

Partnerships in public sector pharmaceutical structures: the case of the North West Provincial Special fund for Health in Cameroon.

***By Cheka Cosmas LLM, PhD and Bergis Schmidt-Ehry MD, MPH.**

Abstract:

In a dysfunctional system plagued by relatively high poverty levels, centralised public sector pharmaceutical institutional arrangements that exclude user participation in the management of drug procurement and distribution impedes access to health care. Conversely, a decentralised public/private partnerships in the procurement and distribution of essential drugs contributes to better access to health care of the critical mass of the population in general.

The above submission is based on an analysis of the situation in Cameroon over a period of ten years from a review of legislation and documents relating to drug procurement and distribution by public sector pharmaceutical structures, health policy, active participation in board meetings of centralised and decentralised drug supply structures, and focus group discussions (Fgd) with policy-makers, providers, and workers of the relevant sector and its users.

Key words:

public private partnerships, Bamako Initiative, community participation, decentralisation, drug procurement and distribution.

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INTRODUCTION

National expenditures in countries of the franc CFA zone on pharmaceuticals is above 1.5 % of GDP per inhabitant¹. World Bank sources rate this as one of the highest in the world². Ninety percent of this expenditure is incurred by households, with serious variations in impact that depend on whether the household is rural (relatively poor) or urban (comparatively richer).

On another score, there exists disparities in the availability and accessibility of pharmaceuticals in general. Appreciation of the enormity of this problem depends on whether the inhabitant is rural or urban - private pharmacies are concentrated mainly in urban areas. This location places drugs within easy access of urban dwellers. The rural population is condemned to rely either on public sector sources or (in the absence of anything), on the informal drug supply sector. How well public sector institutions assure drug availability/affordability depends on the organisational forms and principles on which the latter function. As concerns principles and institutional arrangements, the application of which may assure the continuity of supplies, African Health Ministers have by the Bamako Initiative (1988) subscribed to user participation in *cost recovery* for drugs.

Cameroonian health policy favours respect for community participation, equity, territorial coverage in drug supply³ and cost recovery. There is however not so much coherence in institutional arrangements that ought to translate the policy option of generics into territorially available and affordable drugs. There still exists the idea of a wholly centralised arrangement⁴ in which the inefficiencies and inequities of the recently liquidated national pharmaceutical corporation (Onapharm)⁵ may still be reflected. Uncertainty as to which institutional arrangements seems to be current in other African countries of the sub-region notably the Central African Republic, Benin, and Congo. Against the background of the political system and health policies, this paper states some experiences with centralised and decentralised institutional arrangements for the procurement and distribution of pharmaceuticals in Cameroon.

Cameroon political system, institutional Arrangements and health policy

The Cameroonian system of government is the presidential system *sui generis* with an executive, a judiciary and a legislature. It is *sui generis* in the sense that, the Executive is all powerful. The Chief Executive assures Supreme Magistracy of the Judiciary and appoints, promotes and dismisses judges. Though the Constitution⁷ empowers both parliament and the executive to, the bulk of all legislation passed by the legislature is proposed by the Executive.

The conception and implementation of health policy is the prerogative of the government department in charge of health. Cameroon is currently undergoing a reorientation of the implementation of its primary health care policy (the Reo). The institutional arrangements that bind a nation's health system and its drug procurement and distribution arrangements depend on the political system and the health policy guidelines it incarnates.. An appreciation of the institutional arrangements for drug procurement and distribution of the North West Special Fund for Health (the Fund) as a partnership might therefore be vividly stated by first reverting to the health policy and drug supply institutional arrangements that existed prior to the Reo.

