REPUBLIC OF CAMEROON

Ministry of Public Health

Anticorruption Strategy and Governance Indicators in the Health Sector in Cameroon

Mission of March 24 -April 12, 2007

FINAL VERSION

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Study financed by the World Bank
“La fraude, les détournements de deniers publics, la corruption continuent de miner les fondations de notre société”
(Fraud, misappropriation of public funds, and corruption continue to undermine the foundations of our society)
President of the Republic, 2006 RDPC Conference

“Les poissons ne peuvent voter un budget pour acheter des hameçons”
(People do not dig their own graves)
Old well-known proverb in Cameroon

This internal document was commissioned by the Ministry of Health and financed by the World Bank. The comments and analyses contained herein are solely the opinions of the authors and do not constitute an official position.
Summary

This report is a contribution to the health sector approach that was initiated in Cameroon in May 2006. Governance and corruption were identified as key areas for improving efficiency and achieving the Millennium Development Goals. The mission took place from March 26 to April 13, 2006, and the team worked with members of the technical secretariat and the thematic committees tasked with the preparation of the SWAp for 2008. The report seeks to provide a rapid assessment of the problem, propose strategies to address it, and identify indicators to facilitate monitoring of progress already achieved.

Analysis of the Problems of Corruption

Within the context of this short mission, we identified the main aspects of corruption in the health sector. However, these observations cannot be viewed as a true assessment and, to an even lesser extent, as an audit:

- **Informal payments** in facilities constitute the most common form of corruption cited by the general public. This type of corruption takes various forms, all of which have a particularly serious impact on access to care by the poorest people and the deterioration of the quality of the service (particularly for private activities).

- **Corruption in relation to drugs** was noted in supply conditions (often at the root of relatively high prices) and in sales (leading to significant expenditure on useless and sometimes even dangerous drugs).

- **The rigidity of the public expenditure procedure** has only a limited effect on corruption, and health officials also often have to circumvent these rules in order to administer their departments. It is difficult to distinguish between these relatively informal practices that are justified for the functioning of the department and those that are motivated by personal interests.

- **The large number of controls** (sometimes redundant) is the root cause of inefficiency and sometimes engenders new forms of corruption. Paradoxically, the highly centralized payment system is becoming one of the main causes of corruption, particularly with regard to queue management. While management of own resources is in theory well regulated, it is a rare occurrence in practice.

- **Low salaries** (and their reduction in 1994) is the most commonly cited reason for corruption. To a certain extent, the widespread per diem and payment per service system justifies informal practices. Informal payments have become the main source of income for health care personnel (including administrative posts).

- The main problem in hospital management stems less from abuse of power by directors and more from their lack of authority to recruit personnel and enforce penalties.
Corruption is therefore not only an issue of dysfunction, but also plays a key role in the operations of the health system.

Existing Strategies (Control and Citizen Approaches)

To address this problem, strategies that have already been implemented are essentially guided by a control approach. Although combating corruption has become a major concern for the authorities, the introduction of new programs and new entities has not, to date, been followed by sustained, long-term effects. Actions specifically targeting the health sector have been limited (commissions, “corruption-free hospitals” campaigns). While public finance management reforms are important, they quite often seek to introduce “new concepts,” rather than promote a thorough reorganization.

There are several civil society initiatives in the area of information, education, and communication. They are being developed to track public expenditure. Given the size and complexity of the problem, civil society in Cameroon is still fragile and lacks the legal tools necessary to ensure the long-term effects of its actions. This “citizen” approach cannot yet be viewed as a true checks and balances mechanism.

Given the role of corruption at all levels, its insinuation into most mechanisms and even its often key role in the functioning of the health system (as income distributor or facilitator in the event of bureaucratic blockages), the anticorruption campaign can be feasible only within the context of an overall analysis of governance and should not be a separate program. Combating corruption involves seeking mechanisms (particularly financing and management mechanisms) that would help make corruption more difficult and less “profitable.”

Incorporation of the Anticorruption Campaign into a Financing Mechanism

The control approach (centralization, single channel, complex procedures, double signature system, ex ante controls, administrative silos, anonymity) often produces adverse effects and must therefore be increasingly linked to an incentive approach (deconcentration, checks and balances, streamlining, accountability, results-based monitoring). These various approaches are at times complementary or interchangeable, and the SWAp process must help to tackle the problems of governance in the entire health system. The anticorruption campaign may be incorporated specifically into the financing and management mechanisms and into the approach related to the quality of services provided to patients.

While salary increases should no longer be a taboo subject, they will probably have only a symbolic effect on corruption. Priority should be given to introducing a system that will gradually help to formalize informal payments. Private activities in public facilities will have to be regulated in some way. Instead of increasing salaries with an inflexible scale that is difficult to adapt to performance-based standards, it would be preferable to strengthen the payment system through the facility itself. Given the people’s limited capacity to pay, third party payment systems should be developed and can take various forms (mutual associations, insurance, and purchase funds).

Instead of developing shared decision-making systems, a more “entrepreneurial” approach should grant more authority to the directors of establishments while developing mechanisms to make them accountable. On the other hand, beneficiaries can be included in the selection, implementation, and monitoring of actions, provided the tasks are clearly defined. Their role in the checks and balances or evaluation (accreditation) mechanisms must be fully recognized. Transparency requires a reliable and comprehensive information system
that may be developed on an ongoing basis, only if it is integrated into an automatic financing mechanism with incentives.

Monitoring Indicators

As a complement to the implementation of the financing mechanisms, the quality approach helps to better take into account the opinions of the patients in the anticorruption campaign. Monitoring the “corruption-free hospital” initiative can provide the opportunity to test the questionnaire designed using the SQI (Systemic Quality Improvement) model. More broadly, a questionnaire for each health center (or per district) can help to incorporate key aspects of governance into the SQI process. An analysis of corruption must also be taken into account in a labeling system (rather than in a competition approach). Collecting additional information must be linked to an incentive system. This quality approach “consumes a significant amount of personnel time,” and the sector approach must provide the opportunity to better coordinate the various initiatives that very often mobilize health facility personnel.

According to many perception indicators developed by several organizations, the corruption situation in Cameroon is still cause for concern. These indicators have indeed been criticized for many reasons; there is therefore a need to search for more objective ones.

At each level of the health system and in each facility, it is possible to obtain a number of quantitative indicators that will allow for a more qualitative assessment of vulnerability to corruption. It is still particularly difficult to determine the extent to which inefficiency can be attributed to poor allocation, lack of qualifications and incentives, and the level of corruption. However, estimates of the importance of the informal sector in each facility can be provided. While a table indicating the level of corruption in the entire health sector can be established, it will be difficult to track its development in order to monitor the progress made in combating corruption. A more qualitative approach based on monitoring and implementing reforms is necessary.

This report does not propose the complete restructuring of the health system. However, it must in particular contribute to the debate by the SWAp team on the key governance problems and overall reform strategies. Specifically, the problem of corruption must be taken into account in the planning process. Instead of developing a rigid and detailed plan that will not be followed, it would be wise to develop more flexible, more reactive, and more incentive-based financing mechanisms. “Pilot” experiments can be developed to guide the direction of reforms in stages.

Establishing a health SWAp in Cameroon should also provide an opportunity for in-depth discussion on external financing, by capitalizing on the various experiments (provincial funds, mutual associations, sinking funds). In order to find a support channel that may be less vulnerable to corruption, it would be useful to gradually introduce autonomous, coordinated, and performance-based financing, instead of continually trying to restore a poorly designed network to finance the lion’s share of social expenditure. This more autonomous mechanism should help to increase the participation of the private sector and civil society, which remain indispensable checks and balances mechanisms.

Under the increasingly incentive-based approach, which serves as a complement to the required control approach and the indispensable mobilization of civil society, these financing mechanisms are one of the key pillars of the anticorruption campaign.
Abbreviations and Acronyms

AFD  *Agence Française de Développement* [French Development Agency]
ANIF *Agence Nationale d’Investigation Financière* [National Agency for Financial Investigation]
ARMP *Agence de Réglementation des Marchés Publics* [Public Procurement Regulatory Authority]
C2D *Contrat de Désendettement et de Développement* [Debt Relief and Development Contract]
CAA *Caisse Autonome d’Amortissement* [National Sinking Fund]
CAPP *Centre d’Approvisionnement Provinciaux* [Provincial Drug Center]
CCIA *Comité de Coordination Inter Agence* [InterAgency Coordination Committee]
CENAME *Centrale Nationale d’Approvisionnement en Médicaments Essentiels* [National Drug Procurement Center]
CEPCA *Conseil des Églises Protestantes du Cameroun* (formerly FEMEC) [Council for Protestant Churches in Cameroon]
CNPS *Caisse Nationale de Prévoyance Sociale* [National Social Insurance Fund]
CONAC *Commission Nationale Anti-Corruption* [National Anticorruption Commission]
CPAR *Country Procurement Assessment Report*
CPIA *Country Policy and Institutional Assessment*
DAO *Standard Bidding Documents (SBDs)*
DOSTS *Direction de l’Organisation des Soins et de la Technologie Sanitaire* [Department of Health Care Organization and Health Technology]
ECD *Equipe Cadre de District* [District Leadership Team]
EPI *Expanded Program on Immunization*
FEMEC *Fédération des Églises et Missions Evangéliques du Cameroun* (now known as CEPCA) [Federation of Protestant Churches and Missions in Cameroon]
FSPS *Fonds Spécial pour la Promotion de la Santé* [Special Health Promotion Fund]
GAVI *Global Alliance for Vaccines and Immunisation*
GTZ *German Agency for Technical Cooperation*
HIPC *Heavily Indebted Poor Countries*
HIV/AIDS *Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome*
IEC *Information, Education, Communication*
INS *Institut National de la Statistique* [National Institute of Statistics]
IRD *Institut de Recherche et Développement* [French Institute for Research and Development]
MDG *Millennium Development Goals*
MTEF *Medium-Term Expenditure Framework*
OCASC *Organisation Catholique de Santé au Cameroun* [Catholic Health Organization in Cameroon]
OECD *Organization of Economic Cooperation and Development*
PDCA *Plan-Do-Check-Adapt*
PEFA *Public Expenditure Financial Accountability*
PEFSS *Public Expenditure Tracking Survey*
PFM *Public Financial Management*
PLWHA *People Living with HIV/AIDS*
PNG *Programme National de Gouvernance* [National Governance Program]
PRS *Poverty Reduction Strategy*
PRSP *Poverty Reduction Strategy Paper*
SQI *Systemic Quality Improvement*
SSS *Health Sector Strategy*
SWAp *Sector Wide Approach*
TB *Tuberculosis*
TI *Transparency International*
TOR *Terms of Reference*
TPG *Paymaster General*
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<td>United Nations Development Programme</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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Introduction

The mission is part of a health sector approach that was specifically developed in Cameroon in May 2006, following a workshop that brought together the main actors and partners. The objective is to introduce a SWAp in 2008 for a four-year period. A steering and monitoring committee was established and is supported by a technical secretariat. Thematic groups were established on March 8, 2007 to conduct a midterm assessment, explore methods of funding, and develop monitoring instruments.

Governance and corruption were identified as key areas for improving efficiency and achieving the Millennium Development Goals. The tasks of the mission can be summarized as follows:

- Analyze corruption and anticorruption efforts in the health sector;
- Develop possible strategies for improving governance, managing the health sector, and combating corruption, incorporating them into the sector approach, which must be implemented by early 2007. The SWAp team made an urgent request at the end of the first week for the first output;
- Incorporate governance and anticorruption issues into an SQI approach on a countrywide basis, based on a Plan-Do-Check-Act process. This task must be carried out in close collaboration with the SQI task force; and
- Propose governance and anticorruption indicators that could be incorporated under monitoring and evaluation, which was introduced in the new sector strategy. This task must be carried out with the monitoring and evaluation thematic group.

The report was prepared in the following manner. After a brief chapter on methodology (I), we provide a rapid assessment of corruption in the health sector (II), and the anticorruption strategies that have already been implemented (III). Following a presentation of the various new strategic approaches (IV), we discuss possible indicators (V) to gauge the impact of these measures and present conclusions on the role of governance in the current sector approach process.

This was an ambitious undertaking for a mission lasting fewer than sixteen days, which was actually conducted from March 26 to April 13. This report must be viewed first and foremost as a contribution to the consideration of this subject for the various thematic groups.

We are grateful for the kind collaboration of the many persons who were interviewed. Even if discretion was called for, the discussions were especially candid on a relatively sensitive subject. Based on many discussions, it appeared to us that, contrary to a few years ago, corruption was no longer really a taboo subject in health facilities, ministerial agencies, or among patients and the public in general in Cameroon. This shift in attitude is already an important step for anticorruption efforts.
I Organization and Methodology

1.1 Definitions

In this report, we have addressed the issue of corruption in its broadest sense: “Abuse of power for personal gain.” This definition therefore does not cover all illegal practices, focusing solely on activities for personal enrichment. Thus, a distinction must be made between corruption that is of one’s own volition, and the result of mismanagement or poor health care. It is sometimes equally difficult to distinguish between corruption and the adverse effects of tariff mechanisms or the model for organizing services (e.g., moral hazard, adverse selection).

In contrast, abuse of power is a broader notion than the simple formal non-compliance with regulations, particularly in Cameroon where regulations are not always very clear and are, at times, contradictory. The study therefore focuses on the powers of the various actors and the ways in which they use or abuse them. In our view, the broader issues of governance must therefore be addressed, and the practices of managers and of health care workers and patients analyzed.

Corruption affects the entire health sector and, consequently, both the public and private sectors. Nevertheless, given the position of the public sector in the area of health, particular attention will be paid to public fund management even if these funds often come from households or external aid.\(^1\) The nonprofit private sector (particularly faith-based organizations) is included because they make a significant contribution to public service. A special analysis would be required to analyze the for-profit private sector in itself, and not only its relationship with the public service (provision of equipment or services).

Our study is part of the introduction of a sector approach and is therefore geared toward achieving efficiency and equity. Combating corruption is therefore presented in this study as a way to improve the health system’s effectiveness, particularly for the purposes of achieving the MDGs (maternal mortality, infant mortality), and monitoring anticorruption efforts. Thus, particular attention will be paid to the impact of corruption on access to care and on impoverishment mechanisms.

1.2 Specifics of the Problem in the Health Sector

Corruption is able to flourish in the health sector in particular for a number of well-known reasons that are briefly enumerated below, because they also quite easily apply to Cameroon:

- Size of public funding at stake (7.9 percent of public expenditure);
- Complexity of financing (multiple sources, donors, funds);
- Importance of the relationship between the public and private sectors (task sharing);
- Volume of materials and products purchased (private suppliers);
- Large number and complexity of regulations (drugs, medical practices);
- Share of household expenses (73 percent of health expenses);
- Unequal access to information (the patient is not always able to control the service);
- Best efforts obligation and not an absolute obligation (results difficult to calculate).
- Frequent cases of monopoly (especially of a geographical nature);
- Prestige of the profession which inspires a certain level of a priori confidence;

\(^1\) We have adopted the approach in the Rogerson report, ODI ref. 23, which defines corruption as “the use of public property for private gain.”
• Urgent need (the patient is often unable to have a discussion); and
• Induced demand (demand is often created by supply).

It is also important to note the gravity of the impact of corruption on the health sector in Cameroon and elsewhere. This impact can be summarized as follows:

• Impact on access to health care (delayed, inefficient, and expensive access);
• Impact on the quality of care (motivation, poor resource allocation);
• Impact on mortality (lack of assistance to a person in a life-threatening situation);
• Long-term impact on confidence among health personnel; and
• Impact on the organization of the health care system (non-compliance with references).

