.

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I. Description of the sample

Table 4.1: Description of the sample:

		Central level	District A (Good performer)	District B (Lesser performer)
Total		**12**	**9**	**15**
Gender	Males	3	4	13
	Females	9	5	2
Profession	Medical Doctors/public health	7	6	2
	Nurses	3	3	14
	Others	2	0	1
Sector	Government/Public	8	9	14
	Development partner	2	0	1
	National NGO	2	0	0

A total of 36 persons were interviewed out of the 52 who were targeted from the lists we developed with central and peripheral levels key informants. The two districts surveyed covered 9 and 18 health areas. In general few people actively participate in the planning exercise at the district level; it is mainly the chief of a health district and the chiefs of health areas pertaining to this district. This is due to a lack of funding to invite more people, particularly community members, to participate in this exercise.

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II. Findings at the National Level

The development of the current reproductive health national policy of Cameroon brought together around 25 persons from different institutions and government departments. Almost all of the participants were from the national level. The process was undertaken through a one week workshop after some preliminary analysis of the situation conducted by the department in charge of reproductive health. For the current research, twelve participants from the national level were interviewed. These included officials from three ministries (health, promotion of women, and social welfare); national NGOs; United Nations agencies; and bilateral partners. All were involved in policy development and strategic orientations of maternal health at the national level. The responses indicated that there was a national policy for reproductive health as a whole, which included maternal health as a full topic. There was no specific national policy exclusively for maternal health. This reproductive health policy is centred on four sections and eight priority components. The four sections include men, women, child and adolescent health. The eight reproductive health components that are a priority in Cameroon include:

- maternal and child health,
- family planning,
- prevention of sexual transmitted infections and AIDS (STI/AIDS),
- prevention of childlessness/infertility and sexual dysfunction,
- prevention of harmful practices
- adolescent health
- genital and breast cancers and
- reproductive health of the elderly.

The goal of the policy is to improve sexual and reproductive health of the population of Cameroon. The particular targets are women of childbearing age, adolescents, children under five years old, the elderly, men, and marginalized and vulnerable people. The policy identifies three types of needs to be addressed. The first type, *the health care needs*, includes

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community based services, integrated and quality reproductive health services at the level of the health district, sufficient number of reference health facilities that are able to provide Comprehensive emergency obstetrical care, young and adolescent services, management of obstetrical fistula and management of gender based violence. The second type of needs concerns the resources and includes skilled health personnel, personnel providing reproductive health community services and sufficient financial resources in all facilities providing reproductive health services. The third type of need is the legislative need which requires an adaptation of existing law to include new sexual development and implementation of international initiatives which have been ratified by the country.

II.1. Formulation and dissemination of a reproductive health policy

(i) Relevance of a policy regarding the key issues of maternal health in Cameroon

Almost all the key stakeholders interviewed said that the policy's goals and objectives as they are set in the current policy (described above) do not necessarily address all, but do tackle most, of the key issues of reproductive health in Cameroon. The main justification that most of the key issues were addressed is that the process of formulating the policy included a country-wide situation analysis which led to an identification of those priority problems which the policy needed to address. Moreover, the fact that maternal, neonatal and child health as well as adolescent and male sexual health were all tackled in the same policy, has favoured an integrated vision of reproductive health for the country. Regarding the specific area of maternal health, respondents from the central level likewise recognized that the current RH policy does not address all, but does consider most of the key maternal health issues at the national and at the peripheral levels. They did however also highlight the fact that the situational analysis "*should have*

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included more districts for a better coverage of priority problems at the peripheral level".

(ii) Development/formulation process of the reproductive health policy at national level

➢ Selection of stakeholders involved in the development of the policy.

All the main stakeholders involved in maternal health activities in the country and represented at the central level were consulted at different stages of the policy development process. The selection of stakeholders invited to policy formulation and validation workshops, was done by the Ministry of Health and those most influential in the implementation of reproductive/maternal health interventions in the country: "*The selection of stakeholders was done by a core group put in place by the MoH under the coordination of the technical adviser N° 2 of the MoH in charge of women and child health, and the Director of family health*"; "*The core group met and decided, from their knowledge of the stakeholders active in the field of reproductive health, which of them will take part in the policy development process*". The final list of stakeholders involved in the RH policy development process included:

- Other key departments of the Ministry of Health such as Department of Health Planning, the Health Sector Strategy unit, and the Health Information unit;
- United Nations agencies dealing with women and children's health (UNICEF, UNFPA, and WHO);
- One bilateral partner, The German International Cooperation (GIZ);
- One national Non-Governmental Organization (NGO) named CAMNAFAW;
- Representatives of two national women's associations working in the maternal health field, namely OFFSAD and FESADE,
- Representatives of three national professional associations: the Society of Gynaecologists and Obstetricians of Cameroon (SOGOC),

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and the Cameroonian Society of Paediatrics (SOCAPED); and the Association of Midwives of Cameroon.

- Other international NGOs working in reproductive health,
- Care and Plan International; and other ministerial departments concerned with matters relating to women :
- The Ministry of Women's Empowerment and Family (MINPROFF); and
- The Ministry of Youth Affairs and Civic Education (MINJEC).

➢ Level of involvement and influence of each stakeholder

The Ministry of Health of Cameroon was recognized by all the respondents as the lead of the reproductive health policy development process through its Department of Family Health (DSF). Contributions of each stakeholder varied as per their level of involvement in the implementation of interventions in reproductive health, either by financial or technical contributions. During the process, the DSF had the major role to play, as they coordinated the process, provided national priority orientations, and set the framework for discussions. The UN agencies dealing with women and children's health (UNICEF, UNFPA, and WHO) had the important role of ensuring that the policy fitted into the context of internationally agreed goals and that the process benefitted from latest global developments and standards. As showed in Table 4.2, built from the answers of respondents, stakeholders were variably involved in the process

Table 4.2: Extent of involvement of various stakeholders during the process of formulating the policy

1. No involvement	**2. Limited involvement**	**3.Moderate involvement**	**4.Extensive involvement**
	SOGOC SOCAPED MINJEC	OFFSAD FESADE MINPROFF CARE PLAN International	GIZ WHO UNICEF UNFPA CAMNAFAW

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With regard to the influence of the different stakeholders a respondent from the central level affirmed that "*Each stakeholder has an annual working plan and most of the time, the counterpart department of that stakeholder at the ministry participate to the development of that annual working plan; therefore, each department knows which stakeholder does what on the field of RH and none of them can do anything if the MoH is not included*". However, as one of the bigger funders of maternal and child health, it is likely that UNICEF and UNFPA partly influenced priority areas based on their agenda and the funding that they provided to these areas. This has not always been good to the country as a respondents felt that "*these inputs from partners have contributed to widen the scope of national policy, making it irrational in the context of Cameroon and hardly implementable with the resources available*". WHO as a technical partner exerted the most influenced in the formulation process and the relevance of the technical content. The bilateral partners included the German International Cooperation (GIZ) which was mostly involved in implementation and rather less in funding. They did however emphasise that community priorities differ from field realities and insisted that the realities in the field be recognised and considered when setting community priorities. GIZ brought an insight on maternal health issue in rural zones and emphasised the need for the sustainability of financing of the plan to make it implementable at the peripheral level. Other participants such as the NGO CAMNAFAW and the representatives of women's associations (FESADE and OFFSAD), that were more concerned with implementation, brought in another community perspective and vision, especially in maternal health aspects. Further participants were mainly involved in operational research and implementation; they included professional associations, some international NGOs (CARE and PLAN International) and other ministerial departments. This last group of stakeholders had a much lower influence and made fewer contributions to the policy.

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➢ Process of Identification and prioritization of problems

Identification of maternal health problems during the reproductive health policy development process followed the analysis of the situation. Potential factors that could justify each issue revealed by the situation analysis were listed, and classified by categories, namely; social factors, legislation/policy, finance, and management and coordination. An analysis of bottlenecks was then conducted for each area using the "*Rapid Assessment of Life-Saving Interventions and Commodities for MNCH*" (RAIC) tool, a tool that was developed to assist countries in sharpening their RMNCH plans. This is a tool that incorporates two introductory topics on country profile and health system's information, followed by eight modules that are:[115]

(i) a checklist for review of the national RMNCH Plan including situational analysis and the process;
(ii) the RAIC for Reproductive Health Program Analysis;
(iii) the RAIC for Maternal Health Program Analysis;
(iv) the RAIC for Newborn Health Program Analysis;
(v) the RAIC for Child Health Program Analysis;
(vi) the Bottleneck Analysis which includes the analysis of implementation of RMNCH selected indicators ;
(vii) Procurement Agency Assessment; and
(viii) Regulation Agency Assessment.

The Bottleneck Analysis also helped to understand the influence of contextual factors like social, cultural, political, economic factors on the implementation of the policy (see Table 4.3). This table was completed using the results of the situation analysis presented in annexure 10. Once the Bottleneck Analysis was completed, a "bottleneck analysis workshop" was organized where identified problems were discussed, probable causes listed and some strategies proposed to address the causes as shown in Table 4.3 below:

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Table 4.3: Bottleneck Analysis of reproductive health conducted during the policy development.

Area	Bottleneck	Major cause	Strategy
Social factor	Persistence of certain harmful traditional beliefs and practices	Low prioritization of activities related to communication on the use of health facilities	Develop and implement an integrated communication plan on the benefits of using RMNCH services
Legislation / Policy	Absence of a legal and technical framework for assisting delivery	Lack of a formal framework of collaboration between care providers and Traditional birth Attendants (TBA)	Establish a framework for formal collaboration between care providers and TBAs
	Poor alignment of development partners on national operational plans and weak harmonization of procedures and processes	• Low negotiation capacity of government • Non-compliance with the terms of the health sector's cooperation	• Strengthen the capacity of managers on leadership and partnership . • Monitoring of implementation of agreements
Finance	Financial barriers to access RMNCH services	• Absence of a clear policy on demand-based financing • Very little evidence on priority based financing mechanisms	• Elaborate reforms that place emphasis on equity • Advocacy for the development and implementation of mechanisms for priority-based financing of health care in health districts • Scale up successful experiences of performance based financing

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	No harmonized cost pricing for RMNCH interventions	Weak regulation of the health sector	Re-evaluate and set RMNCH interventions costs by type of health facility
	Mismatch between budget allocation and funding required to achieve the health goals	• Low accountability in the management of resources • **Weak prioritization capacities**	• Establish mechanisms to increase accountability at all levels • **Establish a clear mechanism for setting priorities**
Management /Coordination	Bad governance	Corruption	Set up a system to promote quality of care (accreditation)
		Non-compliance and non-application of the texts	Apply sanctions
	Lack of effective and efficient implementation of RMNCH activities at all levels	• Weakness of the leadership • Weakness of the decentralisation process • Insufficient financial resources for coordination and implementation of RMNCH interventions	• Strengthen leadership in the delegation of priorities RMNCH • Increase the transfer of competencies and responsibilities from the central to the regional level • Advocacy for integrated planning and implementation of health activities at all levels
	Low involvement of partners in the integrated planning of health activities at all levels	• Insufficient coordination of partners	• Advocacy for participation of partners in integrated planning of health activities at all levels

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Following the identification of problems through the Bottleneck Analysis, prioritisation was done by considering the magnitude of the problem (prevalence/incidence, severity…); its feasibility (Infrastructures, human resource, material…) and the context (socio-cultural behaviours, economical factors). Prioritization then happens by "*consensual agreement on the scores provided by each stakeholder for each problem identified*". Strategies are then elaborated to address the selected priority problems. "*Those priorities and strategies were used as the backbone for the development of the policy*".