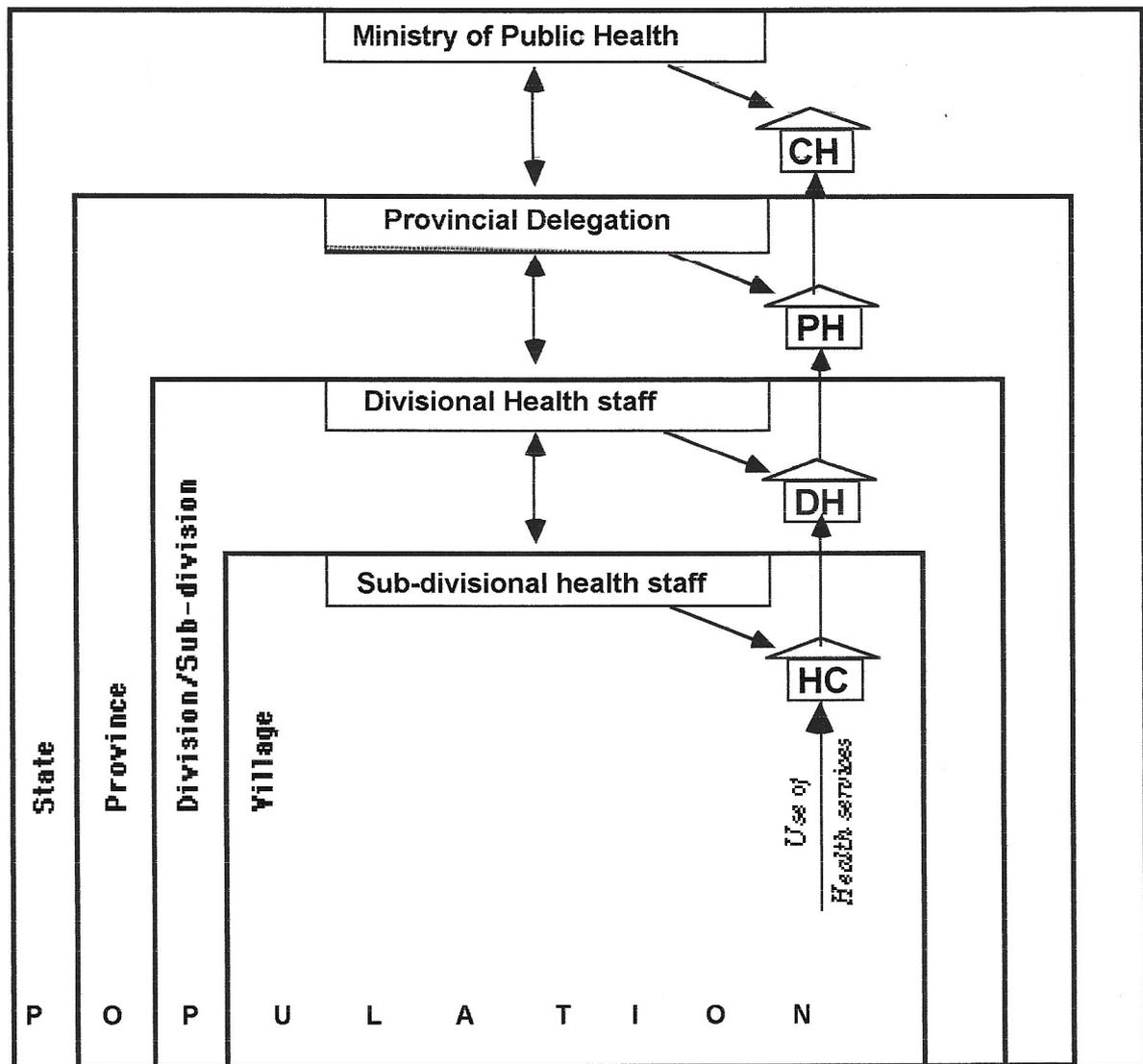
1. Characteristics of health policy and institutional arrangements prior to the Reo. of PHC:

There was an institutionalised national practice of free medical care as well as the provision of free medication to patients using public health facilities. Rules governing the marketing of drugs in their brand names couched and legalised a pharmaceutical policy preference for specialties as opposed to generics⁸. Public sector health planning was centralised i.e. planned at and by the top and simply applied to the bottom. Public sector health care management and its financing was the exclusive preserve of the state to the exclusion of the user population.

In regard of health administration, the Ministry of Health (MoH) had⁹ (and still has)¹⁰ central services, headed by a Minister who is assisted by directors of technical departments. The procurement and distribution of pharmaceuticals for the public sector was assured by the '*l'Office Nationale Pharmaceutique*' (Onapharm)⁵ and primarily financed through subventions from the state. Public health facilities did not have the slightest financial autonomy and were condemned to pay all receipts to, (and expect all financing to come from), the national treasury.

At the intermediate or provincial level, the services of the MoH are headed by a Provincial Delegate who is assisted by Provincial Chiefs of services corresponding to the different technical departments at central level. At the level of the periphery (divisions and sub-divisions) the health services were headed by the Divisional Medical Officer who was in turn assisted by a number of chief clerks (*chefs de bureau*). As is evident from Figure 1 below, the official organisation of these deconcentrated services left no room in the set up for user-participation in the management and financing of health care. Major weaknesses of this organisational framework included the absence of team spirit, poor collaboration as well as little or no focus on the target population (as is evident from Figure 1 below), poor information-flow between providers and users of health care services. In fact, with the exception of the National Assembly, no group or individual could defend, complain or speak for the population on their health needs. Moreover, *reliable* data on pressing health needs and specific drug supply problems of the population was lacking. Again, health care providers of the public sector were hardly accountable to the user and the latter apparently had neither a right of say nor the right to information about what he got from public health care services.