Tackling corruption in the health sector alone may seem a bit tricky, because these problems affect all public services (particularly the civil service and public finances), and are often not specific to health. Questions may also be raised about the room for maneuver for the actors of the actual sector to combat corruption. Corruption, like all health indicators, relies heavily on other determining factors. However, even within the context of a sector approach, it is essential to distinguish between actions specifically designed for the health sector and those where health could be viewed as a pilot sector for reform, which, in order to be sustainable or become truly effective, should probably encompass other sectors.

1.3 Organization of the Mission

The mission began with a briefing at the World Bank office, and then at the SWAp technical secretariat. The decision was then made to participate for one day in the workshop to develop the framework to update the SSS (Health Sector Strategy), which was held in Kribi from March 26 to 30. Participation in this workshop was a useful way to start establishing contact and gaining an understanding of the process. It was nevertheless difficult to immediately incorporate some of the aspects of our terms of reference, because the participants already had an important, clearly defined task, and did not have the time to address the issue of governance during drafting of their “updated conceptual SSS model.” While the consultants managed to secure the preparatory documents for the workshop, the “completed matrix,” the summary document, and the recommendations were still unavailable when the mission had ended.

Owing to logistical reasons and in order to accommodate the schedules of the partners, it was proposed that field visits begin during the first week. The mission was able to meet the main actors and visit a number of public and private facilities at the three levels of the health system (health center, district, and province) in three provinces, namely the South West, Littoral, and West provinces. This was therefore not a truly representative sample of the country. The objective of these visits was to conduct a relatively wide variety of straw polls to identify the various forms of corruption and their prevalence.

The consultants began working in Yaoundé during the second week. While regular contact with the SWAp technical secretariat was maintained, the process was still only in the embryonic stage. To date, no document on the content of the midterm assessment or the strategic themes has been made available. Moreover, the monitoring and evaluation committee, like the majority of the other groups, had still not convened its first meeting. However, we were able to meet individually with many of the members of each committee. Although we held useful one-on-one discussions, we were unable to organize a group session despite our requests.

2 See Annex 1 for the list of persons met.
The mission took place at a somewhat inopportune time (several persons were on leave or on mission, public holidays, electoral campaign), which made it particularly difficult to establish contact with key persons. However, the organization of this mission in synergy with the one carried out on fiscal space helped to establish contacts, gather documents, and take into account the links between inefficiency and corruption.

The mission ended with an in-depth debriefing on the attached PowerPoint presentation and working documents with the members of the SWAp technical secretariat and certain thematic groups. Invaluable tips were provided to better guide the drafting of the final report.

Methodological Indications

Although a true group session never materialized, the mission was nevertheless able to hold in-depth discussions on the issue with the main actors. The majority of these analyses and recommendations were therefore presented, and we took note of the observations and criticisms.

However, this is the first stage of a process that may be continued, particularly by the monitoring and evaluation and the financing groups. Specifically, the tables annexed hereto (such as the questionnaires and the indicators) must be viewed as working documents and not final proposals. We have attempted to present a larger number of alternative choices for the Cameroonian authorities. A more rigorous selection process should be conducted on the basis of the other works developed under the SWAp.

The report also makes a special effort to focus on a more general discussion of the organization of the health system, not by proposing a new model but by steering the discussion of the thematic groups toward topics that, in our view, are crucial to the anticorruption campaign.

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3 Annexes 6, 7, 8, and 9.
## II Rapid Assessment of Corruption and Problems of Governance

### PROBLEMS

#### Informal Payment for Services

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<td>Unofficial private practices</td>
<td>Decline in resources and quality</td>
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#### Management of Drugs

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It is not possible to conduct a true assessment, and even less so, a financial audit in this section. The objective of this chapter is to illustrate the scope of the problems and present the various corruption mechanisms. It is therefore not a comprehensive assessment, and the focus is of course on the breakdown in the system. A general distinction has been made between petty corruption (interpersonal, daily, lack of use of sophisticated techniques) and grand corruption (anonymous, financial, and accounting). However, they are also often linked in a sort of common protection system. The subject was therefore addressed by area of intervention (payment of services, drugs, financial management, and human resources).
2.1 Informal Payment for Services

An attempt is made to distinguish between additional payments for services registered in health facilities and informal payments for other services provided within and outside facilities.

2.1.1 Informal Payments for Public Services

This form of corruption is the most common one cited by the general public. There is an extensive vocabulary to describe corruption, which includes terms such as “motivate,” “aider,” (a patient who is unable to pay the full cost of hospitalization strikes a deal with the cashier who prepares a false invoice and pockets half of the amount indicated therein), “facilitate,” “tarif élastique” (varying rates), and “faire peser le certificat” (a patient pays more than the official rate to ensure that his or her medical certificate is given greater consideration). It is sometimes difficult to differentiate between a “tip” that is more or less compulsory and a freely offered “backshish” (gratuity for services rendered). While corruption is at times blatant, it is often well disguised.

Annex 3 lists the various types of payment charged as soon as the patient enters the facility and the guidance and assistance that he or she receives from the “démarqueurs” and “rabatteurs” (young hospital employees who are paid commissions for each patient they direct to certain specialists in private clinics). There are cases of unrecorded billing (or partially on carbon paper), overbilling for actual or alleged additional services (using timeliness and quality as pretexts), payment for a service that in fact was not provided (e.g., results provided when tests had not even been conducted). Certain areas such as drugs, morgues, and laboratories are more sensitive. Officially free (mosquito nets, HIV tests) or subsidized services (laboratory examinations for PLWHA) can unofficially become paying services. This problem appears to be somewhat less frequent when the free service has been offered for a long time (TB, vaccines).

Although there are numerous and frequent examples of this type of corruption, it is difficult to assess its scope because it generally involves small amounts—though sometimes much larger sums are involved. It has a particularly adverse impact on access to health care owing to its arbitrary and repetitive nature, because it often affects the most vulnerable (they are less able to complain), discourages patients from seeking care (or delays it), and orients it in an inefficient manner.

The 2004 survey on access to and the factors determining use of health care and drugs provides some information on informal payments. It reveals that 10 percent of consultation fees are paid directly to personnel and not to the facility. However, it is estimated that these invoices are on average 45 percent higher than the official posted charges. The reverse appears to occur in the private sector, where the patient makes a deal with personnel to pay less. The invoices provided for the purpose of this survey are probably just a fraction of those paid by patients.

2.1.2 Unofficial Private Activities

We have included these private activities in the list of forms of corruption because they are not officially recognized (and therefore not regulated), result in a loss of significant revenue for

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4 See Annex 3 for the definitions of these and other terms.
5 Reference was sometimes made to the expression “mange mille,” which is used to refer to police officers who are paid the standard bribe of CFAF 1,000.
6 No statute authorizes or regulates the private activities of public health personnel within or outside health
the facilities, and represent an essential gain for personnel. They have a considerable influence on the work time spent by personnel at the facility or carrying out public service activities. This can be described as a *diversion of human resources and of potential revenue*, because these activities especially help to “lure away” patients who are subsequently treated in relatively informal private facilities.

Determining the extent of these payments is also difficult. The aforementioned survey on access to health care indicates that the appeal of the informal sector appears to be more closely linked to better alignment of supplies with demand capacities than to lower unit costs. The average cost of a consultation is CFAF 680, which is close to the official rates of between CFAF 600 and CFAF 1,000, but there are still great disparities (up to CFAF 10,000). The average cost of consultations for the richest citizens (and urban dwellers) is the highest, which would indicate that there is a certain progressiveness in informal payments (a type of payment based on one’s finances). However, other studies (for example, the DIAL study in Madagascar) show that the cost of corruption is relatively higher among the poor than the rich.

These various payments (official, additional, for private service in a hospital, for private service outside of a hospital) *absorb a substantial share of household expenses on health, even if it is not possible to determine accurately the portion of each type of payment*. The 2004 socioeconomic and therapeutic care survey shows that “money problems are the main difficulty faced,” and that self-medication and therapeutic abstention (passive euthanasia) are usually the result of a “lack of money.” The average expense is CFAF 22,000 per person, a high amount compared to the official rates for current health care. The share of household expenses allocated to health care increased from 4 percent in 1984 to 7.6 percent in 2001 (from US$14 to US$21), while 83 percent of health expenditure come from household contributions. Many patients (20-25 percent) take out loans to finance health care (especially from the *tontines* [informal savings and loans associations]).

2.2 The Management of Drugs

The purchase of drugs is the main health expense in households (almost 50 percent) and the main source of revenue for health facilities. It is the product for which patients usually show the greatest willingness to pay, and is the easiest product to misappropriate and resell.

2.2.1 Supply

Although health facilities essentially get their supplies from the CAPPs (provincial drug centers), which receive their supplies from CENAME (the national drug procurement center), a number of the purchases are made elsewhere (owing to a shortage of stocks). There are risks of overbilling, fees, or favoritism associated with these mutually agreed procedures. *Corrupt practices can also affect the quality of these drugs*. The Pharmacy Inspectorate carried out an operation on imported drugs that had fraudulently obtained a marketing authorization during the mission’s visit. The aforementioned report on access to drugs estimates that illegally imported drugs account for CFAF 13 billion of the total consumption of CFAF 48 billion each year. Products that have been fraudulently described (or even false labeling) and fake drugs are serious examples of corruption, because they are usually linked to the payment of commissions to avoid being reported.

This situation could justify the establishment of a centralized system, with purchases being

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7 The 2004 survey on factors determining use of health care revealed that 20 percent was for paramedical examinations, 15 percent for hospitalization, 8 percent for consultation, and 6 percent for travel.
made systematically through bids and quality control. However, monopolies also lead rather quickly to abuse of power. CENAME has seen strong growth in its sales while continuing to retain approximately 15 percent of the margin.\(^8\) Specifically, economies of scale have helped to increase revenue substantially, which were used primarily to cover personnel expenses. The highest level of transparency would therefore be required for an autonomous public entity (meetings of the administrative board, publication of statements). Although its personnel are, in theory, governed by private law, the situation has not been completely regularized for all concerned.

Clarification on the status of the CAPPs must also be provided. The CAPPs retain approximately 30 percent of the margin, but should assume several transportation and supervisory functions. Monitoring these activities and improving their functioning therefore appear to be a priority in order to reduce the price of drugs and limit the potential areas for corrupt practices. More generally control difficulties may at times raise the issue of whether a certain level of competition would not lead to much lower stocks.

2.2.2 The Sale of Drugs

The quality of pharmacy management varies in each health facility, and the same problems of overbilling (or “K direct,” which refers to direct payments to hospital personnel) may arise. Fully autonomous management has often led to embezzlement (too high a markup of prices, gradual stock depletion, sale of free drugs, and use of revenue to pay salaries and not to renew orders). Given this situation, we have learned that it is sometimes necessary to “recentralize” this type of management at the provincial level.

A Special Health Promotion Fund (FSPS) was put in place in three pilot provinces (North West, South West, and Littoral) with support from the GTZ. Although the independent nature of this type of fund is guaranteed by an association status (1990), more specific legislation is still in the drafting stage. The ministry and civil society are currently linked through management. Pharmacies in the facilities become branches for the Provincial Fund, which sets all prices and is responsible for personnel (salaries and appointments). This practice is also helping to keep prices lower, even in distant facilities, by adjusting the fixed margins and assuming a portion of transportation costs.

As is the case with services, there has been an increase in private activities within and outside facilities. Health care workers have “a private pharmacy in their drawer,” which is much easier to mobilize when supplies are out of stock in official pharmacies. A shortage of supplies in public pharmacies facilitates the proliferation of nearby private facilities. The PETS study\(^9\) indicates that there was no guarantee of an availability of certain essential drugs (50 percent of health facilities do not have chloroquine, while only 14 percent have Rifampicin).

A large percentage of private pharmacies are not managed by pharmacists (“pharmacies without pharmacists”). The survey on access to health care indicated that 13 percent of persons responsible for sales outlets declared that they were pharmacists, while 40 percent had had no medical training. The use of front persons by pharmacists who are never in the pharmacies was an often-raised point. However, it is very difficult for the authorities to close a facility, and this is further complicated by corrupt practices.

\(^8\) Between 2000 and 2004, sales increased from CFAF 4 billion to CFAF 7.2 billion, while the wage bill jumped from CFAF 68 million to CFAF 200 million.

\(^9\) Ref. 10
“Street pharmacies” are also very common and are closely linked to corrupt practices (recycling of stolen resources, misappropriated or illegally imported drugs). A circular from the Minister of Public Health, authorizing the “seizure and systematic destruction of any drugs on sale in the streets or in illegal health care facilities,” was issued on March 6, 2006. This directive has rarely been enforced. Numerous links between these informal markets and the public sector exist. The survey on access to drugs indicates that 12 percent of the market sellers stated that they had received supplies from health personnel.

Even more generally, it is often difficult to distinguish between inefficiency caused by the arbitrary prescribing of drugs (useless and costly drugs) and inefficiency caused by corruption, because both processes mutually reinforce each other.

2.3 Financial Management

The various forms of corruption in the health sector are sometimes similar to the corrupt practices in the entire public expenditure system, and are mentioned here for reference purposes. This area also has an extensive vocabulary to describe the “taux de broulage” (bribery rate), and include “mouiller la barbe” (grease someone’s palm), “rendre compte” (make ongoing payments in return for a job acquired through a friend or family member), and “redresser les dossiers” (pay money or grant favors to a health ministry official to have one’s records regularized).

2.3.1 Procurement Rules

Procurement rules have been covered in several statutes and a new public procurement code came into force in 2004. As a division of the State, each government authority or institution has a procurement commission. The new code makes entrepreneurs more accountable, provides for the intervention of neutral observers and an independent auditor, and seeks to limit violations concerning the publication of bids, restricted competition, and confidentiality breaches. The establishment of the Public Procurement Regulatory Authority (ARMP) should help to ensure compliance in this regard. It appears that this agency possesses neither the required autonomy nor, in many cases, the necessary operating resources. Several sources revealed that the observers are not paid regularly.

The work of these procurement commissions has already been covered in several analyses that are at times harsh. Even if conventions are usually respected, problems that were frequently cited include the splitting up of invoices, the inflationary effect of the market price list, the lack of beneficiaries or an independent observer, dummy companies, fees to access files or information, pressure from certain suppliers, fictitious deliveries, and the adverse effects of the director’s fees system. A rapid assessment of the market price list (list of prices not updated) shows that a sort of overbilling charge exceeding 25 percent is immediately applied to a large number of products.

In some cases, suppliers of health equipment or medical supplies are few in number in Cameroon. These relatively captive markets could lead to abuse of this situation. However, technical reasons may also be cited to exclude competitors. The complexity of specific criteria is not always a guarantee of healthy competition. For example, a contract may be declared

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10 We note in particular the increase in the number of the “GIC santé,” commercial interest groups that often offer health care in unsafe facilities with unsuitable equipment and inadequately trained personnel.

11 The Public Expenditure Tracking Survey (PETS) in particular, but also the Transparency International study, which show that more than half of the entrepreneurs have had to pay money under the table to secure contracts. These sums can account for up to 15 percent of the value of the contract.
unsuccessful in order to eliminate a less cooperative supplier and then relaunch the process, in a way that discourages the supplier from repeating the tedious procedure.