➢ Involvement of intermediate and peripheral levels (region and district)

The weak involvement of the peripheral level in the reproductive health policy development was recognized by all the respondents. However, one respondent from the department of health mentioned that "*the views of some health district or region managers were sought during the situation analysis and taken into account in the bottleneck analysis*". A review of the list of participants that attended the policy development workshop (annexure 11) confirmed that one district manager was present (CSSD of EFFOULAN). However, further investigations revealed that this district manager had recently been appointed as district manager in an urban district, and was just coming from a central level position in the department of reproductive health. Contributions from that health district manager were thus likely to reflect more a national level vision than a district one.

➢ Use of the guidance tool for the development of the policy:

There is no real guidance tool that is used during the reproductive health policy development process. The Health Planning Department was invited to provide their expertise in this area and assist in strengthening the tool. The only tool used during this process is the RAIC tool for identification and prioritisation of problems. The main advantage of this tool is that it helps in various steps of the process, from the analysis of the situation to the listing of issues, identification of bottlenecks that will be used to

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prioritize issues and, to define the different strategies to address them. Moreover, the tool also provides the influence of the context as the tool is divided in some contextual areas as described above. However, the tool does not provide a proper framework for prioritization of problems and this prioritization still needs to be done separately.

(iii) Dissemination

In general, the document was made available at the Ministry of Health and an electronic copy sent to national partners who contributed to the formulation process. The policy was not systematically printed in a paper version. Other implementation agencies, NGOs and associations received the policy document upon request to the Department of Family Health. "*The intermediate and peripheral levels are informed of a new policy but the policy document is not automatically sent to them".*

II.2. Planning and Implementation of the reproductive health policy

As recognized by the stakeholders, the need for a national strategic plan is essential for a successful implementation of the reproductive health policy. As mentioned before, a strategic plan was drafted in 2009 but for reasons which are not clear, had never been validated or implemented. In the meantime, the CARMMA strategic plan 2011-2013 was used as an implementation reference document for the reproductive health programme. This document was developed in line with and taking cognisance of the previous reproductive health policy and the international recommendations to reduce maternal mortality. No strategic or implementation plan has yet been developed to sustain the current reproductive health policy. Until an effective implementation is put in place, it would be difficult to achieve the result expected by the policy.

Although the CARMMA strategic plan has been useful so far and received strong support from the highest Cameroonian authorities including the first lady of Cameroon, policymakers are still not very comfortable with it as it is more focused on maternal mortality and does not cover all the priority

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areas of reproductive health. Moreover, they feel that the CARMMA strategic plan remains a "*juxtaposition of different annual working plans of different international partners and tends to reflect more the international orientation than it addresses national or infra-national priorities*".

Another document that drives the implementation of the maternal health policy is the national health development plan, which reflects the health sector strategy and includes a section on reproductive health. When the CARMMA strategic plan was not available, some stakeholders had to refer to the national health development plan for the implementation, and it helped in providing the right orientations.

(i) Financial resources

It was mentioned by all the respondents, that financial resources being allocated for implementation of the reproductive health policy are insufficient. In fact the overall budget allocated to health in Cameroon was around 6% of the total national budget in 2013, very far below the 15% recommended by Abuja declaration[19]. "*This insufficient budget has seriously slowed the implementation of reproductive health policy*". Furthermore, the various bottlenecks that have been identified in the disbursement of funds allocated to reproductive health have made reproductive health interventions harder to implement. As a result, the country developed a "donor dependency" in regards to the implementation of reproductive health activities, which showed its fragility in the past; like "*when USAID was withdrawn from Cameroon in 2004-2005, the family planning services collapsed as USAID was the sole funder of that strategy. In 2013, for the first time, the government has allocated money for contraception, and now the direction of family health is trying to reposition family planning services; they took it as a priority to the government, and put a budget place for that*". Respondents recognized that to address these bottlenecks the DSF must develop plans that result from a good prioritization exercise. This assertion also became apparent from the bottleneck analysis (Table 4.3)

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(ii) Operations and Services

- Coordination of the implementation of reproductive health policy.

The coordinating function of the various stakeholders that are implementing the reproductive health national policy is performed by the DSF. A few meetings are organised from time to time by the direction to brief partners on the situation of reproductive health and to get feedbacks from them on their activities. Although this coordinating function is in place, some actions were still not harmonized with the national agenda. The country has thus put in place in 2014, a Multisectoral Program to Reduce Maternal & Child Mortality (PNLMM). This programme coordinates and harmonizes reproductive health interventions of stakeholders from public and private administrations, technical and financial partners, civil society, community and traditional leaders, etcetera. The PNLMM is quite new and has just developed its strategic plan 2014-2018. The results of its action are not yet measurable.

- Flexibility of adaptation with regard to the policy

In response to the question of whether or not it was possible for the national policy to be adapted by implementers in case of need, a policymaker explained that *"as it is developed, the policy is quite clear and rigid; to make sure that all the implementers are aligned to it"*. He further argued that *"this is the only way to avoid donors and/or partners to create fragmentation of the health system"*. The reproductive health policy just allows key implementing organizations a very little flexibility to adapt strategies and activities to respond to local maternal health needs. Another reason for this rigid policy which allows very little room for change or adaptation is the "*harmonization of field interventions for monitoring and evaluation through a single national M&E frame/plan*". In fact, views on this topic varied but two main trends which were highlighted were: On one hand, some stakeholders explained that allowing flexibility may shift into uncontrolled implementation of unplanned activities. On the other hand, other stakeholders think that the policy should

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be more flexible, as far as any adaptation can be financially covered. However, in any case, the budget allocation is not really flexible.

(iii) Feedback and results

- Existence of feedback from and to the field

Although the new policy has not yet been implemented, "*some feedback on how maternal health components of the reproductive health policy is being implemented has been received from the regions in regard to the implementation of the CARMMA strategic plan*". The feedback arises mostly from selected indicators at national level, These include *inter alia* assisted deliveries by skilled staff, contraceptive utilization rate, and so on. The information is collected to produce semi-annual reports. However, these reports are most often incomplete as some regions are still sending feedback for only three months out of six.

The feedback from the central level to intermediate or peripheral levels is non-existent.

- Monitoring of implementation

The Department of Family Health is in charge of the implementation of the reproductive health policy. At present there is no validated plan of M&E. It is expected however that there will be a section on monitoring in the strategic document, as this is a requirement of the policy.

- Management of information / Use of evidence

The information is coming mainly from National Health Information System and is used during the situation and context analysis to identify the magnitude of the problem. Because of the weakness of the NHIS, periodic surveys are used to undertake situation analysis and take decisions

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II.3. Overall self-assessment of the reproductive health policy and its implementation

Stakeholders at central level are of the view that the goals and objectives of the reproductive health policy 2013-2020 as described earlier are achievable within the timeframe set out in the policy. They argue that the result of bottleneck and context analysis has enabled the policy to tackle the priority reproductive health issues. A lesson learned in providing services under the reproductive health policy has been the improvement of obstetrical and neonatal care, training, and community participation and involvement. An innovative and successful initiative at the local level has been training of community relay agents[xvii]. They have helped to boost quality access to health care and community participation, and their major role in health education has contributed to improve the prevention of mother to child transmission (PMTCT) and the integrated management of child disease (IMCD) in a significant way.

The main challenge is implementation, which can only be completed when strategic and/or operational plans are developed

III. Findings at the District Level

Introduction

The district level has a specific configuration regarding the development of strategic documents. As this is the implementation level, the reference strategic or guiding document at the district level used to be the “Plan de Development sanitaire du District de Santé” (health district development plan) -PDSD-, developed for a period of three (3) years. The implementation document at this level is the “Plan de Travail Annuel”-PTAs (Annual work plan) which stands as the plan of action as described in the literature review.

[xvii] Those are equivalent to Community Health Workers (CHW): in Cameroon they prefer Community Relay Agents, to avoid any confusion with "health workers". Their role is mainly to facilitate contact between the community and the health facility.

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At the level of "health areas", chiefs of health areas are encouraged to develop action or work plans for their areas. Unfortunately, only one edition of the PDSD was developed covering the period from 2009 to 2012. For some unknown reasons the PDSD was not developed further since 2012; the information collected at this level of the survey has thus focused on development of PTAs, and particularly on the process of prioritisation of activities that should address the maternal health issues and challenges faced by the stakeholders of the district.

The people interviewed at that level were those involved in the planning process at the district level, as identified/listed by the health district manager. As showed in Table 4.1 of the description of the sample, most of the health district staff are medical doctors, nurses and midwives. The distribution of these staff members in the two districts shows a disparity in the type of staff: In the so called high performing district, five (5) of the health area managers interviewed and the health district manager were medical doctors, while three (3) were nurses. In the lower performing district, only two medical doctors were found to be involved in the process, including the health district manager; In 13 health areas there were only nurses and one was a nurse auxiliary; There was no midwife. In the lower performing district, 18 health areas were concerned with the planning process and we managed to interview 14 of them, in addition to 3 health district managers.

→ *Knowledge of the national reproductive health policy/strategy*

None of the health district managers and or other district relevant stakeholders (mainly chief of health areas) were aware of the existence of a national policy/strategy document for reproductive health. Indeed, they had never seen it. Therefore they could not really talk about the content. However, regarding the actions implemented at their level in Reproductive Health, they all think that what is being done by the central level with regard to improving maternal health at health district and community levels is insufficient: a district manager reported that "*One of the biggest problems faced here is abortion, but because of political reasons, there was nothing*

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recommended by the national level in this sense, and thus no allocation is provided to plan activities related to it".

Description of the District context

The two districts selected were district of "Nylon" and district of "Maroua Rural".

➔ The district of Nylon belongs to the city of Douala in the Littoral region. It is located in an urban area and divided into eight (8) health areas. The district covers a total population of more than 380.000 inhabitants and is influenced by a high migratory flow among its neighbouring districts. In this district, the regional level is not often solicited for references; "*most of the time references are sent directly to "Laquintinine hospital"* [which is a national reference hospital] *as it is not too far*".

➔ The second district, the district of "Maroua Rural", is located in the city of Maroua, in the Far-north region; a region with a "Sahelian climate" (long dry season and little rain), and where people's behaviour is still influenced extensively by cultural, religious and traditional beliefs. The district of Maroua Rural covers 17 health areas among which two can be considered to be urban areas and 15 rural areas. There is an average of one health facility per health area. However, two of the rural health areas are not functional and depend on the health facilities of their neighbouring area. The first level reference hospital of the district is a faith based hospital (CMAO Meskine) located in the health area of "Meskine" one of the urban areas. The total population covered by the district in 2012 was 201 174 inhabitants of which approximately 7% is not directly covered by a health facility. Table 4.4 and 4.5 give us an overview of its functional organization:

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Table 4.4 : overview of the organization of geographical accessibility of the population covered by Maroua Rural