Figure 1
Cameroon Health Management Structures before Reorientation of PHC



Key:

g arrows indicate the flow of interaction (among health workers exclusively).

c arrows show unique direction and forum at which health workers meet the user

a arrows show the solo direction and purpose of individual movements of the population in the direction of health care services essentially for curative care.

CH = Central Hospital/General Hospital

PH = Provincial Hospital,

DH = Divisional Hospital

HC = Health Centre/sub-divisional hospital.

This policy framework and general institutional arrangements are reflected in greater detail in the organisation of Onapharm.

1.2. Public health sector drug procurement/distribution institutional arrangements prior to the reo of PHC

1.2.1. Onapharm

The distribution of drugs was centralised in Onapharm¹¹ which had specific characteristics.¹²

Onapharm was a State-owned corporation with a legal status under the tutelage of the MoH. The mission of Onapharm was:

- to centralise orders of dietetic and pharmaceutical products, laboratory reagents, and chemicals from all public health units and the procurement of the same,
- to exclusively assure supplies of pharmaceuticals to pharmacies of public health units all over the national territory,
- to assure supervision and control of community pharmacies,
- to control the quality of imported drugs.

1.2.2. Organisation

Onapharm was managed by two organs: a Board of Governors of eleven members (all of them civil servants appointed by decree) who met twice a year and a director general (appointed with an assistant, by decree) responsible for day to day administration. The design objective of Onapharm as an institution was to separate the functions of drug procurement and distribution from governmental bureaucracy. The main office of Onapharm was in Yaoundé (the national capital). Onapharm had agencies in all the ten provincial headquarters. This apart, the rest of the public sector drug distribution system (from hospitals downwards) remained intact (as depicted in Figure 1 above) and with these Onapharm had to interact. Onapharm was therefore not target oriented. It did not seem obliged to satisfy user demands.

1.2.3. Financial Sources

Onapharm was financed from state subventions, gifts and donations, and loans (but had no collateral of its own). For example, state subventions to Onapharm in 1986/87 and 1987/88 were CFA 2.5 billion Frs. per financial year. Resources of Onapharm were centralised in the common public treasury. This meant that suppliers were paid generally in the financial year following that of actual procurement. So at the rupture of state subventions to Onapharm in 1988-89, for example, creditors piled and have remained unpaid.

1.2.4. Procurement and distribution

Drugs in their brand names constituted the bulk¹¹ of orders that were so made by direct contract. Procurement for the whole country was done once a year not by tender but by direct contract with suppliers. This lumped the taxpayer with otherwise expensive drugs purchased under very uncompetitive conditions and procedures. These procurement inefficiencies left room for widespread corrupt practices.

In theory, each divisional medical officer established annual estimates of essential drugs⁸, basing on the number and types of health centre (HC) in the zone. This information was then sent to the provincial branch of Onapharm who incorporated this into provincial estimates before forwarding to the Onapharm Central Office. In practice, all sub-divisions did not make these projections because Medical

officers were neither trained nor were they aided by written procedures, guidelines, or directives for making the same. It was therefore difficult for them to provide information on past consumption or the follow-up of supplies. As a consequence, they conjectured basing on orders of the previous year that were also based on conjecture (which could be the same module or kit for the supply of drugs to all HC irrespective of the pathological specificities of the area). In other words, no data base was developed that encompassed past and current inventories and needs. So decision-making concerning drugs was not based on concrete data but projection (as no written procedures existed).

The only distribution system was based on the unique annual supplies with limited possibilities for urgent orders. No reports of consumption/inventories were kept. Stocks, when available, were generally kept at the central warehouse in Yaoundé or in some of its provincial branches. No system was instituted for periodic reporting of the level of stocks to MoH or Onapharm so as to provide a reliable basis for distribution of stocks. Ministerial orders defined the technical modalities for the transfer and distribution of the stock of Onapharm. The distribution of drug items to public health units was generally for free on the grounds that they will be given on the same terms to patients.

While provincial branches of Onapharm knew the quantities they had ordered, they could not for sure tell when these will be honoured and in what quantities. Health Centre personnel never knew when, what drugs and in what quantities (if any) would come. Such a level of paucity of drug supply information rendered all planning of health care impossible.