Nevertheless, the procurement rules are sufficiently binding to encourage attempts to circumvent them. Reference has often been made to the use of the “4.9,” which alludes to the frequency of invoices amounting to 4.99 million to avoid use of this mandatory procurement system for amounts equal to or exceeding CAF 5 million.

2.3.2 The Public Operating Budget

Despite the large number of projects and extensive discussions, deconcentration of management still remains limited. Allocations for each facility are decided at the central level. Intervention by local political authorities is still very limited and many are of the view that this is a way to minimize the risks of corruption. Owing to the mistrust by the central level of the provinces and a lack of trust by the Ministry of Finance in the technical ministries, the customary expenditure plan has not yet been modified. The Ministry of Finance is still the sole official authorizing entity for expenditures. All payments are made by the paymaster generals (TPGs) or collectors who are responsible to the Finance Agencies (as well as the financial controllers and the comptables matières, who are public servants who receive and manage supplies in the public service). Anticorruption efforts in the health sector can therefore be conducted only in close collaboration with the Ministry of Finance, which has most of the responsibilities.

Although the nomenclature is unwieldy, a very detailed budget (for each health center) does not really protect the facilities. Many possess scant information about their budget (or learn about it at a much later date), and substantial reallocations are frequent yet difficult to calculate (there are no amending finance laws). However, certain recognized centers that employ public personnel have not been receiving “cards” (lines of credit) for several years. These situations persist because these revenues are modest, not only in terms of nominal value, but also in terms of real value. The practice of “withdrawing” and “reissuing” cards has also often been reported. The consensus is that execution periods are too short and do not facilitate good management (they sometimes encourage corruption, a way to quickly absorb budgets).

Indeed, cumbersome budgetary procedures have numerous adverse effects. The various—and often redundant—auditing stages (financial controller, comptables matières), also provide an opportunity for the introduction of commissions, and petty cash slush funds are commonplace. The main problem, which was already analyzed several years ago, is the lack of finances (real or cited) when payment is due. Payment delays for suppliers may exceed several quarters. Most of our interlocutors agree that managing this queue is one of the most common forms of corruption. Suppliers who wish to be paid must first pay a commission. They often offset these losses by overcharging for services while complying in theory with the public procurement rules. An EU pilot project in a number of provinces (West and East) sought to mitigate this cash flow problem through advances to health provinces. This experiment did not last and was not widely adopted, officially because of management problems, but also because it challenged a number of interests.

The rigidity of the procedures and the often unrealistic allocations (which have no bearing on needs) were often criticized. To operate these facilities, there are many ways to circumvent the rules while conforming for appearances’ sake (use of mission funds to pay the secretariat, resale of gas coupons, cash advances by suppliers). The resale of “cards” to suppliers who will

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try to recover a percentage of their value is often the only way to finance activities (training, supervision). It is difficult to know when these practices are justified to develop work-related actions or used for personal ends. This resourcefulness [débrouille] also exists in districts and in provinces. *Provinces in particular have to meet urgent needs without a budget.* They must recover funds from their budgets or the budgets of districts. Similarly, some districts use two percent of the own revenue from their own health centers to cover oversight costs, following elimination of this position from their “cards.”

The operating expenditure rate appears to be high, which is not the case with investment expenditure. Most of the partners agree that the value of the goods that are ultimately acquired in the outlying areas (district, provincial hospitals) in relation to the initial public budget would be on the order of 30 to 50 percent of the initial value of the budget. A value for money comparison of the budgets from their own resources or those of the private sector would be useful.

2.3.3 Own Resources

Although their own resources (earned from direct payments from patients) are limited given the people’s capacity to contribute, *they are the main source of financing for the operations of facilities located in the outlying areas.*

*Management of these funds is mired in complex regulations.* For example, the recovery of actual costs concerns revenues that can be immediately reused (essentially for the laboratories), while other revenues must be allocated to the following year’s budget. There is also the obligation to make deposits into the treasury for consolidated cash management, (a requirement officially justified by the problems in the banking system), the setting of a percentage for the allowance quotas (30 percent) based on salary scales, retention of 10 percent of revenues for the services for the National Solidarity Fund, and 10 percent of revenues from sales of drugs for the Provincial Special Funds. It is difficult to track the use of this “bottom-up” financing, which also leads to underreporting.

These regulations are not always respected (most of the facilities visited were still using bank accounts). This raises questions about how effective these facilities can be with regard to improving management of their own resources and curbing corruption. Theoretically speaking, although these revenues should not be used for investment expenditures, they are used for certain works or purchases of equipment when demand is constant. It is remarkable that the *Ministry has only very limited information* (and with a significant time lag) on this financing. The facilities do not systematically send back these forms and the reports are usually underestimated.

It is therefore difficult to assess management of these funds. In most of the facilities in Cameroon, *the chief doctor has the key responsibility* of initiating expenses, even if checks must be signed by a second signatory—the treasurer—who is selected by the management committee and is usually the “comptable matière” at the facility. *In general, the management committees have rather limited powers, especially in small facilities.* The chairpersons of the management committees often serve to mobilize and build awareness

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13 Originating from a simple letter from the Minister of Finance, while a law authorizing facilities to open a bank account has not been repealed.
14 The FECOM scandal (this entity is responsible for redistributing the capital development funds among local communities) illustrates the risks of this type of mechanism.
15 In some countries, a management association (elected by the patients or the general public) manages these facilities in an autonomous manner. However, this strict separation often leads to tension among chief doctors.
among the people. In larger facilities (in some cases, the mayor is the chairperson of the management committee of the hospital\textsuperscript{16}), local authorities may be more involved in management, which can be both positive and negative.

\textit{It would be useful to carry out a comparison of the facilities of the faith-based private sector in this area, which essentially lives off its own resources.} It is commonly believed that corruption is less prevalent in this sector, not only for religious reasons, but also because of greater management autonomy, increased accountability, and especially, the enforcement of penalties. The problems cited are primarily related to links with the Church (with two-way subsidies).

2.4 Human Resources

2.4.1 Salaries and Allowances

A low salary (and especially the two brutal and “illegal” reductions in 1993\textsuperscript{17}) is the most common reason cited to rationalize corruption as a form of survival, a pretext for fraudulent practices, and as justification for its widespread practice. The devaluation of the CFA franc in 1994 and inflation raised the cost of certain products. All the studies confirm that current salaries do not cover “essential basic expenses” for each profession.

Against this backdrop, the importance of the discussion on the various types of allowances is therefore evident. These include:

- The allowance granted for technical skills is based on the public service grade and usually averages CFAF 50,000 per month for a doctor;
- Other allowances that are determined by the authorities (and often paid from the public budget and not only by donors) for training sessions, seminars, or travel are high, and can reach or sometimes exceed CFAF 50,000 per month; and
- Public servants who participate in most meetings must, quite often, be paid to do so.

\textit{There is a sort of payment per service system\textsuperscript{18} that, even if it is officially recognized, distorts the spirit if not the letter of public service statutes.} While this type of income must certainly not be viewed as the fruit of corruption as such, this system has widely recognized adverse effects. First, this practice often stymies attempts to resolve the key issue of salaries. Second, people who have no access to these earnings seek to recover them through informal payments, eventually using a similar approach (even if this is not regulated). Nevertheless, unlike neighboring countries, salaries are usually paid on a regular basis. However, this is not always the case with allowances where delays are at times lengthy.

Personnel at the facilities also receive a “\textit{share}” of the facilities’ resources as an additional source of income. A percentage of this share (usually 30 percent) is fixed in relation to the salary scale. How the remaining portion is used varies from one facility to the next and appears to be fixed on the basis of performance, with no clear standard criteria in place. There are also other benefits, which are more difficult to measure, but which may be viewed as additional salary provided in various forms (such as allowances in cash or kind, transportation, or services).

\textsuperscript{16} In theory, the laws and regulations in force provide for elections.

\textsuperscript{17} The average monthly salary for doctors in the public sector reportedly fell from CFAF 234,000 to CFAF 204,000 in January 1993 and to CFAF 101,000 in November 1993. There were similar reductions in the salaries of paramedical personnel (from CFAF 123,000 to CFAF 62,000 for nurses, and from CFAF 141,000 to CFAF 63,000 for pharmacists), cf. DROS, ref 5.

\textsuperscript{18} The expression appears in the aforementioned Rogerson report.
In addition to these official resources, informal payments have become the main source of income for health care personnel. One survey\(^{19}\) indicates that doctors spend CFAF 240,000 more than their official salaries. This additional salary is approximately 190 percent of the official salary. While this difference is especially significant among doctors, it is also noticeable among paramedical and even administrative personnel. Additional sources of income abound (agriculture, livestock rearing, small business, and services) and are not always illegal. Nevertheless, private consultations remain the most common and most lucrative practice for health care personnel. During our interviews, we were able to estimate that average basic expenses\(^{20}\) for a doctor in Cameroon are on the order of CFAF 500,000. In this case, more than half of the income would come from other earnings, which is sometimes compensation for real services, but about which we have very little information. This phenomenon also affects all health care personnel at the lower levels, and probably to the same degree. A comparison between salaries in the nonprofit private sector (where informal private practices are relatively less prevalent)\(^{21}\) could also help to determine the level of informal income. Although these salaries are generally 50 to 100 percent higher, private facilities often experience difficulty recruiting personnel.

2.4.2 Recruitment of Personnel

The volume of informal resources (under-the-table payments, private activities in the facility, illegal private practice outside the facility) helps explain why most facilities are staffed by a significant percentage of unofficially registered personnel (often approximately 30 percent), instead of paid public servants who are not on site (fictitious jobs that are difficult to assess)! HIPC financing has, to a certain extent, exacerbated the situation (1,700 contract workers recruited in the health sector under this initiative for CFAF 5.6 billion). There were also several “volunteers” who had been recruited under HIPC, some of whom have been waiting for more than one year to enter the public service. Retired “volunteers” also sometimes carry out activities in the facilities. Similar cases are also noted in administrative positions, such as a district administrator who had been working as a volunteer for one year, and who therefore was not officially earning an income. The chief doctor did not need to “secure allowance cards” to cover this income, as he was obliged to do to pay the salary of his secretary.

This type of personnel should not be confused with the contracted personnel recruited officially by the facility and paid from the facility’s funds. They are usually large in number, particularly among low-skilled workers (cleaners, gardeners, and chauffeurs). Appointing persons to these numerous positions is a very powerful responsibility and also plays a

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\(^{19}\) DROS, Human Resource Management in the health sector, ref. 5.

\(^{20}\) For a standard of living considered “normal” in the profession (vehicle, house, family expenses, etc.)

\(^{21}\) This is only because there are more strict regulations concerning the number of hours spent on the job.
significant social role. Personnel who were interviewed expressed a preference for using the facility’s funds to pay the new contracted personnel rather than to cover an increase in their allowances, and for other various reasons, such as reducing the workload, avoiding certain tasks, or providing employment for a relative. These low salaries (and lack of public service security) also help explain why certain jobs are also covered by informal payments (for minor services).

Most of the qualified personnel are recruited by the public service and directors have very limited authority to assign these personnel. In the faith-based private sector, directors sometimes have greater responsibilities even where personnel are legally recruited through sectarian networks. We were informed of pressure being exerted in a number of cases to appoint personnel selected by the Church, but who became the financial responsibility of the facility (who naturally pays them from its revenue).

2.4.3 The Penalty System

Absenteeism is relatively easier to calculate and can therefore be penalized. INS (National Institute of Statistics) surveys estimate that the average absenteeism rate in public facilities is 5.6 percent, while the rate in provinces varies up to 17 percent.

Penalty procedures exist in the public service. They are onerous to implement, but are particularly difficult to enforce where the director lacks strong political support. The aforementioned Laquintinie hospital has relied especially on a recognized authority that enjoys high-level political support. In the health sector where there are several networks that are often quite united (by common specialties or studies), the use of umbrella protections is an oft-cited problem. Under these conditions, it is very difficult to enforce a ban on private activities outside and even within the hospital. Even the enforcement of penalties for serious infractions (misappropriation of funds) quickly becomes a serious political problem that mobilizes networks. A hospital official can only be effective if he or she has strong political backing. Unfortunately, this support is dependent on his or her level of cooperation.

However, surveys in other African nations reveal that public servants, like the general public, are largely in favor of increasing, or at least of imposing, penalties. One often gets the impression that public servants cling to the benefits that they have gained, while coalitions for change are possible. Most of our interlocutors viewed this penalty issue as the key difference with the faith-based private sector where, even if abuses are sometimes covered up, persons in sensitive jobs such as cashiers and pharmacists are quite frequently dismissed.

Corruption is therefore not only an issue of dysfunction, but also plays a key role in the operations of the health system.

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22 The DIAL survey, ref. 20, reveals that 80 percent of public servants and the general public favor stiffer penalties, while 89 percent of public servants are in favor of merit-based salaries (93 percent of the entire population).
III Existing Strategies

- **Combating corruption** has become a major concern for the authorities but, to date, the establishment of new programs and new entities has not often been followed by sustained, long-term effects.

- **Specific actions in the health sector are limited** (commissions, corruption-free hospital campaigns) and inspection agencies lack resources.

- While public finance management reforms are important, they often introduce new concepts instead of promoting a thorough restructuring.

- There are several civil society initiatives in the area of information, education, and communication. These can allow beneficiaries or patients to participate in the follow-up or evaluation of projects.

- **Owing to civil society fragility** and a lack of legal and financial resources, NGOs cannot yet be viewed as providing a true checks and balances mechanism.

The Government has been engaged in combating corruption in numerous areas for several years. Most partners recognize that achieving the HIPC completion point in April 2006 was a strong incentive to improve governance. This progress is not specific to the health sector but may contribute to an overall improvement.

In 2005, Cameroon signed on to the Extractive Industries Transparency Initiative (EITI), a significant development, given the share of petroleum resources in the public budget. Cameroon ratified the United Nations Convention Against Corruption (UNCAC) in February 2006. The General Secretariat of the Office of the President expressed the desire for Cameroon to be a pilot country for the UNCAC (May 2006 UNDP report on the operationalization of the Convention). However, Cameroon has not yet signed the African Union Convention on Preventing and Combating Corruption and Related Offences. This Convention was signed in Maputo by 30 African countries in July 2003.

3.1 Government Authority Action

3.1.1 *The First National Governance Program*

The first national governance program was implemented between 2000 and 2005. *Anticorruption commissions were established in all ministries and supposedly in all public institutions.* Most opine that the outcomes of these commissions have been modest.\(^{23}\) We were able to meet some of the members of the commission at the Ministry of Health, but it had not yet been convened for 2007.\(^{24}\) The commission at the organizations visited exists only on paper. The most significant activities reportedly took place at the National Commission in the Office of the Prime Minister, but we were unable to meet any of its members because almost all were involved in pre-election campaigning. This program initially included a corruption observatory that does not really appear to have been operational.

Despite the promulgation of the April 26, 2006 law *relative to the declaration of assets and*


\(^{24}\) While evaluating these commissions, the *Programme Concerté Pluri-Acteurs* (PCPA), a multistakeholder development program, was not able to meet with the persons in charge of these health commissions, unlike those in other ministries. In the area of health, the report mentions the existence of two little-utilized letter boxes, the review of 14 complaints, and the setting up of a fax and telephone number for whistleblowing, ref. 43.
property of public officials, this law imposes no obligation to publish this declaration, and its implementing decree has yet to be issued. Displays of wealth and the pronounced level of inequality\(^{25}\) are, however, very visible in Cameroon.