Health area	Name of the Health Facility (HF)	Type of HF	Status	Name of the villages covered by the HF	Population	Walking distance (from village to HF) Hr	min	% of population living at less than 5 km from the HF	Distance HF to 1st level reference km
Dagai	Dagai	Health Integrated Centre (HIC)	Faith based	Dagaï Centre	905		0	17	60
				Kossel Djaolé	402	2		0	60
				Louguéré Velvel	603		15	11,34	60
				Moudouvar	429		39	8	60
				Ndjerving	325		15	6,11	60
				Ouro Karba	818	3		0	60
				Ourogotel	683	2	30	0	60
				Touloum	386		30	7,06	40
				Zama	764	1		14,37	60
Dargala	Dargala		Public	Alakiré	478		30	0	40
				Ayaga	4 625		15	28,53	40
				Gassayel	351		30	30,71	40
				Hardéokessouwo	469		30	0	40
				Sitibirli	6 191	1	30	0	40
Dogba	Dogba		Faith based	Dogba centre	14 960		30	49	45
				Foftourou	553	3		0	45
				Godjigodji	2 315	3	35	0	45
				Mazaguaï	2 942	3	20	0	45
				Ouro Hassana	900	4		0	45
				Ouro Hayatou	682	4	30	0	45
				Ouro Modibo	2 280	4	30	0	45
				Soukoungo Abdoua	818	3		0	45
				Wirdiwo	1 879	4		0	45
				Doga Maoundé	3 306	2	30	0	45
Gawel	Gawel		Public	Badam	1 761	3		0	45
				Fakalao	3 783	2		0	45
				Gawel Centre	1 358		30	17,9	45
				Hardéo	1 375	2		0	45
				Kalaï	1 231	3		0	45
				Kibeng	760	3		0	45
				Mayel Gaïma	216	2		0	45
				Mayo Bantal	1 755	1		23,13	45
				Moudoumboui	521	3		0	45
				Tchofi	1 837	2		0	45
				Wouyang	1 139	2		0	45
				Zamala	866	2		0	45
Gazawa	Gazawa	CMA		Barza	802	1	30	0	20
				Gazawa centre	10 347		15	57,33	20
				Ibbao/Ngariwa	775	1	30	0	20
				Makoumba	427	3		0	20
				Mbankara	1 978	1	30	0	20
				Minawa/Mayel	1 550	1	30	0	20

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				Naoudé					
				Miziling	802	4		0	20
				Péré Péré	749		50	4,15	20
				Zoumba	615	1	30	0	20
Massakal	Massakal	Integrated Health Centre		Hodango	1 413	2		0	30
				Massakal	4 589	1		0	30
				Pourtamaï	3 642	3		0	30
				Yola Maliki	2 574	1		21	30
Meskine	Meskine			Katoual	11 072	1	30	0	1
				Tchasdéo	7 553		30	22,69	1
				Ziling	3 280		15	9,87	1
				Zokok Ladéo	11 175	2		0	1
Ndoukoul	Ndoukoula			Dalawawo	430	1		6,33	60k
				Moulandi	1 837	3		0	60
				Ndoukla C.	1 128		50	16,61	60
				Zongoyawo	2 162	2		0	60
Ouro zangui	Ouro Zangui			Dambaye	2 378		30	16,54	40
				Kahéo	1 940	1	30	0	40
				Koumaïré	549	2		0	40
				Lamordé	1 366	1		0	40
				Mérem	949	3		0	40
				Ouro Zangui	5 961		30	48	40
				Tchocola	1 233	1		0	40
Papata	Papata			Kossewa	5 753	2		0	49
				Papata	6 135		30	42,43	49
				Soukoungo	2 572	1	30	0	49
Salak	Salak			Doulgou	441	1	30	0	25
				Kalwa	675	1		5,82	25
				Louggol	280	1		2,41	25
				Malaoudi	794	1		6,85	25
				Maza	2 014	2		0	25
				Salak Centre	7 377		15	63,69	25
Yoldéo	Yoldéo			Yoldéo garré	3 945		15	31	35
				Addia Wawago	1 409	1	30	0	35
				Doulgouf	2 268	2		0	35
				Gaï Gaï	1 043	4		0	35
				Ngassa Ouro Dalla	1 927	1	30	0	35
				Ouro Garga	424		45	0	35
				Ouro Mayo	787	3		0	35
				Tankirou	911	1	30	0	35

Source: Health District service of Maroua Rural, MoH Cameroon, 2013

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Table 4.5: Health coverage of the district

Public Health Centres	Private Health Facilities	District Hospital	CMA	Community Pharmacies	Private Pharmacy	Physicians	Nurses	Midwives	Pharmacist
13	3	1	1	12	0	5	78	0	0

Source: Health district service of Maroua Rural, MoH Cameroon, 2013

As showed in Table 4.4, accessibility of health services, including maternal health, is a real challenge, with an average of only 7% of the population of Maroua Rural living at less than 5 km from the health facility (HF). In the same district of Maroua rural, not all the health areas are covered by at least one health facility while in Nylon, all the health areas are covered. The lack of sufficient clinical caregiver is a reality (table 4.5) and though 6 health areas out of 8 are managed by a medical doctor in Nylon health district, the district of Maroua rural does not have any midwife and health areas are managed by nurses and community health workers. In addition to the problem of accessibility and availability of skilled staff, we have noticed the lack and/or degradation of infrastructures and material in both districts: in a hospital, we found that benches were used as hospital beds (Figure 4.1). Also, all the respondents at district level reported a shortage of health service supply.

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Figure 4.1: Overview of a hospitalization room, pharmacy, baby scale and toilets of a health centre with insufficient infrastructure in Nylon health district

Hospitalization room

Pharmacy

Baby Scale

Toilets

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III.1. Formulation and dissemination of health district annual work plans (PTAs) and health areas action plans

At the health district level in Cameroon, annual work plans are developed by the district team with contributions from various stakeholders active in the field. At the level of the health area, a few health areas are organising meetings from time to time with the different actors present in their areas. At these meetings they report on activities and discuss the problems encountered; then agree on way forward. The reports of these meetings serve as a baseline for some of their activities and are used as action plans. A respondent admitted that "*in the past, health areas used to develop a budgeted annual work plan every year, but this was encouraged and supported by the former district manager*".

(i) Relevance regarding key issues of reproductive/maternal health

District annual work plans, including the one for maternal health, are developed based on national orientations received during field supervision of the central level and recognized most of the health area managers. In the particular case of reproductive health, the district team is receiving training almost every two years in which they are briefed in maternal health, based on the latest national developments and priorities. As they are not really involved in the development of national maternal health priorities, health district officials find that "*some important aspects of maternal health pertaining to the district/community level are not adequately taken into account by the central level*"; an example is the case of post-abortion care which is, as mentioned earlier, not funded. This feeling is reinforced by the fact that they do not receive the adequate support in terms of material, human and financial resources, as well as the necessary guidance for the planning and implementation of their maternal health priority issues. In its structure, the health district PTA involve all the national programmes available at the peripheral (District) level; consequently, at that level, there is no elaborated or particular plan specific to maternal health, and the implementation plan of activities highly depends on the financing available

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for each programme. The PTAs of the two districts surveyed try to address most of the key maternal health issues at the peripheral level as per the national orientations, but the limited resources allocated to this area strongly influence scope and hinder the consideration of some relevant key issues in the plan. In general, only routine activities that require little funding, such as supply of health facilities with consumables, data collection, processing and transfer to the higher level, etcetera are planned; the other relevant interventions, like family planning, are donor-driven.

Similarly, health areas' action plans, when developed, involve all health activities; maternal health, which is a topic in the little reproductive health chapter of the plan, is in line with the district priorities.

Most of the time, the outline of health district plans is designed at the national level with national priorities, and it comes to district level for completion and implementation. When necessary, some additional information and instructions are provided by the central level through a circular letter or internal note (note de service) providing guidance on how some specific emerging priorities and/or sensitive maternal health activities that are given priority, should be organized. This new information is taken into account and the district plan is adjusted accordingly.

(ii) Development/formulation process of the health district plan of work

- <u>Identification of stakeholders involved in the process of development of PTAs and health areas plans.</u>

Basically, all the stakeholders active in the health sector at the district level are expected to contribute to the development of the PTAs. In both districts visited, stakeholders involved in the development of PTAs are mainly officials from the district and from the health areas. Because of the very low number of government civil servants at district level and because of the key role played by private facilities in filling the insufficient/inadequate public services, some people responsible in private health facilities are involved in

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the district coordination meetings for the development of a plan of action. In addition to health area managers and district office staff, three main categories of the civil society are variously involved in the process, namely community and health committee representatives, faith based community groups and decentralised authorities (mayors). The detailed district office staff members attending are usually the head of the district, the chief of district office (administrative), some administrative officials, and the management team of the district hospital. The Nylon District had 10 people responsible in 17 health areas, while there were 15 people responsible in 15 areas in Maroua Rural (2 health areas in Maroua Rural are non-functional).

A few partners (NGOs, UN agencies) operating in the district may participate in this activity, but it is very rare according to the heads of the two districts; most of them operate at Regional and central levels. Unless they have a particular project going on in the district, they are not always present.

- Level of involvement and influence of each stakeholder

Contributions of each stakeholder to the development process of the health district plan vary according to its level of activity in his area, and the quality and timeliness of his data collection/reporting needs.

District managers: District managers are the chair of the coordinating meetings. They provide the guidance and they drive the overall planning process at district level.

Chiefs of health areas: Chiefs of health areas are key role players in the process as they are the main implementers of the district health plan in the field. They bring their field experience and context realities into the development of the district plan.

Private facilities: Not all of them are involved, but in many districts, health areas are not necessarily covered by a government health centre/facility. Therefore, if they exist, a private health facility can play the role of the lead health care facility and its manager is designated as chief of the health area. Furthermore, Private health centres are requested

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to report to the health district, so that their experiences, issues and challenges can be taken into account in the district health report. Their contribution concerns mainly routine health information from their activities.

Health committees (COSA): Health committees are front-line implementers of social mobilization and sensitisation. They provide explanations on the failure of certain techniques/implementation methods; they give reasons why communities don't adhere to a programme or an activity (why they don't come to the antenatal care (ANC), why they don't go to facilities to give birth, etcetera). They report on what is said or discussed within the community and their vision of a proposed health activity.

Decentralised authorities: Mayors are also invited to contribute to the district health plan and their contribution is mostly expected on the implementation of activities, especially when it comes to mobilization. Mayors are sometimes given responsibility for and leadership of activities like sensitization and they have a key role in resource mobilization. Unfortunately, Involvement of decentralised authorities is not very effective. Most of the time, mayors or any other council members do not attend district coordination or planning meetings.

Faith based community: Faith based communities are fully part of the system; they are "backstopping" the government work in very remote areas and in areas that are insufficiently covered by the public sector. In Maroua Rural they have a strong influence on the formulation of the PTA as two health areas are headed by faith based facilities in that district; one of them being a reference district hospital. They implement the national policy in those areas in the same way as a government structure. In the district of Nylon, there is no faith based community involved in the process.

The reproductive health regional focal person: based at the regional office of health, he is sometimes involved, depending of the region and the district. When he attends, he brings the national vision and guidance as a basic framework for the development of the district plan. His role is more

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as facilitator to the process and as a representative of the central level. In Maroua Rural, because of the proximity of regional directorate of public health and district health office, the focal person is more involved in the health district activities than in the district of Nylon. In Nylon the regional focal person's visit to the district occurs only during regional supervision.

There is no real involvement of other sectors (for example ministerial departments of youth and of women affairs) or partners (national and/or international) in the development of the district health plan as reported by both districts. UNICEF assisted the district of Nylon in the planning process in the past, but they left after the project ended in that district. A few local NGOs were reported as having some field activities in Maroua Rural (OCALPAS, AGADJAS, RESAEC…), with one of them, "Le village du Millénaire" assisting one health area in the development of a so-called plan of activities. These local NGOs mostly depend on the ministry's or partners' funds to implement their plan of action which they try to align with the national priorities.

In terms of involvement in the process, health committee representatives and faith based community groups are fully involved, while private sector and local NGOs are moderately involved. Unfortunately mayors are much less involved. According to the two districts managers this multi-stakeholders involvement in the planning process has had a very positive impact in the process and in the quality of the plan. The institutionalization or a more permanent involvement of stakeholders would then certainly be of high added value.

Stakeholders involved in the development of health area plans or meetings are:

1. Health committee representative of the area: The district health committee designates a representative in each health area. This representative is one of the key contributors to the health area's micro plan,
2. Community leaders (traditional chiefs, notable) have a social role to play in their community to encourage them to participate. They also bring the concerns of the community into the discussion when planning for activities of the health area.