1.2.5. stocks and quality control and supervision

There were no quality control procedures¹³. Available stocks were not distributed on the basis of any quality concerns e.g. where the first in first out rule is the norm. Supervision of provincial branches of Onapharm was done annually by the central level. This supervision was limited to a verification of accounts .

1.2.6 Results

Among the missions assigned to Onapharm by decree were the assurance of territorial coverage of public sector health structures in the supply of drugs. Territorial coverage was not assured because no effective network was established for the the essentially brand name drugs it procured and distributed. Again, Onapharm failed to assure effective supervision and control of those community pharmacies it served. Secondly, a procurement and distribution framework that was at the root of frequent and persistent stockouts (and overstocking of certain non essential drugs e.g.. *Theophenicol*¹⁴) led to negligible rates of consultation at health units that depended for their supplies on Onapharm. Patients who hitherto had been clients of public health units could no longer obtain drugs from the public health units meant to serve their area¹⁵. The monthly mean consultations at health units in the province under study in 1986 was thirty(source). There was large scale corruption in the structure thanks to the absence of transparent management procedures¹¹. These weak institutional foundations for drug procurement and distribution had negative effects on the quality of health care. Health was slowly bleeding to death on the alter of a centralised drug supply institution known as Onapharm¹⁷.

2. Institutional Arrangements for public health management under the reo of PHC

The 1996 law (Law N° 96/03 of 4 January 1996) and the National Declaration on the Implementation of the Reorientation of Primary Health Care (the Reo.), outlines the current health policy objectives, guiding principles and new organisational arrangements within the district health system. By the Reo, health care management is undergoing reorientation within otherwise stagnant or unevolving institutional arrangements and national administrative system. The implementation of this new health policy therefore means grappling with the reality of moulding a suitable framework within the existing political system and the administrative network. The Reo. intends respect for human rights (equity) as a key element of the said policy.

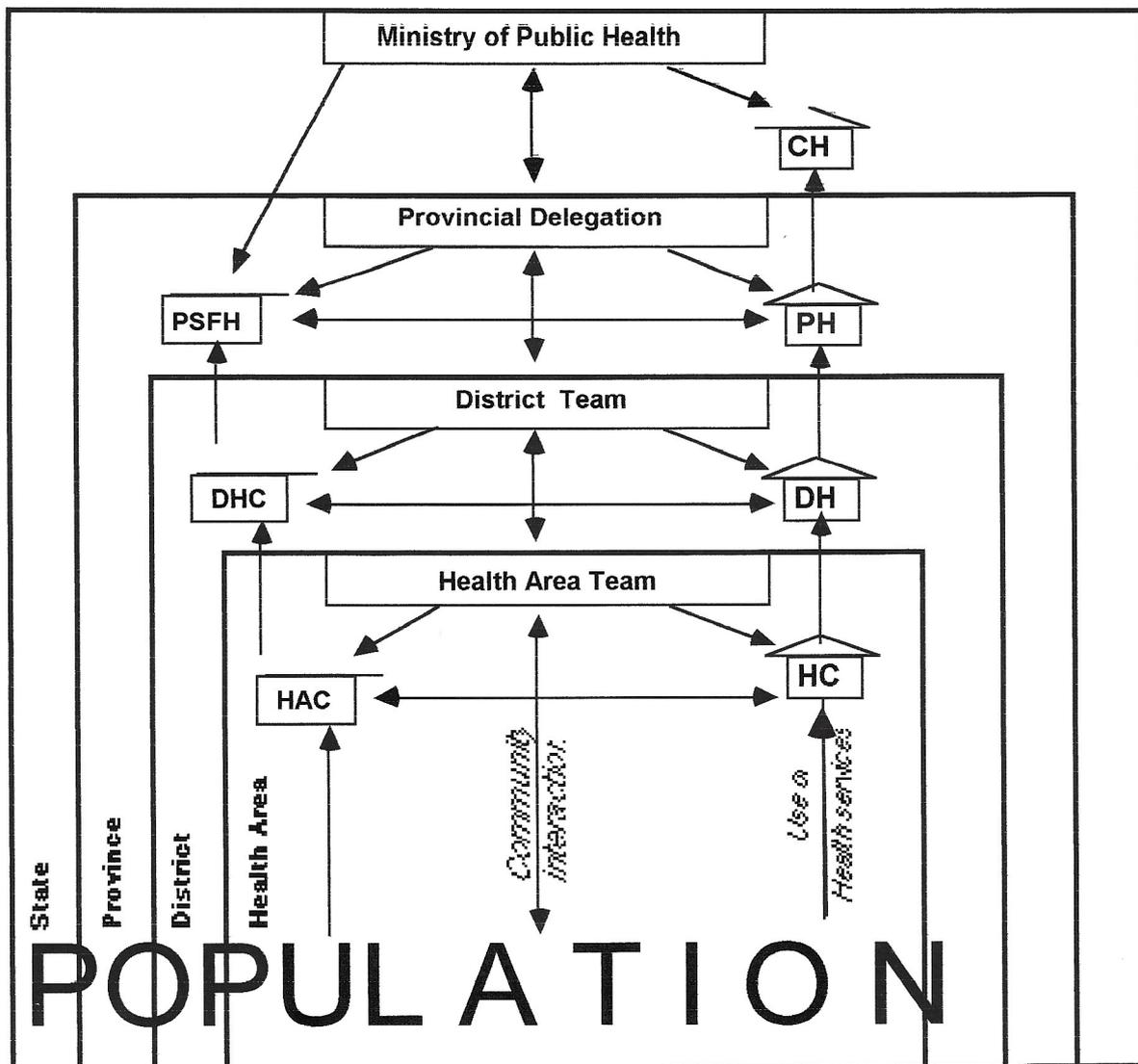
Decree N° 95/013 of February 7, 1995 permits the organisation of public health services all over the national territory into health districts. The minimum package of health care services at each level includes the availability of affordable and essential¹⁸ generic drugs of good quality. As is depicted in Figure 2 below, health units are structured on the health *district system model*. The entry point into the system for the patient is at the peripheral level, through *the health centre*. Cases are then referred from this level to the intermediate referral level which is *the district hospital*. More complicated cases are hereafter referred to hospitals at provincial and national levels. All the hospitals have an out-patients department.