The government initiative to combat corruption, operation *Epervier* [Hawk], began four years ago and above all targets “grand corruption” taking the approach of punishing perpetrators as an example. In 2006, 103 people were indicted, but not in the health sector (Douala port, European Monetary Cooperation Fund [EMCF], Cameroon Forestry Company [Crédit Foncier du Cameroun CFC], and Cameroon Real Estate Corporation [Société Immobilière du Cameroun SIC]). A manager of the provincial program to fight AIDS (Littoral) was arrested the previous year. *These actions, which are appreciated by the general public, appear to be running out of steam.* One oft-heard critique is the failure to reimburse the sums stolen by these persons who will therefore keep their ill-gotten gains after some years in prison. Specific actions have been undertaken in the area of health (circular of October 28, 2005 for a “Corruption-free hospital”). With the exception of posters put up in certain facilities, it is difficult to measure its effect at this stage.

### 3.1.2 The New Governance Program

A new governance program (2006-2010) was put into place and comprises a much wider area:

- Administrative reform;
- Modernizing the public service;
- Capacity-building for state officials;
- Modernizing the justice system;
- Improving economic and financial management;
- Strengthening parliamentary institutions;
- Decentralization;
- Improving the business environment;
- Improving citizen participation in management of public affairs;
- Modernizing the electoral framework;
- Modernizing the human rights sector; and
- Dissemination and promotion of the law.

This program draws a number of lessons from its predecessor, particularly *by providing more support for capacity-building through civil society organization (CSOs) networks*, which will be encouraged to play a significant role, particularly in combating corruption. For this area, the National Governance Program (PNG) plans to organize a national information and awareness-building campaign and a national forum to combat corruption, restructure the National Anticorruption Observatory into an independent institution, and establish a national anticorruption coalition with the NGO networks.\(^{25}\)

It is still too early to evaluate the implementation of this program. The *National Anticorruption Commission (CONAC)* was established in March 2006. Under the authority of the President of the Republic, it has wider powers but has no regulatory authority to codify the conditions and

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\(^{25}\) The Gini index on income inequality is high (0.4) and has, moreover, increased according to the INS poverty survey.

\(^{26}\) With a planned budget of CFAF 915 million, of which CFAF 585 million have reportedly already been provided.
modalities of its mandate. It lacks the authority to order freezing, seizure, and confiscation of assets. Some fear that “establishing new institutions without assigning them sufficient human and financial resources to ensure that they function effectively can only contribute to discrediting overall efforts of the Government in this area.”

The program entitled Changer d’Habitudes, s’Opposer à la Corruption or CHOC (Changing Our Ways, Confronting Corruption) supported by the UNDP and several other donors is part of the new PNG. The main objective of this joint and coordinated action by donors is to help curb corruption in Cameroon by implementing a national strategy for combating corruption based on a comprehensive analysis of this phenomenon, developing and implementing effective legislation, and sensitizing and strengthening civil society. This project has just got under way.

3.1.3 Strengthening Inspection Agencies

Many entities that have long been in place in Cameroon are able to play an important role in combating corruption (General Inspectorates of Finance, Customs Inspectorate, and Supreme State Audit Office). New agencies were established, such as the National Agency for Financial Investigation (ANIF), which was tasked with combating money laundering and the illegal transfer of funds. A chamber of accounts has been set up within the Supreme Court. It is not yet a veritable Court of Auditors and its mandate is limited.

Specific organizations exist in the area of health, particularly in pharmacy inspection and food and health monitoring. District chief doctors also have a responsibility to inspect public and private facilities. Unfortunately, few resources are made available for these inspections. Three persons have been tasked with pharmacy inspection for the entire country. Allowances are paid late and there are cases where the facilities inspected cover the inspection costs. Organizing the coordination of inspections by health authorities and those by the police is also a sensitive matter. In many cases, only the governor can enforce a decision to shut down an illegal facility, or destroy a dangerous product.

3.1.4 Public Financial Management Initiatives

Many reforms were undertaken by the Ministry of Finance in the area of public finances (Public Expenditure and Financial Accountability [PEFA] in 2004 and another being prepared, a new procurement code in 2004, implementation of a new nomenclature for the budget law, draft program budget for 2008). The Country Procurement Assessment Report (CPAR) prepared in 2005 pursuant to OECD-DAC norms indicates that significant progress has been made with regard to compliance with procedures. These measures are above all intended to strengthen the conventional budget practices (consolidated cash management, maintaining a level of centralization, and control of finances). In the context described above, it is difficult to know if they will have a major impact on the improvement of health financing.

Other public finance actions could have a positive effect, such as the drafting of an MTEF for health. Unfortunately, as it is not yet disaggregated by province, this document is far too general to be used for that purpose. There is a small database, but it has not been updated and, above all, contains the different external financing sources. Lastly, significant work has been undertaken to manage the payroll, using in particular the Information System for the Integrated

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27 Rogerson ODI report, ref. 23.
28 For a planned budget of US$1.97 million financed by Canada, the Netherlands, Germany, Great Britain, France, the United States, the World Bank, the UNDP, the AfDB, the DFID, and the Government of Cameroon.
Management of State Personnel and Salaries [Système informatique de gestion intégré des personnels de l’État et de la solde SIGIPES] application. Forty thousand “ghost” workers were identified in this manner. However, it is still too early to use this tool in the health sector.

HIPC implementation was accompanied by a more generalized practice of financial audits, which already constitutes a significant, positive aspect. Some have revealed many instances of bending of the regulations, but indicate just as often that the preceding recommendations do not really have any impact.

Other more radical projects (discontinue or update market price lists, eliminate unnecessary controls, reexamine the role of comptables matières, give technical ministries disbursing authority, and make “cards” electronic) are for the moment only suggested as a working hypothesis. A forum on managing public finances brought together analysis documents on Public Financial Management (PFM) and made proposals in December 2005, but they have not yet had proper follow-up.

3.2 Civil Society Initiatives

Cameroon has a relatively free media that frequently reports instances of corruption. The press therefore acts as a check and balance of sorts, even if the sector is also vulnerable at times given the financial tenuousness of certain newspapers.

3.2.1 “Mapping Civil Society” into Anticorruption Efforts

While civil society has begun to develop particularly because of specific programs, such as governance or combating AIDS, there are still fewer and less powerful NGOs than in other, neighboring countries such as the DRC and Benin. Management problems frequently occur, owing to the often strong dependence on external donors. NGOs often have internal conflicts linked at times to political influences. In all cases, improvement of their legal status can strengthen them. Churches, both Catholic and Protestant, play an important role both as managers of numerous health facilities and as moral authorities. Corruption problems are often raised by religious authorities who are at times represented on anticorruption commissions.

The table in Annex 3 proposes an initial inventory of NGOs involved in health and in combating corruption. Entities responsible for health facilities which thus address corruption problems within their organizations (Catholic Health Organization in Cameroon [Organisation Catholique pour la Santé au Cameroun OCASC], Council for Protestant Churches in Cameroon [Conseil des Églises Protestantes du Cameroun CEPCA], and Ad Lucem) should be distinguished from national NGOs involved in specific actions to combat corruption, such as Caritas Cameroon [Bureau des Activités Socio-Caritatives BASC] and CANADEL. Some have regional branches, while others work only at the provincial level; they, nevertheless, all generally work in networks. They sometimes join together in programs, such as the PCPA and Project for Support to Civil Society Organisations [Projet d’Appui aux Organisations de la Société Civile PRO/OSC], generally around specific financing (USAID, Embassy of France, UNDP).

Unions and professional organizations (for doctors and pharmacists, for example) should also

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29 Officially, only the Minister of Finance is the main authorizing officer, while the central and external officials are credit managers with signing authority.

30 For example, the risks of a split, which occurred at Transparency International last year. However, the problem was resolved.
be included in this introduction of civil society actors. Some participate in certain anticorruption programs (“corruption-free hospital,” for example) or sit on technical commissions. In a number of cases, they can play an important role in the promotion of ethics. However, it is often difficult for them to enforce penalties, and they function mostly as advocates for professional bodies.

3.2.2 Interventions in the Area of Information, Education, and Communication

Civil society is increasingly interested in public resource management. Surveys have been conducted on the monitoring and impact of public investments. Monitoring by independent observers or beneficiaries seems critical, but these studies need more transparency in public management. *Accessing all the data is not always easy, particularly as regards parallel financing and modifications to budgetary appropriations.* One survey on the execution of public investment budgets demonstrates that only 5 percent of these projects would come from local requests and that 22 percent of outcomes are considered to be of good quality. In many cases, these budgets would fund “racketeering, corruption, clientelism, and influence-peddling networks.” Beneficiaries and civil society would like greater influence in the monitoring of these projects, but as some people have said, managing public investment budgets is “like a fighter plane in the sky. It’s very difficult to follow it!” NGOs have proposed training in public management in order to conduct this type of study.

More targeted actions are undertaken to evaluate the impact of public expenditure, for example, in combating AIDS. *At times, associations for HIV-positive persons hold more sway in blowing the whistle on informal payments.* For example, a compilation of texts on access to care and treatment was developed by some of these associations. This can help to better ensure that certain services that have been put in place continue to be provided free of cost. The use of “report cards” in the MAP project allows community involvement in the actions undertaken in combating HIV/AIDS, and thereby renders them more vigilant about corruption problems.

NGOs also use many other IEC tools to combat corruption (*awareness-building campaigns, brainstorming sessions, marches*). A series of posters was designed but did not make much of an impression. The public more often makes reference to newspaper cartoons. In June 2006, Transparency International organized a brainstorming session on corruption in health with the participation of, among others, representatives of the Ministry of Health, the Cameroon National Ports Authority [*Office National des Ports du Cameroun* ONPC], the National Union of Pharmacists, the National Order of Dental Surgeons, and the National Order of Medical and Health Professionals.

While numerous and useful, these actions are still fragile and very limited given the size of the problem. While long-term efforts can be made in the area of awareness-building among the general public (reminder of ethical rules, refusal of small commissions, knowledge of rights, complaints), their impact will be limited if power issues are not addressed. As a member of one of these NGOs said, “when you sweep a staircase, you start at the top.” *The main problem is the lack of legal and financial resources to follow up on this information or these recommendations.* In particular, there are still few complaints. According to a

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31 Concluded by the Support Center for New Local Development Alternatives (*Centre d’Accompagnement de Nouvelles Alternatives de Développement Local* CANADEL) in four communes with a random sample that included health projects.
32 In order to also present the Transparency International 2006 report and comparisons with the corruption situation in the health sector in Senegal and Burkina Faso.
Transparency International survey, victims do not file complaints, particularly because “there’s no point.” This is followed by the magnitude of requests, a fear of having problems, and difficulties in obtaining proof.

Even if financing often encourages joint actions (like the PCPA), coordinating civil society actions is not always easy. Network actions using the internet in particular sometimes facilitate communication. National opinion must play the main role, because if anticorruption campaigns are perceived as coming from the outside, they may be rejected.
IV Proposals for New Strategic Approaches

- **Although to date emphasis has been placed on a control approach, an incentive approach is also needed.** They will be strengthened by the development of a citizen approach.
- **Salary increases** should no longer be a taboo subject but their impact on corruption will probably only be symbolic.
- Priority should be given to finding a system that gradually allows for informal revenue to be formalized. **Private practices in public facilities will have to be regulated** in some way.
- Instead of increasing salaries with inflexible scales that are difficult to adapt to performance standards, **it would be preferable to strengthen the payment system through the facility itself.**
- Given the people’s limited capacity to pay, **third party payment systems** should be developed and could take different forms (purchase funds, insurance, and mutual associations).
- Instead of developing shared decision-making systems, **a more “entrepreneurial” approach** can better empower leaders of organizations by establishing mechanisms that involve their authority.
- **Involvement of beneficiaries** in the selection, implementation, and monitoring of actions can become a reality. Their place within checks and balances or autonomous evaluation (accreditation) mechanisms should be fully recognized.
- **Transparency requires a reliable and comprehensive information system** that can be developed on an ongoing basis only if it is integrated into an automatic financing mechanism with incentives.

4.1 The Different Approaches to Combating Corruption

In this report, we cannot restate all the recommendations already made in numerous, more detailed studies or in genuine workshops specifically aimed at improving public sector management. At this stage of the SWAp process, it appears desirable to consider the strategic aspects of combating corruption. In analyzing different actions undertaken, three main approaches to combating corruption may be highlighted:

4.1.1 The Control and Punishment Approach

The first is a control and punishment approach that **gives priority to more severe management constraints, strengthened centralization, protected single channels, more frequent controls, and supposedly stiff penalties.** Most of the measures proposed by the Government to date have been based on this approach, even if they are at times implemented in a slightly more conservative manner. Given the high level and widespread nature of corruption in the health sector, these interventions will become effective only when they are large enough to become politically and socially unmanageable. Even from a purely technical point of view, this large-scale approach may also become very costly to implement and have negative effects on the functioning of services, at least during a transition period that runs the risk of being long. Indeed, a common control system can mobilize a percentage of the massive resources and

33 In particular, the table of recommendations following the public expenditure tracking survey, ref. 10.
34 The effectiveness of measures should always be gauged by comparing resources used (for example, the budget
create administrative blockages.

4.1.2 The Citizen Approach

The citizen approach is the second approach that attempts to give a voice to victims, in other words, the entire population (gathering complaints, opinions from presumed beneficiaries, informing clients on prices and the organization of care). It requires transparent information (a long-term task given the complexity of public and external financing). With this approach, preferred courses of action are awareness-building campaigns (sometimes including targeted denunciations), as well as training of citizens and professionals in the area of financial expertise and basic ethical rules.

Civil society actions are often based on this approach, even if they still remain limited given the scale of the problem. This approach does not really produce long-term results unless supported by a system that penalizes corruption and protects citizens. Combating corruption is linked at this point with efforts to guarantee human rights and cannot simply be resolved within the confines of the health sector.

4.1.3 An Incentive Approach

Given the place of corruption at all levels, its insinuation into most mechanisms and its often essential role in the functioning of the health system (as income distributor or facilitator in the event of bureaucratic blockages), the anticorruption campaign can be feasible only within the framework of an overall analysis of governance. “Mapping” is needed in each facility to analyze the powers of the different actors, their motives, and the services they offer. Thus, combating corruption cannot be a separate program. It must therefore essentially concern the organization (and in particular, the financing) of the health system.

Combating corruption involves seeking mechanisms, particularly financing and management mechanisms, that would help limit the size of the “leaks,” which would be more difficult to “siphon off,” and of which the negative effects would be better controlled. This approach draws its lessons from ineffective monitoring approaches in many situations. As an example, the following table compares the two approaches in a necessarily exaggerated manner.