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3. Religious leaders (Imams, Priests, Pastors, etc) are not involved in all the districts, but some health areas, very few in fact, are getting them into the community discussions to convince them.
4. One health area reported having a strong and positive support from a local NGO, "le village du Millénaire". This NGO has contributed by guiding and assisting them in drafting and implementing their annual micro plan (plan of activity for the area).

➢ <u>Identification & prioritization of problems</u>

The development process of the annual work plan starts with an audit of the previous plan; identifying what should have been done, problems encountered and the reasons that hindered the implementation. Priority problems which are considered in the district annual plan of work are derived from the objectives set by the central level. One district manager explained that "*the national roadmap 2006-2015 developed by the central level gives national priority objectives and indicators, and district plans try to fit in/align with it*". Some district stakeholders found that "*using only roadmap's indicators is somehow limiting. Some important indicators that are easier to inform at the community level, such as the abortion rate, are omitted by the national level, while indicators that are given national priority, such as the fourth antenatal care visit, are very difficult to inform at the district level, especially where access to health facilities is difficult*". In peripheral level areas, three antenatal visits is considered to be good enough.

There is no particular method for problem identification or prioritisation at district level. Data is collected from the district level and transferred to the higher level for analysis. No analysis is performed at the district level. Moreover, it became apparent from the discussions that the limited resources allocated to reproductive health programme at district level, tend to misdirect the choice of priorities and to restrict the prioritization to interventions that received funds from the national level. In general at the district level "*maternal health interventions are established based on information that is provided to us during the field supervision […] we receive*

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training almost every two years and that is where we have the opportunity to get the latest information about national priorities on maternal health".

When it comes to the health areas, priority problems that are taken into consideration in health areas are based on demand. Maternal health has been involved in the minimum package of care. Schemas and other reproductive health material are shown and explained to women to identify their problems. The most recurrent problems are then considered as priority needs.

- Influence of external factors - Social, Political, and Economic context

External factors have variously influenced decisions taken during the elaboration of the policy. Poverty and economic status of the population are predominantly hindering the process as the major challenge is to increase access to maternal health services. Religious beliefs also constitute a barrier for some activities such as the introduction or promotion of family planning, to which Catholics are totally opposed, or blood transfusion which is against Jehovah's Witnesses principles. "*It is almost impossible to make Catholics adhere to family planning*" a respondent argued.

- Involvement of national and intermediate levels (National and Region)

There is a regional focal person for reproductive health in all the regions of the country also covering maternal health. However, regional levels hardly contribute to the reproductive health part during the elaboration of a district annual plan of work. Yet other programmes which are better funded, like EPI, receive support from their regional and national supervisors. It should be noted that the central level (Ministry of Health) used to send a central or regional staff member to assist the district in development of district plans, but this support stopped in 2012 for unknown reasons.

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➢ Use of guidance tool:

The district team uses the roadmap for maternal health and the strategic plan for CARMMA as reference documents for what is planned at central level. Currently there is no guidance tool for the development of district health development plans. There used to be a "Guide d'élaboration du Plan de Développement Sanitaire d'un District de Santé" (guide for the elaboration of the district health development plan)[96]. This guide was a conceptual model of the "Health Sector Strategy" and was aligned with the national health strategy. It gave the outline of the district plan, and the district team just had to fill it in. The guide was divided into 3 main chapters as described in the literature review: the first chapter concerned the Situation Analysis, with a "*stock-take*" which gives a full picture of the health district, and a "*diagnostic*" that identified and analysed the health districts' facts, problems and possible solutions. The second chapter gave the outline of a logical framework for intervention and the third chapter was about budgeting. Health district stakeholders found it "*unfortunate that neither the tool, nor the guidance of higher level officials still exist […] we just rely on our own knowledge and on the very few available reference documents that we receive".*

(iii) Dissemination

Though the district plan is developed with the contribution of chiefs of health areas, in general, the plan is not disseminated to health areas. All the contributors can only review it during the process and most of the time, other field actors that are not part of the process can only view it upon request.

Chiefs of health areas are not systematically developing the annual micro plans, because of the lack of technical support; especially in Maroua Rural where most of the chiefs of health areas are nurses or auxiliary nurses compared to the Nylon district where the chiefs are almost all medical doctors.

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III.2. Implementation of the reproductive health policy at the peripheral level

(i) Implementation process and plan

Implementation of the reproductive health policy at the peripheral level is done through the annual work-plan that is developed by health districts, and annual micro-plans at the health areas level. Both plans cover the whole health sector's programmes, including reproductive health. Chiefs of health areas say that they are not systematically developing the annual micro plans "*because of the lack of technical support".* This is very important in districts like Maroua Rural where most of the chiefs of health areas are nurses or auxiliary nurses compared to Nylon district where almost all the health areas are medical doctors.

The implementation is very much influenced by the availability of funds for an intervention/activity and most of the time "*the plan is not fully implemented because of underfunding*". A major part of the implementation is done through community representative committees (district or health area management committees); especially in Maroua Rural where there are more remote areas.

(ii) Challenges in the implementation:

Numerous challenges have been noticed in the implementation of the plan that may have direct impact on patient care management:

- Human Resources: In the district of Nylon, the challenge is mostly the quantity of human resources rather than the quality, while in Maroua Rural, both quantity and quality are challenging. Nevertheless, in both districts, there is a need for more training on new approaches of patient care management, especially in providing essential obstetric and new-born care (EONC) and post-natal care. Those who attended the two weeks training on EONC provided by the central level, now recognize that they were operating the wrong way: "*it really teaches us that in maternal health everybody is concerned and can help at his level, but one should know how*

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to handle specific cases" recognized a respondent who participated to the course.

- Infrastructures: Infrastructures are described by stakeholders in both districts as insufficient in number and of medium quality. Regarding the public sector, some health centres have very nice infrastructure and some others don't. The private facilities are obliged to comply with the quality requirements of their infrastructures or they will be closed by the government. However, many health facilities of the public sector are timeworn, especially in the district of Nylon where some facilities were built more than 20 years ago and were never renovated. In that district, because of the considerable size of population covered and its location in town, health centres become so narrow that women now prefer to go either to private facilities or to the nearest health area that offers a bigger infrastructure.

- Equipment: in general there is enough equipment to provide fair maternal care to the population. With few exceptions, most health centres are equipped with the minimum required material; and the quality of equipment is globally good. Each level (district and health areas) can easily acquire the small material/equipment from cost recovery.

- Information: Two levels are considered: information from higher levels of which there is very little but it is of very good quality when it is provided, and information from lower level which is available in large quantities, although sometimes incomplete. The managers of both districts recognized that they "*have to run after the chiefs of health areas and health facilities, sending reminders, making calls, etcetera to get them to provide information*". In terms of quality, information coming from the lower level is still a matter for concern; districts managers sometimes receive false or incoherent information, with many discrepancies, which they always need to double check and correct.

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- <u>Financial resources</u>: The principal source of funding of the health district is the government. Funds allocated to the health district are not sufficient and push them to reconsider their priorities or to rely on donors' priorities. Moreover, health district funds are coming as one global amount that covers all the health programmes of the district. Funds allocated to reproductive health are insufficient. Out of 3 615 000 XAF received by one of the districts, 675 000 XAF (19%) was intended for women and children's health, with specific purpose of covering procurement of vaccines and tests, stationery, fuel, and to sponsor training and organize seminars. District managers don't have any control over the money or its distribution; allocation in diverse subtopics is decided at the central level and is not necessarily equitable, nor representative of local priorities.

  The budget allocated to the health district is VAT and other tax inclusive; therefore, the actual amount received by the health district is sometimes up to 40% less than the amount allocated. The biggest challenge is to get funds: "*it may take four to six months to collect the money*", and meanwhile, the work is slowed down significantly; especially supervision.

(iii) Operations and Services at district level

Field Implementation of district health plans is coordinated by the head of district health and implemented by the chiefs of health areas. District plans are quite flexible depending of the financing. Some important local issues that are not part of the national priorities and thus not properly addressed in the district plan, can be funded by a partner and put back as a district priority activity.

(iv) Feedbacks and results

➢ Flux of information with the higher level is literally one way, from the bottom to the top. There is feedback from the district to the region, but very

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little feedback is given from the region to the district. This situation creates a breakdown of the dialogue between the region and the district, relegating the health area manager to a position very far from the decision making process. Regarding that aspect, the District health managers reported that "*Information received from the region or the central level is mostly instructions, information notes, or guidance; it does not really concern a feedback of the analysis of the district data*".

At district level, there is a lot of supervision from the district office to health areas. Information is flowing in both directions and has enabled the district to address some major issues from health areas.

- Monitoring of implementation

The follow up of the implementation of the activities planned is made by the head of the health district through monthly coordination meetings and regular field supervision. There is no monitoring and evaluation plan for the district level, and no proper monitoring and follow up is done by the national and regional levels. In some health areas where a micro/action plan has been developed, an evaluation of the implementation is done after about six months. This is done through a meeting with field actors of the health area (COSA, COGE, CHA), and adjustments to the plans are made accordingly.

- Management of information / Use of evidence

The information is sent through routine health information systems. Only data from nationally agreed indicators are collected, and sometimes data from specific programmes and donors. At the level of the health district, they do a very basic analysis of data collected (frequencies, new events, etcetera) This is discussed during coordination meetings to identify problems and find out how they can eventually address them with their very limited resources.

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CHAPTER V:
DISCUSSION

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Discussion

Though we acknowledge the insufficient competent clinical and community care givers (especially gynaecologist and midwives), the lack of supply, the poor conditions of work (infrastructures, material) and the limited accessibility to maternal health services as major contributing factors to the current maternal health issues, the focus was put on policy and planning development as a substantial supplementary option to impact on maternal health outcome. Therefore, the aim of this study was to develop a tool that can help district managers in the planning process by identifying the different steps and elements to be considered while setting priorities in maternal health planning at the district level. To that end, we had to describe and analyse the policy-setting process in maternal health at the national level, and of the planning process at the peripheral level, in Cameroon.

The literature review of Cameroon health sector showed that the MMR has significantly almost doubled in the period 2004 - 2011, compared to the period 1991-1998, increasing from 430 (1991-1998) to 782 (2004-2011) deaths per 100 000 live births.[13] The most important increase took place during the approximately five years between 1998 and 2003 followed by stabilization since around 2006. In the context of achieving MDGs in 2015, these figures caught our attention and stimulated our interest on how to overcome the maternal health issue in Cameroon. Two possible explanations were then considered in our investigation to explain the bad indicators which were reported: (a) An issue with the quality of maternal mortality statistics and/or (b) an issue with the whole organization of maternal health in the country.

1. *Poor numbers, poor statistics*

During the survey, it has been difficult to get disaggregated data for the country. Among the two selected districts, it was difficult to have a

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consensual maternal mortality ratio (MMR) for each of them; some figures exist that are not official as the MMR calculation is not officially disaggregated up to this level. The Family health department of the Ministry of Health (MoH) announced no maternal deaths in the district of Nylon, and 32 maternal deaths in the district of Maroua Rural in 2010. We could however not confirm these statistics with the district managers who recognised that there is a lot of missing information on maternal deaths, especially for deaths occurring in the community or referred to a higher level. Reference facilities in some health areas are under frequented because they fail to offer adequate care to pregnant women or during delivery, hence the difficulty to have a reliable monitoring of maternal death in these areas. One controversial aspect of the maternal mortality ratio is its measurement, and specifically the multitude of methodologies.[116] There is, in addition, the low capability of the African countries to provide reliable mortality data. Cameroon, like many other Sub-Saharan African countries, has very weak Civil Registration and Vital Statistics (CRVS) and health information systems, which are incapable of providing reliable mortality data. However, the major weakness of CRVS and health information systems is that they have a margin of error, but this margin of error cannot by itself justify the bad maternal health data. There exists therefore the need to consider going deeper in the investigation.