4.1.4 From a Control Approach to an Incentive Approach

In certain countries, decentralization has led to a significant increase in corruption because facilities located in peripheral areas did not have the required management capacity. These deconcentrated facilities would also often be more vulnerable to local political pressure. However, in the still very centralized system of Cameroon, the main problem comes from the concentration of power (and often the abuse thereof) in the form of management expertise. The incentive approach involves deconcentration to assign responsibility, by supporting the process with training actions. The division of roles between local governments and local health officials is also key to defending public health actions that can quickly fall afoul of political decisions.
## Frameworks for Transitioning in Certain Areas from a Control to an Incentive Approach

<table>
<thead>
<tr>
<th>Control Approach</th>
<th>Disadvantages</th>
<th>Incentive Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centralization in the form of management expertise</td>
<td>Monopoly on power quickly creates abuses of power.</td>
<td>A certain level of deconcentration supported by training</td>
</tr>
<tr>
<td>Shared decision-making or multiple signatures</td>
<td>Inaction and dilution of responsibilities</td>
<td>Assign responsibilities while developing checks and balances</td>
</tr>
<tr>
<td>Single channel</td>
<td>Monopoly situation creates excess profit (payment queues).</td>
<td>Develop alternatives and harnessed competition</td>
</tr>
<tr>
<td>Complex procedures</td>
<td>Each control can become an opportunity for corruption.</td>
<td>Streamlining</td>
</tr>
<tr>
<td>Ex ante rules and detailed following of procedures</td>
<td>Difficult to establish and therefore poorly applied. Tedium follow-up of procedures, often abandoned.</td>
<td>Results-based monitoring</td>
</tr>
<tr>
<td>Create anonymity</td>
<td>“Cold money” (money from external sources) is more easily stolen</td>
<td>“Reheat the money” (get greater portion of funds from local sources) by involving beneficiaries</td>
</tr>
<tr>
<td>Administrative silos</td>
<td>Corruption develops in these networks</td>
<td>Cross-cutting analysis to ensure overall coherence</td>
</tr>
<tr>
<td>Specific department to combat corruption</td>
<td>Temporary and quickly exhausted actions</td>
<td>Incorporate into the quality and the strengthening of management</td>
</tr>
<tr>
<td>System of penalties</td>
<td>Unfortunately, only to be used in symbolic cases</td>
<td>Make corruption less profitable</td>
</tr>
</tbody>
</table>

Sharing roles does not mean shared decision-making as is often recommended to combat the abuse of a monopoly on power. A double signature system is justified when there is a sharing of responsibilities (for example, between the treasurer and the president), whereas the multiplicity of signatures often seen in Cameroon amounts to a watering-down of responsibilities.

The single channel for funds (and in particular that of the treasury in the French tradition) allowed only a limited number of persons to have access to public funds and thus ensure better control. With the multiplicity of collection points in the area of health, this practice is no longer a reality in Cameroon. However, for a percentage of public expenditure, bottlenecks have become the main window for corruption. While heavily controlled systems are justified for the State’s sovereign functions, social expenditure (and health in particular) has become so significant that another mechanism is called for. In many countries, public health expenditure no longer goes through ministries of health per se (nor, moreover, through ministries of finance).35

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35 Even in countries where the public health system predominates (UK), specific competition mechanisms have been developed.
To improve controls, procedures are made more complex and are often redundant. At times, each control becomes a new opportunity for a new form of corruption in much the same way as multiple roadblocks. Circumvention (and sometimes corruption) then becomes the only way to get around an obstacle. *Priority has been given to controls at the beginning of and during the process, while forgetting about the result.* While results-based financing practices are becoming more prevalent in Cameroonian, there is a danger that they may merely become artificial window-dressing used for budget submissions if consideration is not given to reforming the financing approach. The key principle is to assign responsibility for resources in order to assess results. By constantly interfering with resources, persons in charge are given numerous excuses for failing to obtain results. Financial and human resources must also move from meticulous control of procedures to an in-depth analysis of results (and not only based on relatively artificial indicators).

In certain areas, *anonymity helps to curb corruption because it avoids the establishment of networks.* For example, internet access to bidding documents can prevent extortion from applicants who must provide their contact details to collect bidding documents. Corruption plays an important role in “mutual assistance” networks. This “politics of the belly” principle (system where the political elite uses informal networks to wield political and economic power) is now prevalent in Cameroon, becoming one of the essential ways of life (or survival) at all levels. In this context, it is difficult to adhere to rules of anonymity. An examination of the list of health sector suppliers immediately reveals relatively hidden networks, from the doctor to the private pharmacy, or from the hospital director to the works company.

Another viewpoint holds that anonymity would generally encourage graft in many areas because “the money belongs to no-one.” To reemphasize the terminology explained in the attached insert, we believe that money is often “too cold” in a very centralized country like Cameroon. Even if petty corruption practices are widespread, the people are still committed to ethical principles, even if only for religious reasons. *In contrast, loss of confidence in the State is quite commonplace.* “Stealing from a dishonest State is not stealing.” In this context, it is probably better to accept the existence of visible and responsible networks than to constantly promote superficial neutrality or theoretical competition, which moreover lead to burdensome and costly procedures. Collusion risks linked to decentralization, to the autonomy of facilities, and to the involvement of actors in projects seem to be lower than the risk of widespread misappropriation of resources that are not truly “embezzled” by anyone.

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**After witnessing the pursuit of a cell phone thief by an irate crowd in a Douala market, we were struck by the distinction between “hot money” and “cold money.”** 38 My interlocutor seemed to understand this typical punishment while we conversed in fairly lenient terms about millions of US dollars anonymously embezzled from project lines. “Hot money” is marked by a social link (in this case, local market habits). Breaching these rules of the social fabric is particularly serious (you don’t steal from a friend). Indeed, community involvement in managing health centers consisted of “reheating” money. Likewise, selection of needy persons by communities is often considered more effective than a selection conducted by a Ministry of Social Affairs that has more elaborate criteria. This difference can be explained by the fact that the faraway Ministry has less knowledge about the people, but also because the population will try harder to cheat in order to obtain a card from a large, anonymous administration.

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36 Cf. the book by H Bayart, which was just republished.
37 Rather than tirelessly combating the risk of collusion of interests in a vision that is probably highly Eurocentric, perhaps quality should be sought in the social link by making it visible and useful.
38 Terminology developed by Olivier de Sardan in Niger.
Similarly, administrative silos are often arranged in such a way as to curb corruption (the well-known separation between the authorizing officer and the accountant!). Often, this strategy only creates pockets of corruption or specialized networks of officials with little connection to the final objective of their work. This clear division of tasks is needed, but approaches that allow for a certain level of cross-cutting perspectives must also be developed to better take into account the objectives of the department. Well compartmentalized networks develop corrupt practices without any concern for the impact of their actions on the sequence of services. As such, the PETS study allows expenditure to be traced in order to observe, at the end of a series of decisions, the real service provided. Such inquiries have been conducted in Cameroon, but this process has never been conducted regularly by health facility officials. They could, however, clearly highlight the impact of inefficiency and corruption.

Instead of developing an “umpteenth” program to combat corruption or establishing a new institution, a mechanism is needed to make corruption less profitable. Attempts must be made to increase the marginal cost of corruption (with its share of risk and fear) and to reduce its marginal profit (always uncertain, sometimes prevented).

4.1.5 Complementarity between these Approaches

To clarify, while we have compared the different approaches (control, citizen, and incentive), the links between them are significant. They are often even complementary. The “appropriate dose” of each depends on the context (level of corruption, personnel qualifications, economic conditions, type of activities to be conducted). We would like to call attention to the incentive approach in this report, because it seems to have been neglected until now in programs to combat corruption in Cameroon. It is, however, particularly appropriate in the health sector because of the size of the private sector, the role of patients, and the number of doctors. These three approaches could be presented in a three-dimensional diagram in an attempt to guide Cameroon toward greater equilibrium.

A true governance policy must take into account these three approaches. This overall vision allows for a better understanding that corruption problems are not only technical but also political. Bad management can facilitate or hide corruption, but the two are not the same. Contrary to the prevailing views, in Cameroon, as in many African countries, accounting systems at certain facilities (particularly concerning the management of their own funds) are at times fairly well maintained—even with the rudimentary means available. Accountants often do tedious and elaborate work, but the most frequent problem simply stems from a decision by the manager who is “on the take.”

The anticorruption campaign is certainly an important political matter, and not just because it is equipped to settle current internal conflicts in a large administration. It is often used to strengthen centralized power, and financial departments and controls. In short, it promotes an organizational model that is not necessarily the most effective to reduce poverty and achieve the MDGs in the name of good management and supposed local constraints. The problem of political decisions regarding resources and objectives should be raised in a SWAp. This is why it is important to show through the example of the health sector that there are other ways to combat corruption.
Even if other approaches exist, it is useful, in our view therefore, to incorporate the anticorruption campaign into the sector strategy using two additional components:

- the financing and management mechanisms; and
- the approach related to the quality of services provided to patients, which will be examined in the next chapter.

### 4.2 Incorporation into Financing and Management Mechanisms

Incorporating the anticorruption campaign into the health sector strategy can be done by better defining the tasks and motives of different actors at all levels. However, it is for this reason that the choice of financing and management mechanism is essential, thereby giving rise to the recurring salary increase question.

#### 4.2.1 A Token or Real Increase in Salaries?

Naturally, increasing salaries (fiscal space permitting) raises problems that have often been analyzed:

- This policy would require an overall review of the payroll file, which would be a mammoth task;
- It runs the risk of rapidly spreading to the entire public sector, thereby creating a serious inflationary effect (with presumed “ratchet effects”); and
- It does not automatically reduce corruption.

Targeted increases on the order of 20 to 30 percent have been granted to the police and subsequently to the judiciary. They have not been granted to the entire public service. It is difficult to assess the impact of these measures, even though it would appear that extortion committed by police officers has declined somewhat. The experience of raising salaries in foreign countries appears encouraging at times with regard to petty corruption, if these increases are accompanied by awareness-building campaigns and increased controls. Cameroon’s 1993 salary decreases undeniably had a marked impact on increased corruption both small and large, because they both justified each other. However, an increase in salaries would not necessarily reduce corruption because the elasticity is probably not the same in the other direction (“habits are easier to develop than to break”). These increases will in any case, of necessity, remain very modest when compared with informal income.

On the other hand, salary increases cannot remain a taboo subject in Cameroon. A moderate increase could have a symbolic effect in showing that the system is changing. However, bringing salaries back to the level they were in 1993 would involve a very large increase. The tradeoff of such an increase would be controlling informal activity, which is extremely difficult to do. Given the magnitude of informal activities in public facilities, it is hardly likely that a ban or controls will solve the problem. A system of incentives that gradually allows a part of this informal sector to be regulated must be found.

39 The DIAL study in Madagascar showed a decline in corruption with the 1998-2001 increase in salaries. After the political crisis, the decline in corruption appeared to have continued between 2002 and 2004 during a particularly active campaign.
4.2.2 Gradually Formalize a Part of the Informal Sector

Acknowledgement of the existence of private activities in public facilities is often considered to be a Trojan horse that would make carrying out public activities even more difficult, by creating an unequal situation between both types of activities. However, formalizing a practice is a condition for being able to regulate it. Given Cameroon’s situation, the question is therefore worth asking. Formalization should take place under specific conditions (while setting out the duration, rental payments, and prices for patients) and very strong political will will be needed to ensure compliance.

It is better to find a system with enough incentives for the personnel to accept a reintegration of a portion of informal payments into the facilities’ own resources. This will be possible only if the portion of revenues from these funds increases and their distribution appears to be more equitable. This is why experiments with performance bonuses or even of “segregated funds” for certain revenue-earning departments, such as the laboratory, should be developed. More generally, instead of increasing salaries with inflexible scales that are difficult to adapt to performance standards, it would be preferable to increase performance-based payments paid by the facilities themselves. These mechanisms are more decentralized and more flexible with regard to changes in the context.

The grave salary conditions in Cameroon therefore offer an opportunity to rightly propose overall reform, and to not revert to the former system. Using the traditional salary system without politically difficult overall reform will probably not have much of an impact on corruption. It is therefore a question of regularizing and making a payment per service system more efficient, given that it has become something of a current practice in Cameroon. The last advantage of this salary increase mechanism is that it is specific to the health sector, the only sector, along with education, that manages such large amounts of its own resources.

4.2.3 Develop a Performance-Based Financing Mechanism

Nevertheless, increasing the facilities’ own revenue will be quickly limited by the people’s capacity to contribute. The essential problem is the population’s capacity for payment and their willingness to pay. People pay more in the private sector, but will not be prepared to pay more in the public sector if it does not make substantial changes. It is therefore not possible to automatically transform informal payments into official ones. They are borne of another approach, and another form of distribution. Certain rate increases are probably possible if the quality improves and exemption systems for the poor are operational. However, these two conditions are difficult to achieve in the short term. The only long-term way to increase facilities’ revenues is to develop third-party payment mechanisms.

Cameroon is developing a mutual association program, and we had the opportunity to visit one that is considered to be a success in the district of Tiko.

40 A mechanism for redistribution between departments could be factored in, but it must be transparent. Failing this, current practices of under-reporting will continue.
The Tiko pilot experience in the Southwest province is one of the rare examples of relatively established mutual associations (1998) in Cameroon. It has been able to maintain its financial equilibrium by reimbursing fairly substantial care packages, including hospital services. However, only a few hundred persons are covered. The management office basically works with a private missionary hospital. The involvement of the mutual association in the health district is modest, and has limited potential for growth because free health care is offered to the workers from the large plantation that employs a large proportion of the district’s population.

Mutual associations in Cameroon, as in most African countries, are developed under specific conditions (religious community, companies) but cannot be quickly replicated. They can play a social and awareness-building role, but cannot really be considered as financing strategies. On the other hand, to combat corruption, mutual associations can constitute a useful counteracting force (knowledge of prices, negotiations, representation, and defending the interests of patients). They also ensure that a payment per service system is in place in the facilities (rarely the public ones, unfortunately!), which, in our view, is a powerful incentive for their good governance. Insurance, and especially social security, systems can have these effects on a much larger scale. However, they are difficult to put in place in countries where a large segment of the population participates in the informal economy.

Purchase funds or performance-based aid systems are currently being considered in several countries. The risks of corruption are known (moral hazard, overbilling in particular), as are the solutions (contribution from patients toward the cost of treatment, follow-up of invoices). Their main advantage is the allocation of resources for real and verifiable activities, and giving patients the essential role in the financing system (on demand). They are incentives for good governance and can react in a progressive manner to problems of inefficiency, and sometimes corruption. Of course, specific mechanisms should be set up to take into account specific circumstances (for example, in facilities located in particularly poor regions).

4.2.4 Broaden the Powers and Increase the Responsibilities of Health Facility Directors

Contrary to what is often said, it appears to us that in managing an establishment in Cameroon, the essential problem probably originates less from the risks of abuse of power, and more in terms of the powerlessness of hospital directors in the face of various pressures, particularly in the area of human resource management (appointments, promotions, leniency when mistakes are made). The private sector example shows that a more “entrepreneurial” approach results in, somewhat paradoxically, fewer incidences of corruption. In the private or even the nonprofit sector, the director of the facility must also be much more accountable (decline in revenues or even bankruptcy caused by inefficiency). It is essential that ways be found to give more power to directors while establishing accountability mechanisms. Purchase fund systems can also be an incentive, because resources are dependent on the activity and therefore on the proper functioning of the facility. In addition, to benefit, the facility must be accredited and may be removed from the medical register if it fails to satisfy certain conditions.

While more authority should be granted to the director of an establishment in an anticorruption strategy, he or she should not be the sole individual to wield this power. In the abovementioned example of the Llaquintinine Hospital, the establishment of forums played an important role in strengthening the authority of directors. However, these mechanisms are not compatible with a shared decision-making and “multiple initials and signatures” approach.

In the country’s current situation, the clear sharing of responsibilities probably appears less risky, provided that an incentive and penalty system is put in place. The most appropriate penalty
is not always the one from one’s immediate superior or supervisor (that may take long or be disproportionate), but can come from the automatic effects of a financing mechanism in place (such as in the purchase fund system with a relatively gradual decrease in financing).