2. *Failure in addressing adequately maternal health key issues*

The main causes of maternal morbidity and mortality in Cameroon are identified as (1) haemorrhages during pregnancy or delivery, (2) infections, (3) eclampsia and (4) clandestine abortion.[117] Means to address these causes are well known and taken into account in the reproductive health national policy; what seems to be failing is organizing and implementing the necessary actions to tackle them. In other words, setting up and implementing the adequate reproductive health policy. Consequently, failure to address maternal health key issues may result from the non-relevance of national policies due to gaps in the policy development process, or the lack or insufficient implementation of the strategic plan. To understand what the

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origin of the low level of progress shown by Cameroon in improving maternal health could be, the current research considers 2 steps.

First: to analyse the context surrounding the organisation of maternal health in Cameroon, including the reproductive health policymaking process at the central level and the planning process at the peripheral level;

Second: to propose a solution that would contribute to the improvement of maternal health indicators.

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I. Analysis of the organisation of maternal health in Cameroon

I.1. The Reproductive health policy process

The country has placed great importance on maternal health by making it one of the four national health programmes. However, between the beginning of the 1990s and 2013, two documents defining the national policy for reproductive health and one strategic plan (2001-2009) have been produced, none of which was effectively implemented or disseminated; Most of the stakeholders do not even have knowledge of these 3 documents and their formulation process is not clear. The current reproductive health national policy which was developed in 2013, tried to address the gaps of the previous policies in terms of development process and content; however, analysis of the process still shows that some important steps, such as consultations with the peripheral level, are missing or need improving.
The current policy covers the period 2013-2020. By March 2015 the country has not yet developed a strategic plan for implementation, nor even disseminated the policy. Meanwhile, the ministry of health is still referring to the CARMMA strategic plan and roadmap (2011-2013) for reproductive health; which may create more confusion if we have to consider the new policy. To avoid such confusion it is important to integrate the unfinished CARMMA strategic plan, roadmap and other reference operational documents, into the national strategic plan for a harmonized implementation of the new policy. Ideally, the new policy should be unique, replace all existing policy documents and be available in all the relevant structures of the different levels immediately it is validated. It should be supported by a strategic plan setting the overall national health priorities and directions, and implemented through an operational plan detailing activities as well as their modes and levels of implementation.[88] If this process were to be followed, it would be possible for the policy to fulfil its function of guiding choices on how to organize and finance health services[69] to obtain the desired outcome.[118] Any failure on the development of the policy necessarily

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misleads the implementation and affects the health status of the target population. The reasons for failure of effective implementation of the revised (2013) policy can be attributed to weaknesses in the formulation and content of the policy, in dissemination of the policy and in monitoring and evaluation of the policy. Each of these is described below.

Formulation and content of the policy

As shown in the results, the policy development is still strongly driven by external factors such as international requirements, and the global context, relying mostly on CARMMA. A national situation analysis is made during the process but some results are not reflected broadly enough in the national policy as shown in the RAIC analysis of the strategic documents (Annexure 10). National information, evidence and knowledge systems outputs are not really used, probably because of their limited availability and disputable quality. Although the political, socio economical, and cultural context are considered in the situation analysis, they are not effectively integrated.

The choice of stakeholders involved in the development of the policy is still not very clear. It is more likely that the selection of participants is influenced either by their proximity to the Ministry of Health or by the fact that they are referred by key officials who know them individually (snowballing process), and by their capability to fund reproductive health activities. This lead to the absence of representatives from important areas who are active in reproductive health developments, such as academics and researchers, civil society, faith based communities, pharmacists, etcetera. Among the participants at the 2013 reproductive health policy development, only two local NGOs out of the plethora of NGOs operating in the field of reproductive health in Cameroon and few development partners, were involved. It appears that some key national and international partners are not fully involved in the exercise. It is the same with infra-national (regional and districts) health managers. This limitation in the stakeholders' participation comes from the fact that there is no proper stakeholders'

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analysis that justifies who should or should not participate in the development of the policy. It further contributes to narrowing of the vision and the scope of maternal health issues to be addressed, as well as the understanding of the full context around it. Not having focal persons from health regions reproductive health involved in the process results in some district managers eventually overshadowing priority problems in this area at the peripheral level and creates discrepancies in addressing them. Consider, for example, the Far north region, which is the most affected region in terms of maternal mortality.: there was no representative of stakeholders working in reproductive health in that region, associated with the policy formulation process. It is thus difficult to imagine that the critical reproductive health priority concerns of this region will be correctly addressed in the national policy.

Regarding the other government departments active in the promotion of women, men and adolescent health, such as education, youth, social welfares, etcetera, their absence or subdued participation also narrows the contextual vision of the policy, as it would not adequately reflect the environment. These departments should be represented as they will need to relay their important role in the implementation process to their regional offices.

In its content, the reproductive health policy and its maternal health component aligns with the country's main guiding documents such as the national health development plan and the poverty reduction strategic paper;[119] however, it does not refer enough to the evidence provided by regional, district and community levels. It is not clear what the vision for the decentralised level is and how it should be organized. Major international requirements are covered by the policy but the link with sub-national priority issues is still vague. The assessment conducted through the RAIC to identify district priorities that should be taken into account in the national policy was not nationally representative. All these failures also lead to an inadequate and inequitable financing of reproductive health, which is critical in addressing the problem at the infra-national level.

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The reproductive health policy formulation process of Cameroon shows an unbalanced relationship between actors, content, and context, where actors are not fully represented and international and other exogenous factors are still highly influential. It is therefore difficult to consider key steps in the process, such as assembling information, developing arguments, developing alternatives, and persuading others.[71,120]

Dissemination, Implementation and Monitoring

Lack of awareness of the policy at different levels of the health system of Cameroon shows the limit of its dissemination. The central level should ensure that the national policy is available in all the relevant structures for ease of reference to national priorities. Dissemination of the policy at all level should be the first step for its implementation, and then the national policy and strategic plan should be introduced and discussed in coordination meetings at the regional level, involving the health district managers. What is expected from regional and district health managers will be clearly explained to them and feedback will also be collected from them to improve the policy and the plan. This exercise can be organized as a "Regional Forum", and it will also allow the regional levels to take the lead for implementation at peripheral level.

Another major barrier to the implementation of the maternal health component of the reproductive health policy in Cameroon is the lack of a national strategic plan; especially in the context where, after two years, the number of health districts and health areas in the country has increased. This increase is leading to a change in the action needed for some geographic areas, or to new health districts and health areas officials who need to develop their district or health area's action plan, etcetera. Strategic orientations are important to drive the implementation of the policy. To cope with the unavailability of the national plan and to facilitate the implementation of the policy, a compensatory temporary policy action can be the issuing of circular letters, directives or operational guidelines from the hierarchy.

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The weakness of implementation of the national policy or plan in Cameroon can also be explained by the disconnection between the central, regional and the peripheral levels. As mentioned earlier, both national and sub-national officials and stakeholders confirmed that infra-national levels were not effectively associated with the development of the national policy and therefore did not feel connected with it. It is important to raise the interest of decentralised levels towards ownership of the reproductive health policy and accompany them for its effective consideration in the planning of their activities.

As far as the monitoring of the implementation of the policy is concerned, a Monitoring and Evaluation (M&E) section was reflected in the previous reproductive health policies, but it was never assessed. The absence of supervision from the central level was one of the biggest failures for the implementation of the previous national strategy. As for the current policy, an M&E section has been developed. The framework should be reflected in the strategic plan, and should include regular supervisory visits by the higher level. These visits should be designed to assist with and follow up on the implementation of the policy at the peripheral level, and provide feedback between all levels. In general, Cameroon national policies are static ones, meaning for a fixed period (usually around ten years), allowing one mid-term evaluation after four or five years, for readjustments.

A more dynamic strategy would allow shorter time rapid assessments and updates (annual) to ensure more efficient implementation and address the regular changes that occur in the health system's structure.

I.2. Planning process at district level

The methodology for the development process of health district plans in Cameroon is unclear. Prioritization at the peripheral level strongly depends on national strategic orientations, rather than district priorities. Moreover, the most influential aspect for establishing priorities during the

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planning process in Cameroon is likely to be availability of funds for the planned programme, which compromises the objectives and equitable planning. Here, district level depends financially on the government, and the distribution of funds among priority programmes is decided by the central level. As a result, distribution of resources among the different programmes may not reflect the local priorities, leading to some areas, such as reproductive health, being under-resourced and related actions hard to prioritize and implement. The Cameroon system shows a disconnection in the communication between the central level and the peripheral level which explains why local priorities are not sufficiently taken into consideration in establishing national strategic orientations. As a result, allocation of resources fails to be needs-based and district health plans do not necessarily reflect the local priorities. In general, the identified problem is what should guide the priority setting process rather than the funding. The decentralisation advocated in the health sector reform policies that is being pursued in a number of countries also includes a shifting of the authority to make a decision as to how resources are used, to the lowest administrative level possible.[88]

A major gap in the planning process at district level in Cameroon is the lack of involvement of the health district team (HDT) in this exercise. Indeed results show that the HDT is not well equipped in planning methodology and needs more support to plan their activities. The unavailability of national reference documents, like reproductive health policy and plan, at the district level can be strongly associated with the failure in implementing the policy. In the past, when district plans used to be more coordinated by the higher level, there was a tool that was very helpful. An evaluation of district planning in Kenya revealed that even the supposedly technical people at district level lack the required skills and knowledge to implement the policies.[121] Incidentally, a strong role of the central and intermediate levels is still necessary in the district planning process, to guide them through an objective and realistic planning that can ensure equity, needs based allocation of resources, and monitoring and evaluation of results. A balanced alternative can thus be to allocate

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resources in broad financial terms on the basis of the needs of the decentralised management areas. This broad allocation of resources would leave local managers free to determine the details of how such resources are used, and hence budgeted.[88] Training sessions in planning at all levels, including health areas; and norms and standards for reproductive health, should be developed for each level of the health systems.

Involvement of stakeholders in the planning process in the health district in general, and specifically in setting of priorities at the district level in the two health districts surveyed, is very limited. Some important actors are left out as they are just considered either as implementers or funders. Collaboration with all the stakeholders at the district level has shown good results in terms of planning and coordinating the health response. Partners should be encouraged to get involved in local planning in order to share experience and align with district priorities to enable a more efficient support. When the community and civil society representatives are used in the planning process in the district is very useful and effective for the implementation. Actors then feel involved in the full process, provide more accurate information on community needs and, most of the time, they have more influence on the population than health workers. The choice of community layers to be involved in the planning varies according to the environmental context, including the community lifestyle and socio-cultural constraints: In the district of Maroua Rural, the traditional chieftancies/chiefdoms are very powerful and have a huge influence on the population's behaviour; hence the importance of having them on board when planning. In another context, the district of Nylon is more urbanized, and more influenced by local administrative authorities such as decentralised local authorities (Councils); in this context, Council members will be very beneficial to the planning process. Councillors' roles in health vary from country to country but their potential power and influence must not be underestimated;[122] there is a need to build their capacities by including them in training programmes already provided for District Health Councils.[123] The community involvement and commitment should reflect the "community accountability".[124] In line with one of the principles of the

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Alma Ata declaration in 1978 stating that "*the people have the right and duty to participate individually and collectively in the planning and implementation of their health care*",[125,36] community participation should be seen as a fundamental right of the population and that it is a principal factor in the success of development programmes.[126] When people (individuals and communities) understand that they are given the scope to exercise their rights in terms of Alma Ata, the successful implementation and completion of programmes is more likely to result. Given a chance to set priorities the community can make suggestions, even though not all their suggestions can be taken into account in their totality.[127]

Monitoring and evaluation of the implementation of maternal health activities at the district level is weak; the follow up from the higher level is really insufficient. "*For now they just do basic analysis of routine information and not enough supervision*". Only programmes considerably funded such as the Expanded Programme of Immunization (EPI) is effectively supervised. Despite the lack of funds, routine activities are still possible. An effective monitoring and evaluation of district activities by the regional level with proper reporting to central level is critical to adjust and improve the planning steps.

Challenge

Beside the common constraints that such as insufficient resources, accessibility, and the strong socio-cultural influence, the main challenge remains to be able to plan unfunded priorities like maternal health, that are not sufficiently covered by the resources allocated by the central level. Beyond the minimal guidance "*available to public health practitioners who wish to understand how issues get onto policy agendas, how policy makers treat evidence and why some policy initiatives are implemented, while others languish*"[69]; there is a need for a guidance tool to help health district planners to increase their action in regards to local priorities. That need for such tool became apparent from the survey's interviews, and the tool would represent an innovative approach that would help them.

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CHAPTER V:
THE TOOL

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Background

"*It does not make sense to plan for activities that cannot be funded or implemented... we need to get assurance from the higher level for each of the activities that we are planning as it is very frustrating and discouraging to plan so many activities and being funded about half only when we know what the needs are*" a respondent said. As presented in the previous sections, the result of the investigations clearly demonstrates that the major problem that prevents health district managers from planning and implementing the activities related to their priority maternal health problems, is the insufficient funding in this area. To this we can add the insufficient emphasis placed by the central level on their local priorities and the lack of accompaniment in planning and monitoring.

Another challenge in addressing maternal health issues at the peripheral level is the unavailability of the required number of skilled attendants. This highlights the importance of thinking upstream by identifying and implementing interventions that should be provided as part of routine antenatal and delivery care by the available staff and which should be integrated into the primary health care system. Interventions such as malaria prophylaxis and active management of third-stage labour can have some impact on maternal mortality by preventing complications. These interventions certainly should be provided as part of routine antenatal and delivery care. Similarly, complications of unsafe abortions could also be prevented or at least reduced through access to contraception and safe abortion services.[128]

All the planning tools that we reviewed consider priority setting as depending on the magnitude of the problem and the feasibility of solving it; with the lack of financial resources seen as an obstacle to the feasibility of finding a solution. This assertion also emerged clearly from the interviews of stakeholders involved in the planning process at both the national and the district levels, hence the challenge of making these unfunded priority actions

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implementable, by considering the district health system as an integrated subsystem. Since the health districts are autonomous, the question of how to plan and implement the activities that will help the district to address its local priority maternal health issues that have not been prioritized, nor funded by the higher level, remains pertinent.

I. Proposed solution: The Tool or Integrated matrix for priorities

I.1. Concept of tool development

Planning involves deciding how resources should be allocated, and determining how to implement these decisions. For developing countries attempting to improve poor levels of health with extremely limited resources, a judicious health planning with carefully selected priorities is thus critical. As described in the literature review and confirmed in the survey, setting priorities is a step of the planning process that follows the identification and analysis of problems compiled from the situation analysis. This step enables the planner to prepare its intervention planning (objectives, targets, interventions, activities) and resource allocation. In Cameroon, District managers have limited flexibility to decide the priority interventions (these are set at national level) and have only the choice of activities. The question of how to develop an effective and realistic district health implementation plan that will take into consideration unfunded local priority activities and be effectively implemented in this context of limited resources and flexibility, thus remains. The current tool was developed with the expectation of being able to respond to questions that arise from investigations, as follows:

a. How to implement local priority activities in maternal health that are not funded at the health district level?
b. How to efficiently plan maternal health priority activities in the context of restricted resources?
c. How, in the implementation plan, can we prioritize, the activities aiming to address maternal health priority issues with the available resources, and by considering the constraints imposed by the context? [Resources: human,

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financial, material; context: acceptability or not (can be religious, cultural or socio economics factors) / accessibility]

The whole idea is to identify priority activities for each national health programme in a cross table, and see which under-resourced priority activity can be covered by other resourced programme's priority activity, keeping in mind the other contextual constraints of the activity with which it is associated.

I.2. Presentation of the tool

The tool was developed in the form of an integrated matrix of priority activities/interventions, introducing the concept of "Package of Priority Activities" (PPA), and designed as a dynamic cross-table. The tool was developed keeping in mind the need for it to be user friendly at every level of the health system, without a need for extensive training. It is composed of 2 main elements: the diagram for elaboration of the "package of priority activities" (Figure 5.1), and the matrix for prioritization (Table 5.1), all explained in paragraph I.3 "How to use the tool".

The diagram for elaboration of the package of priority activities gives rationale and sequence of the use of the matrix. It shows elements of the magnitude and the feasibility and how they end up in the package of priority activities.

The matrix appears as a dynamic table for cross analysis of priority activities and elaboration of the package of priority activities.

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Figure 5.1: Diagram for setting package of priority activities in Maternal Health at the district level

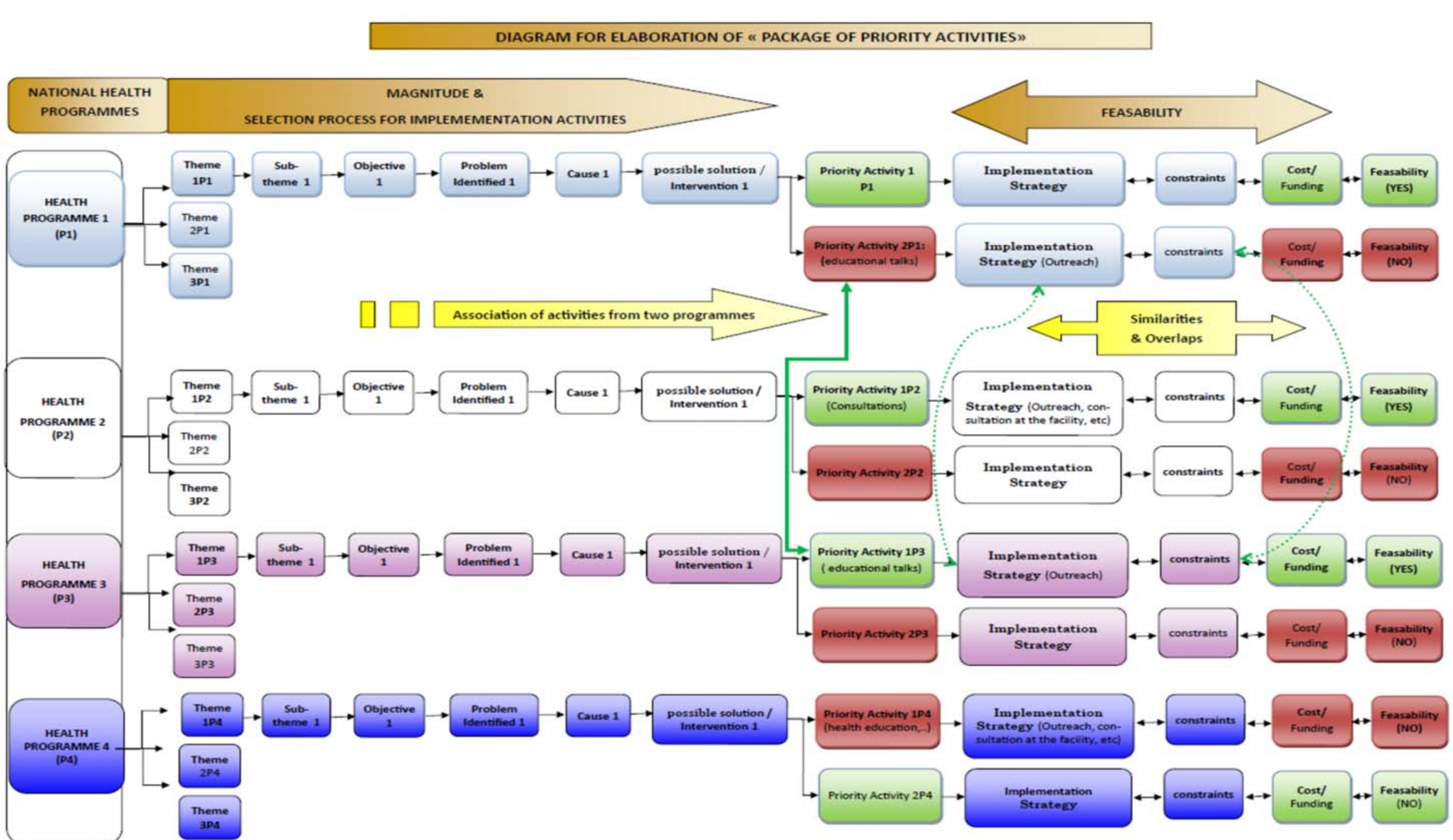

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Table 5.1: Matrix for setting priority activities in Maternal Health planning process at the district level

MATRIX FOR CROSS ANALYSIS OF PRIORITY ACTIVITIES

NATIONAL HEALTH PROGRAMMES	MAGNITUDE & IMPLEMEMENTATION ACTIVITIES						Priority Activities	FEASABILITY					Package of Priority Activities
HEALTH PROGRAMME 1 (P1)	Theme 1P1	Subtheme 1	Objective 1	Main Prblems	causes	solutions/interventions	Priority Activity 1P1	Implementation strategy	constraint	cost	Funding	Feasability	
				Main Prblems	causes	solutions/interventions	Priority Activity 2P1: (Educational talks)	Implementation strategy: Outreach	constraint	cost	Funding	Feasability	Cfr Priority Activity 1P3 (educational talks)
			Objective 2										
			Objective 3										
		Subtheme 2	Objective 1	Main Problems	causes	solutions/interventions	Priority Activity		constraint	cost	Funding	Feasability	
			Objective 2										
	Theme 2P1	Subtheme 1	Objective 1										
			Objective 2										
			Objective 3										
		Subtheme 2	Objective 1										
			Objective 2										
		Subtheme 3											
HEALTH PROGRAMME 2 (P2)	Theme 1P2	Subtheme 1	Objective 1	Main Prblems	causes	solutions/interventions	Priority Activity 1P2	Implementation strategy	constraint	cost	Funding	Feasability	
				Main Prblems	causes	solutions/interventions	Priority Activity 2P2: (Educational talks)			cost	Funding	Feasability	
			Objective 2										
			Objective 3										
		Subtheme 2	Objective 1	Main Problems	causes	solutions/interventions	Priority Activity		constraint	cost	Funding	Feasability	
			Objective 2										
			Objective 3										
	Theme 2P2	Subtheme 1	Objective 1										
			Objective 2										
			Objective 3										
		Subtheme 2	Objective 0										
			Objective 1										
HEALTH PROGRAMME 3 (P3)	Theme 1P3	Subtheme 1	Objective 1	Main Prblems	causes	solutions/interventions	Priority Activity 1P3 (educational talks)	Implementation strategy: Outreach	constraint	cost	Funding	Feasability	Priority Activity 1P3 (educational talks) + Priority Activity 2P1: (educational talks)
				Main Prblems	causes	solutions/interventions	Priority Activity 2P3: (Educational talks)		constraint	cost	Funding	Feasability	
			Objective 2										
			Objective 3										
		Subtheme 2	Objective 1	Main Problems	causes	solutions/interventions	Priority Activity		constraint	cost	Fubnding	Feasability	
			Objective 2										
			Objective 3										
		Subtheme 3											
	Theme 1P3	Subtheme 1	Objective 1										
			Objective 2										
			Objective 3										
		Subtheme 2	Objective 0										
			Objective 1										

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I.3. How to use the tool:

Step 1. Preparation phase:

This phase is to set the framework by ensuring that some of the following basic requirements are followed:

- Participation of higher levels,
- Financing of the planning process/activity,
- Analysis of the situation, including of analysis of available resources (financial, human, material resources), identification and measurement of the magnitude of maternal health issues, and mapping of existing opportunities for implementation of national health programmes' priorities at the district level. The priority setting should always be considered as part of the whole planning process.