4.2.5 Integrate Beneficiaries into the Selection, Implementation, and Monitoring of Interventions

Beneficiaries are the first to be able to verify the existence of services provided and are therefore able to verify whether they are in line with financing. They must therefore know about the financing, which is rarely the case as we have previously demonstrated, participate in the selection (which should not only be based on representation from technical ministries), be consulted about procurement (civil society appears only rarely as an independent observer), and about monitoring and approving works. This approach would require a certain level of decentralization of investments which has been called for by many stakeholders.

In criticizing the effectiveness of beneficiary involvement, the lack of qualifications of these persons, the “overly political” investment choices, and the risks of collusion deemed to be greater at the local level are often cited. The choice of an appropriate level (often rather the provincial level) and the clear division of roles (in particular between mayors and deconcentrated departments) would help to limit these risks of corruption. At present, mayors have been entrusted with certain responsibilities (for example, chairmanship of hospital management committees), with risks that are probably greater still. Under pressure from a number of local elected representatives, districts were established with no justification from a public health standpoint. Their establishment may be viewed as an example of inefficiency and an element of corruption.

4.2.6 Integrate Independent Entities and Checks and Balances Systems

Strengthening certain powers must go hand in hand with the development of checks and balances within specific areas that allow for the development of a health system with such checks and balances. The current pyramid structure can include independent entities (for accreditation, the statistics observatory, quality control). The main problem is enshrining this independence in a law (length of terms, guarantees). While civil society participation may be a way of achieving this objective, true independence is greatly contingent upon the conditions under which members are appointed and their real autonomy. Civil society members are also heterogeneous, open to influence, and not always representative of the population.

Instead of seeking a rather utopian independence of an ideal entity, checks and balances systems must be developed by sharing duties. The purpose of the purchase fund systems is to clearly separate duties (the purchase fund, which is in principle purely a provider of financing; facilities tasked with providing services; an autonomous establishment tasked with accreditation; and in certain cases a trustworthy third party charged with evaluating the services). Recruitment terms of each institution take into account the specifics of its functions. This organizational model also helps to better define the State’s sovereign functions, which it is not in a position to perform (by increasing interventions in all directions).

4.2.7 Integrate Transparency Mechanisms into the Management System

Financing based on results, or even simply on activities, and no longer based on processes should be supported by increased transparency in management. Project expenditure control
was often conducted using invoices and bidding documents (the legality of which could therefore be theoretically verified). Financing by activity allows less of this type of control (that was moreover often barely effective and often too tedious to be conducted regularly). Management is not, moreover, a black box and the reliability of the information and financial management system is an essential component of accreditation. Collecting data is first and foremost a condition of accreditation that can nevertheless be largely streamlined along the lines of the process developed in Europe. Audits of all the facilities, and not only of the financing, are needed, constituting a more substantial but much more effective task. Many projects appear to be operating within the bounds of probity, simply because the corruption was externalized on the periphery.

The problem with the current information system is that it is not truly integrated into the current management. The gradual computerization of the facilities will help to improve the situation. However, simple measures can bring about immediate improvement. The installation of electronic cash registers that we saw in faith-based facilities is already helping with the register balance reported electronically each day. To estimate corruption problems, it is often practical to establish a link between the financial data (which are generally underestimated) and the activity data (which tend to be overestimated). Such an analysis cannot be conducted smoothly with the current system, which is often too sophisticated and therefore not really implemented.

Under the current system in Cameroon, facilities must regularly submit a significant amount of data, but do not receive much feedback. Having an insurance or purchase fund mechanism is advantageous because providing data is a condition of financing. Because the amounts disbursed are linked to the data, there may be concerns on the other hand that the system creates a bias in the data. Controls are therefore also needed. Should the mechanism be extended to several facilities, significant data will be available for analysis. For example, the comparative cost analysis will be facilitated and this will eventually help to improve detection of pockets of inefficiency or of corruption (see Chapter V).
V Monitoring and Evaluation Indicators

- As a complement to the implementation of financing mechanisms, the quality approach enables the patient’s point of view on corruption to be taken into account.

- Oversimplifying these sensitive issues of governance, however, poses specific problems. Corruption analysis must be taken into account in labeling models, rather than when competitions are being organized.

- The collection of additional information should be linked to an incentive system in order to ensure sustainability. The sector approach will better coordinate the various initiatives that will be used for large-scale mobilization of personnel.

- According to many perception indicators developed by several organizations, the corruption situation in Cameroon is still cause for concern. These indicators have of course been criticized for many reasons, and there is a need to identify more objective indicators.

- At each level of the health system and in each facility, it is possible to obtain a certain number of quantitative indicators that will allow for a more qualitative assessment of vulnerability to corruption.

- Many specific surveys are now possible and the collection of these statistical data on each facility will be facilitated by a third party payment mechanism. An attempt should be made to measure the importance of the informal sector not only because of diverted revenues, but also because of the loss of resources mobilized.

- While a table indicating the level of corruption in entire the health sector can be established, it will be difficult to track its development in order to monitor the progress made in combating corruption. A more qualitative approach based on monitoring and implementing reforms is necessary.

5.1 Incorporation of Monitoring into a Quality Approach

To combat corruption, a quality approach is, in our view, entirely complementary to financing approaches. Indeed, invoicing mechanisms may easily be manipulated by changes in the quality of the services. Corruption may take the form of overbilling and underproviding quality. It is indispensable to provide financial control along with quality control.

This incorporation into the quality approach in public health care facilities is also particularly important for a number of reasons:

- It is one of the critical conditions necessary to increase the number of patients frequenting facilities and also their “willingness to pay.” It is therefore one of the key elements for reducing the practice of informal payments.
- Problems such as scarcity, disruption in supplies, delays, and payment queues, which affect the quality of services, are the breeding ground for corruption. Informal payments are often made just to alleviate these problems.
- The quality approach gives voice to the patient, who can thus talk about the problems
encountered and in particular the demands for payment. It therefore measures the patients’ perception of corruption problems.

- The quality approach helps to address the issue of corruption at all levels of the health system, beginning in particular at the grassroots level.

Work on the quality approach, however, is still in the initial stages in Cameroon. Even if the SQI concept has reportedly been officially endorsed by the Minister, it is still in the draft stage. To this end, a mission comprising Cameroon dignitaries went to Morocco in 2006 and another mission was scheduled for May. An initial SQI seminar is scheduled to take place in Kribi in mid-April. We were only able to obtain documents on the methods proposed in Guinea and Morocco and hold oral discussions on projects for Cameroon. It would be useful to have external evaluations done of these experiences.

Based on the GTZ’s SQI manual (and particularly on the questionnaires developed in Morocco), we have been able to highlight two types of questionnaires, one relating to hospitals, the other relating to health centers.

5.1.1 Follow-up Questionnaire on the “Corruption-Free Hospital” Initiative

Transparency International Cameroon has proposed that there be a follow-up to the Minister’s circular of October 18, 2005 relating to “combating corrupt practices in hospital training programs.” A survey of approximately forty training programs was conducted in July 2006 in Yaoundé, Douala, Bafoussam, Ebolowa, and Bamenda. The findings are as follows:

- 18 percent of centers have instituted the wearing of badges by personnel (which does not mean that all employees wear them regularly);
- 71 percent of centers have established a system of directional signs as a point of reference for patients;
- 37 percent of centers surveyed do not post their prices;
- 30 percent of centers surveyed do not have suggestion boxes; and
- 18 percent of centers surveyed boldly denounced corruption by posting public notices.

Following this survey, TI asked a number of specific questions based on the different points raised in the ministerial circular. Obtaining this quantitative information was apparently not enough and the conditions under which these measures would be implemented were also questioned. A more qualitative approach was necessary. These questions were examined in depth in Annex 7, and an attempt was also made to include the other points in the circular, which were more difficult to evaluate quantitatively (discipline, penalties, and the prohibition of parallel sales).

5.1.2 Monitoring the Quality of Governance in Health Centers or Health Districts

A health center questionnaire is also set out in Annex 6. As the questions are more general and do not deal merely with the implementation of a ministerial circular, they have been ranked as follows:

- Patient’s point of view (information and advice);
- Financial management (informal payments, budget, and management);
- Human resource management (recruitment, evaluation, dialogue, and penalties);
- Management of drugs (stocks and sales); and

41 No official document signed by the Minister on this matter was obtained.
• Transparency (dissemination of information and controls).

These questions relate to a control approach. It would be useful to develop them in a more incentive-based approach, as previously indicated. However, it is difficult to develop this other type of question so long as the authorities have not opted to proceed with reforms.

More than a questionnaire, these points are a sort of check-list for group discussion (based on the focus group technique). Many relatively homogeneous groups (patients, drugs, administration) may have to be formed in order to facilitate dialogue.

Monitoring the quality of governance in a health district may be done in a similar manner, and a proposed questionnaire is set out in Annex 8. The SWAp thematic groups are in the process of drafting very detailed guidelines, which should be available shortly. They all relate in some way to aspects of governance (supervision, training, and management). It will therefore be useful to adapt the questionnaire, while taking into account incentive aspects.

5.1.3 Conditions for Integration: Score or a Label?

Although the techniques integrated into the SQI model—self-evaluation, audit, peer evaluation, benchmarking, participatory audit, participatory planning, and qualitative information—may contribute significantly to improving governance of health care facilities, their proper application is a complex matter. Before drawing up a manual or a list of questions, it is indispensable that this measure be tested on a small representative sample at different levels of facilities. Some of the main problems in using these methods in governance matters are as follows:

• With regard to several questions, the persons surveyed are not empowered to take action to resolve problems relating to many issues, either because of lack of authority or resources. These issues could appear frustrating and at times counterproductive but, even so, awareness among the actors could be a step toward a change of attitude. However, the risk of disillusionment, of parallel discourse, or of other adverse effects (scapegoats, settling of scores) is important and must be tested.

• Sensitive issues of governance often run the risk of being “denatured” if one looks at the big picture too quickly. One cannot expand coverage simply by increasing the training of trainers. Even with regard to more detailed arrangements (for example, in clinics or mass distribution organization), simple questions take on a different hue where training is increased. The benefit of the quality approach is that it builds awareness among the participants, and care should therefore be taken to ensure that it is developed gradually over time.

• While wishing to extend the qualitative approach rapidly, there is a risk that it will be reduced merely to the obtaining of “scores,” which in the context of the country will quite likely be used as a political tool. Even though “anonymous” competitions (and more objective scores) are widely criticized, a centralized competition between hospitals, as has been proposed, is certainly open to question.

• The policy of awarding prizes, which is merely symbolic from a financial point of

42 Several stakeholders have indicated that they have already welcomed several missions on governance and have been quite critical of their cost/effectiveness.
view, is also in our view a system that is very vulnerable to various types of manipulation and is probably not an incentive. The creation of an independent system of evaluation may be necessary, but should be handled with care, because there is a chance that it could be bogged down with many other priority responsibilities. In this regard, the best indicator is still the number of patients frequenting the health care facilities—patients who vote with their feet. It bears repeating, however, that improving governance in the Cameroonian health sector by utilizing a centralized control, punishment, and reward approach appears to be particularly inappropriate.

Unlike the “score,” the label approach is sometimes described as an interesting alternative, first because it offers a series of commitments (a sort of charter) and second because, in a certain sense, the consumer will be the judge. This alternative, for example, guarantees that a patient will not be held to ransom, that rates will be advertised, and that drugs will be available. Labeling provides more information to the patient and cuts down on uncertainty, which is a component of corruption, as previously shown. It would, however, be useful to analyze the impact in Cameroon of labeling experiences similar to the “baby-friendly hospital” initiative, with a label granted by an autonomous organization (UNICEF). In general, labeling only has a long-term effect if it is accompanied by access to financing, that is, if it allows for certification by a third party (insurance company, mutual association, or purchase fund). The true incentive is therefore not a “more or less honorary first prize,” but the introduction of a financing mechanism that is automatic, consistent, and progressive.

5.1.4 The Organizational Impact of the “Quality” Approach

The annual collective labor project in each district on quality can provide an opportunity for the numerous aspects of governance to be discussed. However, the sector approach could be used as an opportunity for reflecting on how the numerous meetings, training sessions, and missions can be coordinated. In Cameroon, as in other neighboring countries, the promoters of new “methods” should carefully take into account time spent in these activities and frequent absenteeism (particularly in the case of health personnel). This opportunity cost should be calculated and the priority options for these activities determined by common accord of aid donors. It is important to plan for these “support activities,” because there is much demand for the per diems associated with them which have largely become a useful complement to salary.

Top priority should also be given to data gathering. Feedback on basic data on health indicators is already an extremely sensitive issue. Feedback on the financial data is so incomplete as to be almost unusable. In our view, sending this type of questionnaire to all the health care facilities will be a great challenge, but by proposing a review at the district level, this limitation will be given consideration, even though the process risks losing one of its advantages. The quality approach in matters of governance appears above all to be a tool for discussion that must be decentralized at the lowest level and used by the actors who receive some concrete benefit from it. The important thing is to build an environment at the financial level in particular, where this approach is taken into account, fostered, and monitored.

5.2 Governance Indicators

5.2.1 Perception Indicators

For some years now, governance indicators have proliferated. The OECD has more than 140
series. This proliferation ended with the publication of several guides and directories\textsuperscript{43} that can furnish useful tools for analyzing corruption in Cameroon. We have briefly outlined below the main current indicators and how they are applied in Cameroon.

The most well known indicators are perception indicators, and these are based on opinion surveys of different groups.

- The Transparency International indicator, developed from at least three different surveys, indicates a slight improvement in the Cameroonian situation. In 2005, Cameroon nevertheless placed 137\textsuperscript{th} out of 158 countries.

- Cameroon slipped from 147\textsuperscript{th} to 152\textsuperscript{nd} on the World Bank’s Doing Business 2006 survey of 175 countries, mainly because other countries made more improvements.

- Freedom House (2006), an independent American organization that measures political rights and civil liberties, designates that country’s status as “non free,” and points out that corruption is a significant obstacle to growth.

- The United Nations Economic Commission for Africa (UNECA) is also particularly harsh in its African Governance Report 2005.

- According to studies by the World Bank Institute (WBI), which publishes sets of indicators for many countries on a regular basis, corruption control is particularly weak in Cameroon just as are most other governance indicators (voice and accountability, political stability, government effectiveness, regulatory quality, and rule of law). In 2005, corruption control was estimated at -1.15 on a scale of -2.5 to 2.5. The situation has apparently deteriorated because the indicator was at -0.84 in 2004.

- The Country Policy and Institutional Assessments (CPIA) which are produced annually by the World Bank present a more complete qualitative assessment, but they remain largely confidential.

5.2.2 The Limits of these Indicators

The above-mentioned indicators have often been criticized for the following reasons:

- They are based on interviews of persons who are mainly from the business sector, senior officials, or specialists. The opinions of businessmen or “experts” would appear very biased because of their prior knowledge of international rankings, with the result that the opinions of experts tend to be self-confirming and to develop on the basis of their common prior knowledge.

- Certain bodies such as the IRD\textsuperscript{44} have pleaded for the use of complementary surveys that take into account the point of view and experiences of the actors concerned and the general public. The patients’ (or the public’s) perception of corruption is probably very different from that of the experts or health professionals. These surveys are designed to better take into account petty corruption, which has a significant impact on access to health

\textsuperscript{43} For example, the one produced by USAID, ref. 16.

\textsuperscript{44} UR 047 DIAL (Development, Institutions, and Long-Term Analyses), which is engaged in an international program that includes in particular AFRISTAT (Economic and Statistical Observatory for Sub-Saharan Africa).
care. According to a “mirror survey” comparing the two modes of perception, which was conducted in eight African countries, experts tended to regard corruption as a much more serious matter than the general population (when asked whether or not one had been a direct victim of corruption).

- Biases are also evident in population surveys. No patient or population survey conducted on this topic in Cameroon was found. *Satisfaction surveys on the use of health services*[^45] revealed that satisfaction rates are very high (88 percent of persons were satisfied with how they were treated in public health facilities and 97 percent in private facilities). However, the people’s discontent with public health facilities is striking when the statistics on visits to health care facilities are analyzed. The INS explains this paradox by citing “the limited expectations” of the public, who believe that health care personnel are also victims of the system. Questions on corruption are not directly addressed in this type of survey.

5.2.3 More Objective Indicators?

There is an abundance of literature[^46] criticizing these perception indicators.

- Even if they combine the indicators from several different surveys, the weighting between these indicators is difficult. It is often thought that those associated with the private investment approach, such as the International Country Risk Guide, are, in fact, given priority.

- The same indicators are sometimes integrated several times, and finally end up as a self-fulfilling prophecy.

- Generally, the data are not perfectly comparable in time because of the change of method. It is even difficult to compare two countries where corruption has developed in very different environments.

Certain series also propose margins of error that will enable comparisons to be made with some degree of probability. However, given the often wide margin of error, many comparisons are not really significant.

Certain organizations (such as the OECD) have attempted to construct indicators based on more “objective” data. One can cite the following as examples of “objective” governance indicators:

- The existence of anticorruption laws and organizations tasked with instituting legal proceedings;
- The number of prosecutions for corruption;
- The existence of procedures that strengthen the dismissal process;
- The number of steps required to start a business;
- The time it takes to obtain a telephone line; and
- The people’s voting rate.

It is dangerous to think that indicators founded on facts are necessarily more objective than those founded on perception.

[^45]: Cf. INS survey of July 2006, ref. 10.
[^46]: OECD 2006, Uses and Abuses of Governance Indicators.
• The problem may arise as much from the selection of facts as from how the facts may be interpreted and the conditions under which the indicators are summarized.
• These “objective” indicators convey only the de jure and not the de facto reality. Informal practices are precisely the main problem of corruption. Thus, the existence of regulations does not mean that they are enforced in practice.
• The interpretation of these indicators may be very different and even completely contradictory. The number of prosecutions may also be interpreted as a high or low level of corruption. Do more restrictive rules on dismissal protect the independence of personnel, or do they make penalties in cases of corruption more difficult?

In order to highlight the quantitative indicators in accordance with the terms of reference, it seemed prudent to analyze the problem according to the level of facility (health center, district, and province). Quantitative indicators were selected from the data theoretically available on the activities and financing of each facility. Once the data have been gathered for each facility the corruption level still cannot be truly measured; instead, the question regarding “the degree of vulnerability to corruption” arises.

This analysis allows for the development of a sort of vulnerability matrix, based on the level of the facilities, as illustrated by the hypothetical example in Annex 9. This matrix, which appears to be more an outline of a survey, was used in a certain manner during our brief site visit. Although it allows priorities to be identified and comparisons to be made, a national summary is a much more difficult undertaking.

5.2.4 Analysis of Standard Data and Specific Surveys

Other specific surveys are possible. A proposal is made in Annex 10 to try to break down the different inefficiency factors, according to the following formula:

\[ \text{Inefficiency} = \text{poor allocation} \times \text{unsuitable qualification} \times \text{poor organization} \times \text{lack of motivation} \times \text{corruption} \]

Another survey proposal that was also presented in Annex 10 seeks to measure the importance of the informal sector in different health facilities. Loss from earnings and services diverted (compared to the private sector) must be taken into account. The assumption to be verified would be that more than half of the resources are managed by the informal sector. It would also be interesting to compare the prices of equipment (and to establish more reliable and flexible standards than the market price list), note the number of bidders and how they correlate with prices, measure the proportion of sales by mutual agreement or the share of a supplier in the different markets. The SWAp monitoring and evaluation group may select a limited number as an example to address the updating of the strategy document.

All of these surveys are specific and require the collection of primary data. On the contrary, the implementation of another financing mechanism similar to the purchase fund can over time furnish a considerable amount of data on each health care facility. Corruption analyses should be integrated into studies on the comparison of costs, ratios, and budgets. This is how social security organizations in many countries manage to identify inefficiencies (overprescription) and fraud (false invoices).

In the anticorruption strategy adopted for the health sector, data analysis remains a critical area, first, because the medical information system is traditionally more developed than that of
other sectors, and, second, because computerization will help to increase the number of comparisons, establish correlations, and analyze allocations.

5.2.5 More Comprehensive Analyses

More comprehensive analyses have been proposed to address these problems. The OECD recommended an integrity assessment framework for the public sector by proposing an analysis of anticorruption measures in three phases:

1. The laws and regulatory framework;
2. Anticorruption agencies; and
3. Enforcement of these laws.

The other categories of governance indicators also involve aspects associated with combating corruption. These include: civil society (access to information), elections (financing policy), government accountability (the budget process), administration (procurement and contract termination rules), and regulation (audits, ombudsman).

Transparency International has also put in place terms of reference for National Integrity Systems (NIS), which highlight different criteria (institutions, resources, accountability, integrity mechanisms, transparency, penalties, and links between these criteria). It is proposed that these criteria be applied to the government, parliament, political parties, the legal system, civil society, and the media (list of questions).

Transparency International recently conducted a survey showing that the health sector is one of the most corrupt sectors (just after water and forests, and transport, but less corrupt than customs, taxes, the police, or justice). Business persons estimate the cost of corruption to be approximately 10 percent of their sales.

These methods of evaluation are not peculiar to health. We have tried in Annex 4 to group the criteria that are more applicable in the context of a health sector approach in Cameroon. This “check list” can serve as the basis for the work to be undertaken by the thematic groups to develop a new formulation.

It would be advantageous to be able to monitor the progress under the SWAp, using comprehensive sector indicators. In Annex 11, in accordance with the terms of reference, we have selected eight key objectives and a number of indicators for each one. It appears to be indispensable to indicate, for each, the reasons for these choices and the underlying assumptions. The different possible interpretations to be given to these indicators may be taken into account under this heading.

5.2.6 Process or Impact Indicators?

In order to monitor government efforts in combating corruption, it seems preferable to seek process rather than impact indicators. Annex 12 sets out the main reforms that significantly contribute to combating corruption. Some have already been approved, while others have been suggested in the report. The final choice will be made in the final document on the sector approach. It is possible to track, year after year, the development of these reforms, from

47 The study involved a panel of 835 businessmen. Business leaders probably have fewer contacts in the health sector and also experience corruption differently from the patients.
conception, launch and implementation to their evaluation. But the manner of noting these various stages will inevitably be very subjective. The purpose of this grid will instead be to recall “forgotten or blocked projects.”

While it is our view that there is a crucial need for more objective figures, the desire to develop an overall score appears unrealistic and dangerous. *Furthermore, it will not be easy for the monitoring and evaluation group to establish the type of “baseline” in areas such as health and financial data, where more studies have been done.* The annual monitoring of these very important data, however, appears to be a very serious challenge, given the situation with the health and financial information system in Cameroon. The question even arises about the possibility of establishing an overall score (a sort of health development) that can truly be monitored annually.48 The desire to extend this model to even more sensitive areas, such as governance, may be counterproductive, owing to the *risk of hiding the true impact of corruption behind fairly reassuring figures.*

While respecting the priorities of the health sector, it is indispensable, in our view, to put in place an official collection of health and financial data. To the best of our knowledge, the only comprehensive data available and presented in a coherent manner are those in the 2001 strategy document for year 1998. Other data are scattered over programs or projects, depending on the different methodologies used.49 *Monitoring governance should be done as soon as the basic data have been updated, and in accordance with the end result of that priority.* It is undesirable to burden a system that already experiences difficulty functioning. Monitoring the SWAp must establish a number of priorities, ensure the quality of the figures collected, and then an in-depth (and therefore also a quality) oversight of developments in the health system.

**Conclusion: Issues of Governance in the SWAp Process**

The implementation of a sector approach process in Cameroon provides an excellent opportunity to reflect on the problems of governance in the health sector and to propose reforms.

**Governance Issues in Strategic Planning**

It is important that the recommendations in this report be debated and included in the documents to be drafted under the SWAp. This process should also contribute to consideration of the planning exercise undertaken.

**The New Strategy Document**

The 2001-2010 Health Sector Strategy Paper includes a chapter on institutional development which is divided into two parts: (1) strengthening institutional capacity; and (2) partnership development. The first component was part of the overall framework of the PNG and was aimed at making the institutional framework compatible with Cameroon’s health policy. The second component sought to coordinate the interventions of all actors in the health sector.

The plan of the new strategy document to be drafted shortly is not yet known, but it would

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48 Even the human development index calculated by the UNDP cannot be used in this way.

49 The study on fiscal space carried out at the same time as this mission shows the difficulties encountered in filling out a basic table with the country data (particularly in relation to the budget).
most importantly be an update. In that case, governance strategies (now taking into account the 
new 2006-2010 PNG) could be included in the aforementioned chapter. Even if it is probably 
necessary to set out the institutional framework and the anticorruption campaign in a different 
manner, most of the other aspects developed in this report must be incorporated into the other 
chapters, in particular those on diagnostics, financing, the management process, and quality. 

The team working on the sector approach has put in place a new conceptual framework aimed, 
in particular, at establishing the strategic pillars in accordance with the MDGs (for example, 
infant mortality, maternal mortality, poverty) and the overall objective of the PRSP. A matrix 
facilitates the identification and analysis of the different components of the strategy (services 
offered, drugs, financing, partnership, management process, governance, services provided, 
and quality care) and the various levels of the health pyramid. This major task, which was 
done in a participatory manner in Kribi during the mission, has not yet been completed. The 
“governance sections,” in particular, have not yet been completed. In this regard, the 
“governance” component is divided into three headings:

(1) Social control;  
(2) Incentive mechanisms to promote good governance and ethical behavior; and  
(3) Regulation. 

While a working group could try to combine the sections developed in this report in this 
manner, it is our view that it would be difficult to do this in a manner that is external to the 
process. Should awareness and information (the citizen approach described above) be 
developed under the heading “social control?” Should performance-based aid and regulation of 
the informal sector both be addressed under “incentive mechanisms?” Should the auditing and 
inspection institutions be included under the heading “regulation?” This process is useful only 
if it is participatory. 

Governance and the Planning Model 

Generally, only moderate planning is necessary when developing the SWAp\textsuperscript{50} because the data 
are incomplete, unreliable, and the context quite variable, as shown by the mission on the 
fiscal space. The SWAp governance debate must focus, above all, on the development of a 
system that allows for adaptation to needs that occasionally change, the regulation of demand 
in accordance with the constraints, and a more efficient supply. Very detailed and rigid 
planning runs the risk of not being respected despite a multiplicity of controls. 

An approach that is too structured and is difficult to regulate, the risks of corruption can 
increase considerably. The main means of limiting corruption is to put forward more flexible 
financing mechanisms that enable resources to be transferred in the most direct manner 
possible, serve as incentives to provide quality service, can react automatically—or at least 
rapidly—when problems arise, and gather data in a comprehensive manner. 

Coordination of External Financing 

The creation of a SWAp in Cameroon could also be an opportunity to begin an in-depth 
discussion on the issue of external financing by learning from the different experiences 
presented. 

\textsuperscript{50} After analyzing the various MTEFs in Sub-Saharan Africa, it is increasingly being recommended that a three-
year forecast be designed instead of a very detailed budget (EU seminar in Cotonou in March 2005).
A New Model or Clarification of a Change that has Already Begun?

The role of “off-budget” financing is already considerable in Cameroon, particularly in the area of combating AIDS (Global Fund), vaccinations (UNICEF, Global Alliance for Vaccines and Immunization [GAVI], WHO), and the expenses budgeted in the C2D (AFD). Most of this financing passes through the National Sinking Fund (CAA) or through bank accounts. Surprisingly, in the case of state-administered entities, the districts and provinces often have accounts in banks into which large contributions from different donors are deposited. The increase in the number of these funds makes it more difficult to exercise control and can give rise to double billing.

It is difficult to determine the role of corruption in those channels, but they are considered by most respondents as a far more effective way of obtaining results. Moreover, they inspire confidence in most partners. Instead of trying to cut back on these funds, it would first be important to increase their transparency and visibility, because it is still difficult to have a clear and thorough overview of them.

The fundamental issue of SWAp governance is not so much the integration of these different funds into a system that is difficult to reform, but rather the merging or coordination of the different funds. Moreover, in many countries, health financing is not a budget item for the State but for the social security funds that are fairly independent. This separation of roles was carried out as much in the interest of efficiency as of better governance. The serious crisis in the Cameroonian health system is probably an opportunity to begin to change the system. It would be a pity for the SWAp to attempt to return to previous models instead of facilitating this change.

This trend takes into account the real institutional capacities of the country, but requires a strong political will. The serious nature of the anticorruption campaign is gauged more by the undertaking of real reforms than by proclamations or specific actions. Implementing these reforms is certainly a long-term task, and it is useful in the short term to develop certain tools, such as those presented in the quality approach, or in the improved budget procedure. The SWAp process should, however, not be limited to the development of these specific initiatives, but should also involve in-depth discussions.

A Phased Process

Coordinating these funds could begin at the provincial level. The creation of provincial funds appeared to be a useful experiment even if the focus is now on drugs. Other provincial fund projects are being prepared in the north of the country with the backing of the AFD. Under the C2D, it has been proposed that the nonprofit private sector that provides more than half of all health services be subsidized. For the moment, these allocations would focus on consolidating

51 HIPC funds (even if project selection is done through an independent organization) are, on the contrary, integrated into the public financial network.
52 Recently advertised compliance with the exemption from payment for treatment for PLWHA merits the greatest attention. If this financing system is not effective, the health facilities will bear the losses and unofficial payments will proliferate. The problem is already evident in the late payments of laboratory invoices, which are normally largely reimbursed by the CNLS. As is the case for the public system, the cash problem is critical and consideration should be given to the need to provide advances (as in the case of mutual associations, for example).
53 Summary tables on these types of financing exist for some areas (such as the fight against AIDS), but it is still difficult to ensure coherence among the various sources.
the debt of these facilities, and would include an investment grant for upgrading. However, an activity-based operations grant to be measured using a contractual approach could be considered. One of the terms could be reliable health and financial indicators and relief on certain rates. In our view, the reduction of the financial burden of health care for households is indeed essential under the poverty reduction strategy.

If the health authorities wish to have a more ambitious and innovative policy, third party payment systems, with a customized policy of patient contribution to medical costs, could be developed under the SWAp for purchasing targeted services in accredited public and private facilities. The accreditation of facilities could also undergo a quality improvement process which, as has been shown, should include governance criteria (management transparency, tariff visibility, reliable information system). These experiments with the purchase funds can be developed gradually in a number of provinces by building on previous experiences. Indeed, the idea of purchase funds was taken from the insurance industry, or mutual associations, for the purchase of a package of specific services (formalization by contract and accreditation), from the sector approach (by “pooling” public, private, and international resources), from a results-based financing policy (payment for services rendered), and from the independent management policy of a budget freeze (with the participation of civil society).

Even if the strategic choices of the Government tend to follow a more statist model, a number of the principles presented in this report geared toward an incentive approach (based on performance, deconcentration, and accountability) may also be implemented. Given the actual extent of corruption in the health sector, it will be difficult to abandon old habits without a radical change in approach. The aim of this report is not to propose a model, or even a finished tool, but to help to advance the discussion on funds, and the work of the thematic groups.