Step 2: Linear analysis of national health programmes

This step consists of completing the details in the integrated matrix of priority activities/interventions required by programme. For each of the four national health programmes, the team should consider the following elements/topics to be filled in the matrix:

a. Name of the programme
b. Theme (Goal)
c. Sub-theme
d. Objective
e. Problem identified
f. Causes (including socio-cultural, religious and financial causes)
g. Possible solutions/Interventions (Public health intervention will be understood as a set of actions with a coherent objective to bring about change or produce identifiable outcomes, intending to promote health or prevent disease in communities or populations)[129]
h. Activities (planned activities to address the problem and get to the solution)

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i. Implementation strategy
j. Eventual constraints
k. Cost
l. Source of financing
m. Activity implementable/achievable (Yes or No, based on previous elements) – if No, identify the reason/gap
n. Associated Activities : this topic of the matrix will be filled during step 3 (see below)

Step 3: Cross section analysis of priority activities and building PPAs

Some interventions/solutions to address problems in two or more health programmes may require similar activities. After completing the information from item "a" to "m" for each of the 4 national health programmes, the planning team goes to **item "n"** 'associated activities', the key item of the matrix. It consists in a cross analysis of **similarities and overlaps** in priority activities and integrating them. More specifically, it is about selecting all the priority activities of the maternal health programme that are "not achievable" for insufficient resources reasons (associated activities), and associate each of them with activities in another programme that are similar or overlapping, and that are achievable (mother activities), to build the "package of priority activities". The integration of priority activities should therefore consider criteria such as implementation feasibility of the package of activities, and ensure that the associated activity will not harm the implementation of the « mother activity ». This process ensures that the package can be covered by the same strategy and almost the same logistical, financial and human resources.

Step 4: Selection of Package of Priority Activities

As a result of the cross analysis of the matrix, packages of priority activities are set and integrated in the district health development plan for implementation.

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Different approaches can be used to develop the matrix. The recommended approach would be that the health district team (health district officials and chiefs of health areas) prepare the matrix, and further organize a planning workshop of one or two days with all the relevant health district stakeholders and the subnational and/or central level support teams, to consolidate the matrix and finalize the whole district plan.

I.4. Utility of the tool.

It order to check the utility and measure the performance of the tool, a workshop was organized with three major events: (i) an introduction to the planning process at the health district level as described in the literature review, with a presentation of each district planning activities highlighting the prioritization step; (ii) presentation and review of the tool by the reproductive health stakeholders of each level of the health system; and (iii) conducting a planning exercise in two districts using the tool.

II. The workshop for review and testing of the tool

The tool was reviewed by policymakers and planners during a national review workshop with working group discussions. The workshop brought together teams from the 2 districts surveyed (head of the health district and chiefs of health areas), central and intermediate levels of the MoH, including Family health directorate's team, regional focal persons, and some few partners (NGOs and civil society).

Description of the planning process at the health district level

On the first day of the workshop, the research and its methodology was explained to the participants. Then they were asked to describe, in a presentation, the planning exercise as they are currently undertaking it. At that time, the tool was not yet presented to participants. After the discussions that followed the presentation, two groups were organized,

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taking into account the two different districts. The groups were to discuss and brainstorm how they see the role of the central and intermediate levels in the health district planning process, The groups were tasked to identify the weaknesses, strengths and needs in the current process of planning at HD level, including the establishment and implementation of priority problems. The results of this brainstorming were discussed in plenary and summarized in Table 6.1 and 6.2.

From the result of discussions and brainstorming, the tool was slightly adjusted before its introduction to participants the following day.

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Table 6.1: Summary of the brainstorming on the planning process: 2 tables as per the level of the health system

Table 6.1a: Role of the central level on the planning process at the HD level

Weaknesses	**Current contributions**	**Expected contributions**
1. Not physically involved 2. No technical support during the planning exercise 3. No implication of HD in setting priorities by the central level 4. Does not provide an adequate technical support (No planning tool or guideline to support the planning at HD level 5. No dissemination of national and programme's strategic or operational plans. 6. No financial support for planning at HD level 7. Inconsistency between budget lines allocated by the government and activities to be conducted in districts	1. Availability of national roadmap for reproductive health. Dissemination of the national roadmap 2. Financing of planning of Prevention of Mother to Child Transmission's (PMTCT) activities (in one of the districts)	1. Prioritise the bottom to top approach by making the planning process from health areas to central level effective. 2. Physical presence and participation of higher levels during the consolidation of HD plans 3. Take into account and reflect more consistently the priorities of HD levels in national priorities. Make all the necessary technical documents available to health districts, 4. Enter a budget line for planning at the district level 5. Dissemination of national and programmes strategic plans 6. Introduction of an harmonized planning tool 7. The central level should train the heads of districts and heads of areas on the Programme Budget 8. Take into account annual work plans when allocating partners financial contributions to different districts.

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Table 6.1b: Role of the regional level in the planning process at the HD level

Weaknesses	Current contributions	Expected Contributions
1. Not physically involved 2. No technical support during the planning exercise 3. Does not provide an adequate technical support (No planning tool or guideline to support the planning at HD level 4. No strategic documents to serve as background	1. Availability of national roadmap for reproductive health 2. Provide guidance during certain meetings 3. Financing of planning of Prevention of Mother to Child Transmission's (PMTCT) activities (in one of the HD)	1. Privilege the bottom-top approach by making the planning process from health areas to central level effective. 2. Physical presence of higher levels during the consolidation of HD plans 3. Take into account and reflect more consistently the priorities of HD levels in national priorities 4. Make available to health districts, all the necessary technical documents 5. Technical Support 6. Availability of strategic documents

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Table 6.2: Summary of the discussions on setting priorities during the planning process at district level

Strengths	o Involvement of dialogue structures in the planning process o Development of Annual Work Plan o Strong involvement of the community including traditional and religious authorities in the health activities. o Availability of the data o Availability of exhaustive inventory
Weaknesses	o Weakness of health district managers in the advocacy with local partners to support the planning o Weak implication of related services in the planning process o Limited skills of health district stakeholders in planning o No harmonized framework for planning. o Low involvement of municipalities in health activities o Lack of funding for planning. o All stakeholders are not involved because of lack of funding. o Lack of motivation of staff because of non-implementation of Annual work-plans o Overlapping activities and scheduling conflicts. o Strong "top-down" structure of activities supported by partners
Needs	o Coaching of districts by the regional and the central levels. o Training of health district staff in planning technics o Allocation of funds for planning by the government
Elements identified as to be taken into account in the prioritization	o The Magnitude (frequency, severity) o Relevance (ability to obtain a noticeable positive change) o Vulnerability (existence of endogenous or exogenous solutions) o Feasibility o Efficiency

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Review of the tool

During the second day, the tool was presented and explained in a plenary to all the participants. Stakeholders were then divided again into two groups representing the two districts present. The groups were tasked to review the tool and give their views in some critical point of its implementation, such as the relevance and the usefulness. A brainstorming session was organized around these two points by discussing the importance of the matrix and what they think was missing as regards their current needs.

Elements of discussions here enabled us to reshape the tool again and come to a final draft of the tool to be tested the following day in the two districts. Some recommendations were made of which the major ones were to "*Use the terms of the programmes*" to comply with the nomenclature in use in Cameroon; "*Replace some of the terms by those used in Cameroon such as "methodology*" by "strategy", etcetera; and "*If possible, insert more columns such as Indicators, Responsible, Source of information"*. After the discussion, it was agreed to not include additional columns in order to keep the tool simple and more efficient. The main argument which led to that conclusion was that this is only a part of a full planning process and the other suggested columns will still be taken into consideration in other steps.

Testing the tool

On the third day, the tool was tested through a 'prioritization exercise' as part of the planning process in the two districts. Each district planning team was comprised of 12 participants (see Annexure 12) , namely, the chief of the health district; the chief of office of the health district, 3 chiefs of health areas, also responsible for the integrated health centre of their areas, the regional maternal health focal person having this district in its jurisdiction, one NGO person active at the community level in these districts and representing the community, 3 technical officers from the central level, and 2 policymakers also from the central level. Development partners were not part of the review to avoid any bias, as it was understood that the most

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important people to review the tool were district health teams and their direct official support officers from the higher levels.

This exercise gave to the district planning teams the opportunity to assess the tool and provide their feedback on the applicability of the tool and its ease of use/convenience.

The 'prioritization exercise' consisted of selecting, from all the priority activities to address maternal health priority problems, the one that can be chosen to be implemented in the district plan, using the tool. The tool was filled in by the two district teams with the contribution of the central and intermediate levels representatives, and the comments were made on the different aspects. The exercise was conducted with a cross analysis of two of the four national programmes: the mother and child health programmes and the disease control programme. The output of the exercise clearly showed a substantive increase in the number of previously unimplemented activities in maternal and child health that can now be implemented, if associated with similar or overlapping activities implemented in other programmes (Table 6.3a and 6.3b). One major output was the important provision of services for mother and child health at community level estimated at over 50% more than what it was.

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Table 6.3 : Result of the planning exercise done by two district management teams using the tool for setting priority activities in maternal health in Cameroon (overview): 2 tables as per the district

Table 6.3a. Results of the planning exercise using the prioritization tool in 'Maroua Rural' health district.

Programme	Theme	Type of intervention	Objective	Identified problems	Causes (Including the causes socio - cultural)	Possible solutions	Activities	*Associated activities*	Strategy	Constraints / potential	Funding
Maternal, child and adolescent health	Maternal health	ANC 1	Increase from 55 to 70% by December 2015	-Low compliance of women with ANC 1	- Lack of awareness -Low Purchasing power of women -Influence of religion and custom	- Strengthen awareness in places gatherings of men and women	- Advocacy with the authorities - Organize sessions of educational talks	**- VIH screenings -VAT -IPT -MILDA**	Advanced integrated strategy	**overlapping of activities**	
		ANC 4	Increase from 27 to 40% by December 2015	- Late 1st contact ANC	-Ignorance -Weight Custom	Perform awareness at every level	- lead the educational talks to every contact.		Group facilitation Individual counselling		
				-Insufficiency of ANC follow-up	-Insufficient Counselling, -Lack of trust -weak Promotion of Birth planning	- Systematically organize educational talks and counselling - Set a starting time for the ANC	-Retrain staff in communication.	**- VIH screenings Test 2 -VAT -IPT -how use the MILDA**	Advanced integrated strategy		
				Lack of information and advice during the ANC	- shortage of staff - deficiency of working organization	- Assigning staff - Reorganize the service, the women's circuit and staff tasks with emphasis on educational talks	Redeploy staff Define the duties of staff and the women's circuit..	**Support from CHWs/Association for mass mobilization**	Advanced integrated strategy	Lack of means of transportation	
				Very low involvement of partners	Insufficient of men awareness in maternal and new-born mortality	- Raising awareness of men on maternal and new-born mortality	Organize sessions of information and communication targeting men related to the fight against maternal and new-born mortality	**Demonstration using flipchart**	Demonstration	Men devotion	
Disease control and promotion of health	Fight against malaria	PECADOM	**Revive** PECADOM activities	PECADOM activities are no longer conducted	-Frequent disruption of inputs - lack of motivation of Relays	-Revive the activities of the PECADOM	Train/strengthen capacities of CHWw	**-screening of malnutrition - Mobilization and raising awareness in favour of the PF.**	- Demonstration educational talks		

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		Intermittent preventive treatment	Reach a rate of 40% in IPT 1 in December 2015	Frequent interruption of SP	- Infrequent supplying by the CAPR						
	fight against malnutrition	community-based screening	reduce the prevalence of malnutrition in the District	- Increasing number of malnourished - High rate of death due to malnutrition.	- ignorance - poverty - climate hazards	Sensitization and early diagnosis	Awareness and Early Detection	**-EPI** **- deworming** **- Vit A supplementation**	Demonstration Dietetics Community screening Home visits	- scarcity of rain -Insecurity	
	HIV	HIV/AIDS testing	Decrease HIV/AIDS prevalence among pregnant women in 2015	- Unprotected sexual intercourse - Forced marriages	- Ignorance of prevention method - Poverty - Low power of decision for women	- Raising awareness about contraceptive methods. - Raising awareness of parents regarding forced marriages.	Lead educational talks among communities Conduct voluntary screening Conduct MTCT during ANC/	**- Family Planning** **-Management of adolescents' reproductive health**	Site visit Make adolescents' reproductive health centre fully operational		**Yes**

N.B: Similar strategies have been given the same colour to easily link up activities in the matrix.