Under the true incentive approach, in addition to the policy of checks and balances that is considered necessary, and also the mobilization of civil society, the above-mentioned financing mechanisms are one of the key pillars of the anticorruption campaign.

Annex 1: List of Persons Met
Annex 2: Corrupt Practices — Glossary of Terms
Annex 3: List of the Forms of Corruption
Annex 4: Criteria for Measuring the Level of Corruption
Annex 5: “Mapping” Civil Society
Annex 6: Questionnaire on Governance in a Health Care Center
Annex 7: Questionnaire for a “Corruption-Free Hospital”
Annex 8: Questionnaire for the Monitoring of Districts
Annex 9: Vulnerability Indicators
Annex 10: Survey Proposals for each Facility
Annex 11: Health Sector Summary Indicator
Annex 12: Monitoring Reforms
Annex 13: PowerPoint Presentation
Annex 14: Bibliographical Indicators
Annex 15: Terms of Reference

54 This criterion has already been taken into account when allocating the initial grant.
In order to highlight the quantitative indicators in accordance with the terms of reference, it seemed prudent to analyze the problem according to the level of facility (health center, district, or province). Quantitative indicators were selected from the data theoretically available on the activities and financing of each facility. The indicators were grouped using these different criteria, and then into a limited number of categories.

Therefore, the traditional aspects of facility management identified are:

- Budget preparation process (participation, knowledge, flexibility, execution);
- Mobilization of resources (portion of each resource, visibility of rates, exemptions, integration of external aid);
- Human resource management (recruitment, payment, ethics, qualifications);
- Financial management (procedures, transparency, decision-making powers, monitoring of materials);
- Management of drugs (record-keeping, storage, accountability, motivation);
- Control (hierarchical, specialized, legal, moral and social); and
- Transparency (information system, computerization, dissemination, use of information).

A heading focusing on the impact has been added to take into account the results of this system (cost comparison, availability, delay, and the opinion of the public).

The table below presents the list and classification of these quantitative indicators. For a number of these criteria, however, measurements are done by the binary method (whether or not they exist, or whether or not they are used) or qualitatively (good, average, or rarely applied, for example). The criteria developed in Annex 4 could therefore be used, but most of them apply at the national level in particular, and less at the level of each facility.

*Once the data have been gathered for each facility the corruption level still cannot be truly measured; instead, the question regarding “the degree of vulnerability to corruption” arises. This notion is truly qualitative. There are situations in which the risks of corruption are high (monopolies, delays, scarcity, etc.).

The quantitative data cannot be added for they relate to very different areas, and may be interpreted in a manner contrary to what was intended. Long waiting periods for payments may give rise to corruption, but may also be evidence that no commission has been paid in order to obtain payment more quickly. The size of a facility’s own resources justifies an analysis of their proper usage, but is also an indicator of good management or the good quality of the services provided. A high level of vulnerability does not necessarily imply the existence of corruption, but indicates that particular attention should be paid at this level within the framework of anticorruption efforts.

This analysis allows for the development of a sort of vulnerability matrix, based on the level of the facilities, as illustrated by the example below. This matrix which, in our view, appears to be more a framework for a survey, was used to a certain extent during our brief site visit. Although it allows for priorities to be identified and comparisons to be made, a national summary is a much more difficult undertaking.

<table>
<thead>
<tr>
<th>Budget Preparation Process</th>
<th>Participation in the process</th>
<th>Knowledge</th>
<th>Flexibility</th>
<th>Budget compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>% total requested/received</td>
<td>No. of persons who know about the budget? date of notification</td>
<td>% modifications authorized</td>
<td>% budget voted/executed</td>
<td></td>
</tr>
<tr>
<td>Mobilization of resources</td>
<td>Portion of each type of resource</td>
<td>Simplicity, visibility, and knowledge of rates</td>
<td>Conditions for exemptions and their use</td>
<td>Integration of external aid</td>
</tr>
<tr>
<td>% of own resources (by type)</td>
<td>No. of rates</td>
<td>No., % and value of exemptions</td>
<td>% of external resources % received after local request</td>
<td></td>
</tr>
<tr>
<td>% of public budgets</td>
<td>No. of posted rates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Human resource management</strong></td>
<td>Recruitment rules and their application</td>
<td>Payment rules and their application</td>
<td>Ethics framework</td>
<td>Qualifications</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------------------------</td>
<td>-----------------------------------</td>
<td>------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>% of locally recruited personnel</td>
<td>% of allowances in relation to salaries Average waiting periods for payment of salaries</td>
<td>% of persons who know about this framework % absenteeism</td>
<td>% personnel having received training? in the more specific area of ethics?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Financial management</strong></th>
<th>Purchasing procedures and their application</th>
<th>Quality and transparency of management</th>
<th>Decision-making powers</th>
<th>Monitoring of equipment and materials</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of calls for bids No. mutually agreed contracts No. of unsuccessful calls for bids No. of suppliers</td>
<td>% of documents available, completed on a regular basis % full reports</td>
<td>No. of signatures for each type of decision</td>
<td>% of equipment inventoried % of equipment out of service</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Management of drugs</strong></th>
<th>Record and stock card keeping</th>
<th>Conditions for orders, storage, and delivery</th>
<th>Accountability and autonomy</th>
<th>Motivation</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of inconsistencies % loss</td>
<td>% out of stock % expired drugs</td>
<td>% of orders not filled or pending</td>
<td>% of allowances linked to sale</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Impact</strong></th>
<th>Unit costs</th>
<th>Delays</th>
<th>Availability</th>
<th>Opinion of the patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>% in comparison to the average unit cost of inputs</td>
<td>No. of days for deliveries No. of days for payments Average waiting period</td>
<td>% of missing essential “tracer” drugs %</td>
<td>Number of visits No. of complaints Rate of satisfaction % of prescriptions not fully utilized</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Controls</strong></th>
<th>Hierarchical</th>
<th>Specialized</th>
<th>Legal</th>
<th>Moral and social</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of penalties No. of contacts at the workplace and interviews</td>
<td>No. of visits (planned/unplanned) No. of inspections No. of audits</td>
<td>No. of criminal sentences No. of civil sentences (reimbursements)</td>
<td>No. of entities in which civil society participates No. of NGOs involved in the facilities’ activities</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Transparency</strong></th>
<th>Information System</th>
<th>Computerization</th>
<th>Dissemination of information</th>
<th>Use of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of reports per facility Frequency of reports % data missing</td>
<td>% of management that is computerized (finance, drugs, activities)</td>
<td>No. of persons receiving these reports</td>
<td>Amt. of “feedback” given to these reports</td>
<td></td>
</tr>
</tbody>
</table>

Once these data have been collected for each facility visited, it will be possible to establish this type of matrix for an entire zone studied. It will be difficult to establish a national average because there are significant differences between each health center and district.

Therefore, as a working hypothesis, a number of high vulnerability areas were identified during our short site visit, and hence the priority areas of intervention within the anticorruption context.

**Corruption Vulnerability Matrix (example)**
Based on this table, it was evident that there were some sensitive points at the facilities visited which we could use as examples. According to this first straw poll in the health centers, priority for combating corruption could be given in particular to budget preparation (to ensure proper allocation) and the mobilization of resources (payment system). At the district level, priority can be given to financial management and the control function. At the provincial level, the management of drugs at the CAPPs appeared to be one of the main problems. The central level maintains, for the time being, the highest level of accountability for financial and human resource management. This table is therefore a sort of guide or “check list,” and a guide for a more in-depth survey.

As indicated in the terms of reference, the establishment of a “score” would enable the data to be integrated (but would probably not allow for a comparison of facilities!). For each criterion, a scorecard based on the following models can be established:

**Participation in the budget preparation process**
- 1 point: No knowledge of the budget and non receipt of cards;
- 2 points: Knowledge of the budget but at year’s end, and budget partially utilized;
- 3 points: Involvement in the process and budget completely utilized; and
- 4 points: Budget received is quite comparable to that requested.

**Compliance with rates**
- 1 point: Rates not posted and very variable;
- 2 points: Rates posted but usage very variable;
- 3 points: Rates posted and used.

The establishment of such “scores” for all the criteria would be a long-term undertaking and should be done in collaboration with Cameroonian health professionals. One wonders if such a task is really a priority.

Generally, the indicators proposed herein already seem too numerous, and it will be difficult to collect these indicators under the current conditions of the Cameroonian information system. In light of the difficulty experienced in Cameroon to establish basic indicators on activities and more so financial data, the utmost care must be taken in establishing more sophisticated models that may be limited to a number of “pilot” experiences, which, however, do not pilot much.
The indicated amounts are not the norm but estimates of the prevailing situation in Cameroon in 2007. We were able to provide these initial estimates on the basis of the interviews and the documents referred to in Annex 12. The accuracy of these amounts must be discussed with the partners at the beginning of the process. The purpose of fixing these amounts in this manner is to initiate discussions, and corrections (or comments) are welcome. In the absence of statistical information, an estimate that is similar to the DELFI method would therefore be available. A number of these indicators will also be included in the new information system. As the score will be established based on the annual variation of this indicator, it is important to use the same method of calculation.

The Ministry of Health is most directly responsible for the indicators appearing in italics. Other indicators are more linked to the overall economic trend or the policies of other ministries (Finance, Civil Service…).

The score measures the decline in corruption and the improvements in anticorruption efforts. The relationship is positive when the variations in the score and the situation are moving in the same direction. In a number of cases, the positive trend of these indicators probably demonstrates an improvement in anticorruption efforts (+), while in others, it reveals a deterioration (-). Unfortunately, in a large number of cases, movement in a particular direction can have different interpretations (+/-). The most delicate problem is giving weight to each of these indicators. We have achieved this based on the extent of corruption which we estimated in Chapter 2 (+++). This subjective assessment should therefore be used within the context of a working group.

### Annex 11: Health Sector Summary Indicator

<table>
<thead>
<tr>
<th>Objective</th>
<th>Indicators</th>
<th>Rationale and Problems</th>
<th>Estimated Amount in 2007</th>
<th>Impact on the score*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Personnel recruitment requirements are more impartial and transparent</td>
<td>% of locally recruited personnel</td>
<td>The risks of favoritism may be higher. However, facilities also have better control over the activities of these personnel.</td>
<td>30%</td>
<td>+/-</td>
</tr>
<tr>
<td></td>
<td>% of &quot;voluntary&quot; personnel</td>
<td>Some have to live off commissions</td>
<td>20%</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>% of new contracted personnel in the Civil Service recruited based on anonymous competition</td>
<td>This may relate to HIPC jobs but respect for competition may be a mere formality</td>
<td>100%</td>
<td>+</td>
</tr>
<tr>
<td>2 Salaries are more attractive</td>
<td>Differential between the % increase of the entire salary grid in relation to the % increase of the cost of living (or rate of inflation)</td>
<td>Persistently low salaries in relation to the cost of living may encourage corruption</td>
<td>3%</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>Ratio of range of salaries at the Ministry of Public Health (between the lowest and highest levels)</td>
<td>Do salary disparities promote corruption?</td>
<td>10 times</td>
<td>+/-</td>
</tr>
<tr>
<td></td>
<td>% of average income from allowances</td>
<td>Do widespread allowances promote corruption or are they payment for services?</td>
<td>50%</td>
<td>+/-</td>
</tr>
<tr>
<td></td>
<td>Delays in the payment of salaries</td>
<td>Payment delays sometimes push personnel to seek other means of survival</td>
<td>1 month</td>
<td>++</td>
</tr>
<tr>
<td>3 Personnel are evaluated, and if necessary, penalized</td>
<td>% of personnel that have received a standardized evaluation</td>
<td>What is a standardized evaluation? This indicator can instead take the form of monitoring of a new program</td>
<td>0%</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>No. of penalties imposed</td>
<td>Is this an indicator of the</td>
<td>+/-</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>4 There is better control of the sale of drugs</strong></td>
<td>% of number of drugs sold on the informal market in relation to total consumption</td>
<td>A large percentage of these drugs come from “leaks” from the public sector or fraudulent imports</td>
<td>30% - - -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No. of seizures of fraudulent drugs conducted</td>
<td>The large number of seizures is also a good indicator</td>
<td>+ +</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No. of illegal pharmacies closed</td>
<td>As it is difficult to inventory the number of illegal pharmacies, no denominator is available</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td><strong>5 Public budgets are more visible</strong></td>
<td>Rate of execution of expenditure</td>
<td>Is good “absorption” a sign of good management or corruption?</td>
<td>Operations 90% Investment 60% +/-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of reallocation of budgets</td>
<td>Visibility and control of these reallocations are more difficult</td>
<td>40% - -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of own resources of health facilities</td>
<td>Own resources are less well controlled but are often more effectively used</td>
<td>70% +/-</td>
<td></td>
</tr>
<tr>
<td><strong>6 Public contracts comply with the requirements for good competition</strong></td>
<td>% of commissions with an independent observer</td>
<td>The law makes provisions for this rule only in certain cases. What is the selection process for these observers?</td>
<td>? +</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of contracts canceled owing to lack of participants</td>
<td>This may be a sign of weak local capacities and a lack of confidence of the entrepreneurs</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of the use of exceptions procedures</td>
<td>Exception procedures are sometimes justified. Their number is also important.</td>
<td>+/-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Average payment delays to suppliers</td>
<td>Lengthy delays facilitate corruption; however, a shorter delay period is sometimes possible with the payment of a commission</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td><strong>7 External aid is better coordinated and integrated</strong></td>
<td>% of aid from channels outside the treasury</td>
<td>This indicator may be a reflection of the confidence in the treasury’s system as well as the vulnerability of external aid</td>
<td>60% +/-</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No. of various financing channels</td>
<td>The financing amounts can vary significantly</td>
<td>15 -</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of projects monitored by the beneficiaries (or by NGOs)</td>
<td>The notion of true monitoring by beneficiaries must be clarified</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td><strong>8 Anticorruption efforts are more effective</strong></td>
<td>No. of NGOs involved in anticorruption efforts</td>
<td>Gauging not only the number but also the significance of their actions would be necessary</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No. of independent audits</td>
<td>Their scope and the independence of the auditors vary considerably</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of recommendations of the audits followed by actions</td>
<td>The content of these recommendations is also</td>
<td>++</td>
<td></td>
</tr>
<tr>
<td><strong>Metric</strong></td>
<td>Description</td>
<td>Value</td>
<td>Rating</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td><em>No. of sessions held by the anticorruption commission this year</em></td>
<td>The staging of meetings is no indication of the content of the meeting</td>
<td>0</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td><em>No. of penalties for corruption</em></td>
<td>The hierarchical level of the persons involved is also important</td>
<td>104</td>
<td>+++</td>
<td></td>
</tr>
<tr>
<td><em>No. of complaints filed for cases of corruption</em></td>
<td>A distinction must be made between complaints from patients and entrepreneurs (public contracts)</td>
<td></td>
<td>++</td>
<td></td>
</tr>
<tr>
<td><em>% of complaints followed by actions</em></td>
<td>Follow-up with action means penalties against the offenders as well as preventive measures</td>
<td></td>
<td>+</td>
<td></td>
</tr>
<tr>
<td><em>% increase of budgets of inspection agencies</em></td>
<td>A comparison between the size of the budgets of these agencies and their activities can be made</td>
<td></td>
<td>++</td>
<td></td>
</tr>
</tbody>
</table>