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Table 6.3b: Results of the planning exercise using the prioritization tool in “Nylon” health district

Consolidation priority activities between two programmes

Programme	Themes	Sub theme	Objective	Problems identified	Causes	Possible solutions	Activities	Associated activity	Strategy	Possible constraints	Funding
Maternal, child and adolescent health	Safe motherhood	ANC	56%	Low attendance of ANC services	Insufficient homes	Improve reception	Brief the staff involved in the reception	Organize training sessions in communication techniques for actors	Organization of a training workshop		Health facility
							Set up a system of additional staff motivation		Awarding bonuses/gifts/ congratulatory letters/sanctions	**Funding**	Health facility
							Apply texts on staff motivation		Awarding bonuses		
				Late start of ANC	Long waiting time	Revise the client ‘circuit’	Develop a simplified circuit		Meeting with all stakeholders		Health facility
							Spread the simplified circuit		Display in the health facility and reprography		
							Inform the public on the circuit	Conduct integrated advanced strategies	IEC/BCC		CHP
					Ignorance of the importance of the population by ANC	Raise awareness on the importance of ANC in the community	Awareness in the district associations	Conduct integrated advanced strategies	IEC/BCC		CHP
							Advocacy with community leaders for lifting the socio-cultural barriers	Advocacy	Advocacy		CHP
							Search for lost and unreached	Home visits	Home visits		CHP

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Programme	Themes	Subtheme	Objective	Problems identified	Causes	Possible solutions	Activities	Associated activity	Strategy	Possible constraints	Funding
					Low social mobilization	Raise awareness on importance of ANC in health facilities	Develop an IEC calendar integrating all programmes		Meeting IEC committee		Health facility
							Implement IEC plan		IEC/BCC		
Fight against disease and health promotion	Malaria	Intermittent preventive treatment (IPT)		Insufficient coverage of FE IPT	Low attendance of ANC services	Provide the IPT in the community	Conduct integrated advanced strategies		Advanced integrated strategies	Insufficient funding	Health facility/ HD
				Low attendance of ANC services	Insufficient home	Improve reception	Brief the staff involved in the reception		Training		Health Facility
							Set up a system of additional staff motivation		Awarding bonuses / gifts / congratulatory letters / sanctions	**Funding**	Health Facility
							Apply texts on staff motivation		Awarding bonuses		
				Late start of ANC	Long waiting time	Revise the client circuit	Develop a simplified circuit		Meeting with all stakeholders		Health facility
							Spread the simplified circuit		Display in the FoSa and reprography		
							Inform the public about the circuit	Advanced integrated strategies	IEC/BCC		CHP
					Ignorance of the importance of the population by ANC	Raise awareness on the importance of ANC in the community	Awareness in the district associations	Advanced integrated strategies	IEC/BCC		CHP
							Advocacy with community leaders for lifting the socio-cultural	Advocacy	Advocacy		CHP

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							barriers				
							Search for lost and unreached	Home visits	Home visits		CHP
Fight against disease and health promotion					Low social mobilization	Raise awareness on the importance of ANC in health facilities	Develop an IEC calendar integrating all programmes		Meeting IEC committee		Health facility
							Implement planning IEC		IEC/BCC		
	Social mobilization	Behaviour Change Communication (BCC)		Promotion of insufficient health	Insufficient communication media	Make communication media available	Expressing need for hierarchy		Correspondence		MoH
					Absent demonstration kits						
					Insufficient training	Train actors in communication techniques	Organize training sessions in communication techniques for actors		Organization of a training workshop	**Funding**	MoH
					Demotivation of players	Financing declining actors in the community	Assign transport packages / snack for actors	Assign transport packages / snack for actors (PTME)	Incitement		CHP
					Inadequate planning	Planning communication activities	Develop a communication plan	Organize training sessions in communication techniques for actors	Organization of a training workshop	**Funding**	

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Outcomes from the testing of the tool.

The main conclusions of the test exercise that came up from discussions after the planning exercise are summarized in Table 6.4 below.

Table 6.4: Result of the discussion for the testing of the tool

Question	Group I: Nylon	Group II: Maroua Rural
How do you perceive the relevance of the matrix? (Importance with regard to the current needs, the capacity to fill the gap)?	• The tool is relevant as it allows to take into account the activities which have no financing by associating them with those who are financed	The tool is relevant in the process of planning because: • The tool is simplified and can be used at any level without always requesting support from the higher level • Non-existence of a previous simplified planning tool • The tool allows you to put together the various interventions that are implemented at the operational level through the notion of associated activities, hence the more resources available (human, financial, logistics and time)
How do you perceive the applicability	• The tool is applicable at all levels (peripheral, intermediate and central)	• This tool is simplified and can be used at any level of the health pyramid. • <u>Comment</u>: to better use this tool at the peripheral level, the process of prioritization must be simplified.
Is this tool useful? Why?	1. This tool will be very useful **2.** "It allows you to plan and carry out more activities than before. This will lead to the inclusion of nearly 50% of additional activities.	1. This tool is useful 2. It will allow us to • Take into account all the priority problems in once through the notion of priority package of activities. • Harmonize the prioritization of activities for planning at every level
Ease of use	• The tool is easy to use • <u>Comment :</u> It will require an accompaniment to undertake the first planning, then it should go, as it has the advantage of being simple	• Easy to use because it provides a comprehensive view of all activities related to a problem and its causes.
Recommendation	• Experimental use of the tool in other districts of health	• Extend the tool to other programmes

Regarding **relevance**, the tool allows one to take into account activities that, although priority, receive no funding. It is therefore possible with this

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matrix, to associate them with the funded activities, to form a group or a package of priority activities; It provides a comprehensive view of all the activities that can be related to a problem or to similar causes; it responds to a need, as there was previously no priority setting tool; and it helps to put together the various interventions implemented at the operational level, through the concept of associated activities; Hence the gain in human and financial resources, in logistics and in time.

Regarding **usefulness**, the tool shows district teams how to plan and perform a higher number of activities. It increases the number of priority problems that can be tackled at the peripheral level in a context of limited resources, and it helps to avoid duplication, fragmentation, and waste of resources; and to harmonize prioritization and planning at all levels of the health pyramid.

The tool is **user-friendly** as it provides an easy and simple way to combine activities and logical frame to build the package of priority activities.

The matrix is **applicable** at all levels and can be linked to existing monitoring tools such as the EPI tool. As already described, health district levels are considered like sub health systems; therefore, the integration side of the tool constitutes a major asset to strengthen the vision and concept of integrated health systems. Regarding time and resources, it took the district a half day to apply the tool considering two national programmes.

Given that the Country has four main programmes/areas of interventions, it may take the whole day to complete the entire package of priority activities. This is time saving as it is anticipated that steps like identifying a source of financing. The whole planning process can then be less than the 5 days that are usually required to conduct the planning exercise at district level.

Monitoring and evaluation of the tool:

To be able to properly monitor the tool and evaluate the outcome, a baseline data should be taken including maternal mortality and morbidity, level of implementation of priority activities for maternal health and unfunded priority maternal health activities that are planned but not implemented. The monitoring of the implementation of the tool will therefore

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enable us to assess/evaluate its efficiency through the existence in districts of more comprehensive HD plans showing integrated priority activities; as well as the level of implementation of unfunded activities related to priority maternal health problems and the overall trends of maternal mortality and morbidity in the district.

III. Conclusion of the test and perspectives

From observations the three parts of the workshop enabled the researcher to see what was happening before the use of the tool and after. The introduction, presentation of the current practice, the short training and use of the tool showed us that what district management teams were considering as non-implementable activities could now be planned with the tool in a whole set of priority activities, with the certainty that they could be implemented. This also contributed to enlarging their vision of what they can do, with what they have.

Another observation was the satisfaction expressed by the participants at the end of the workshop. It sounded like a breath of fresh air with the tool filling a gap where something had been missing. This change in attitude and perception, together with the tool, would facilitate improvements in their life by reducing their workload while simultaneously reducing the burden of disease.

As mentioned in the literature review, Cameroon has made it a point of honour to address the issue of maternal health by putting in place, in May 2014, a Multisectoral Programme to Reduce Maternal & Child Mortality (PNLMM), a special programme under the coordination of the Ministry of Health. Following the encouraging outcome of the national workshop to review and test the tool, the Directorate of Family Health of Cameroon and the PNLMM have endorsed the concept and requested to be permitted to run a pilot phase for the use of the tool in a bigger sample of districts. If the experience is positive, they intend to scale it up to the national level.

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Further development of the tool implies the development of an Excel programing that will use key words to merge/integrate activities among different programmes. In the event of a successful integration and implementation in Cameroon, the long term perspective is to propose a development, adaptation and use of the tool in other countries with similar context, and to extend the tool to prevent other major public health issues that can directly or indirectly affect maternal health, including emerging and re-emerging disease such as the Zika virus disease.

Limitations:

The official relevant documents for specific health areas are sometimes not easily accessible and difficult to reference, as some of them cannot be found elsewhere than at the department concerned within the MoH. In addition to that, most of these documents stay unfortunately with the "draft" status. Consequently, it becomes difficult to rely totally on those documents and to fully quote them as evidence. In addition to the tight agenda of the survey, the low level of involvement of the community in the planning process did not allow the researcher to get good feedbacks from the community regarding their perception of the planning at peripheral level. Time and resource constraints also prevented us from selecting more districts for the testing of the tool. Lastly, due to the fact that it needs more than a year to see the impact of the tool in the field in terms of a reduction of MM, the actual validation of the tool by a demonstration of its capacity to produce impact on the maternal health outcome is lacking. We believe further steps should be considered in order to fill these gaps.

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General Conclusion

The insufficient and inadequate resources allocated to maternal health have compelled many countries to make constraining choices in setting their maternal health priorities, especially at the peripheral level; sometimes to the detriment of the health of the local population as it relates to preventable deaths. Cameroon has faced the same challenges, affecting an effective planning in regards to maternal health. Setting priorities has always been seen as a step in the planning process rather than a continuous process across the different steps. It requires making sure that the priorities which are set are implementable by whoever develops those priorities. In the context of pyramid type of structure in health systems, with a strong control from the central level, a peripheral level should target and plan what it can effectively afford to undertake with the means at its disposal. Major recommendations from this research are (i) the strengthening through capacity building of peripheral level staff in strategic planning, (ii) a closer monitoring and follow up from the central and intermediate levels in planning and implementation of maternal health priorities at district level, and (iii) to provide district management teams with an adequate guideline for a more efficient planning. The tool developed for setting priorities in maternal health at the peripheral level, which can be described as a matrix for integrated priorities, bringing up the concept of "package of priority activities", will contribute to improving the effectiveness of the integrated primary healthcare system in Cameroon through more realistic planning. This is the ideal way to go in order to reduce the burden of maternal mortality in the country, and eventually in Sub-Saharan Africa.

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