Under the Reo, at the intermediate or provincial level, the services of the MoH are headed by a Provincial Delegate who administratively is assisted by Provincial Chiefs of services corresponding to the different technical departments at central level. At the level of the periphery (health districts and health areas) the services that are responsible for health service management are headed by the District Medical Officer who is in turn assisted by a couple of chief clerks. Most important, this arrangement creates room in the formal health system for community participation structures¹⁰ made up of the entire target population. How this differs from the pre-Reo. situation is depicted in Figure 2 below.

The foregoing framework recognises, through formal community health structures (on left of the above chart), elected representatives of the population as spokespersons for the community on health problems, deficiencies, expectations and priorities. They provide feedback about health care inputs. This constitutes useful data base for decisions touching on the health (and drug supply) of the target population.

Nevertheless, (as was the case prior to the Reo. of PHC, per Decree n° 89/011 of January 5, 1989 reorganising the MoH), under the Reo. the limits to the role and administrative powers of each responsible officer at each level are spelt out in the Decree N° 95/040 reorganising the MoH. The taking of management decisions relating to almost all health matters must be sanctioned by the Minister through the technical director at central level. This rule applies all along the chain of interaction in descending order. In relation to administration and power, there is a deconcentration of institutions in contradistinction from decentralisation of power. These general policy and organisational features are reflected with some difference in institutional arrangements in regard of public sector health structures in Figure 2 below.

Figure 2 Organisational chart of
Cameroon Health Management Structures under
Reorientation of PHC



Key:

g arrows indicate interaction

f indicate interaction between health workers and the population as groups.

dc arrows show multiplicity of fora of interaction between health workers/ user

a arrows show direction of movements and contributions of health service users.

CH = Central Hospital,

PH = Provincial Hospital,

DH = District Hospital

HC = Health Centre

PSFH = Provincial Special Fund for Health.

DHC = District Health Committee.

HAC = Health Area Committee.

= Technical structures of the MoH

= Community participation structures of the MoH

per : Cheka/Berg/Schmidt-Ehry; GTZ/PHC/Cameroon (1994)

2.2. drug procurement/distribution institutional arrangements under the Reo. of PHC

This concept started in the NW Province with a three year pilot phase under the German-Cameroonian Project for the Reo of PHC. The PHC project operated an Essential Drug Programme (EDP) as one of its key components. The objective of the EDP was to :

Set - up a drug supply system with full area coverage. The drug supply system should provide drugs of good quality at an affordable cost to the 1.4 million population of the North West Province. In addition the EDP must involve the beneficiary community in its financing and management and have in-built guarantees of a certain degree of sustainability and perpetuity.

The North West Special Fund for Health¹⁹ is the result of the said pilot phase. It has been conferred legal personality as a non-governmental organisation. The form of ownership, management and organisation, sources of finance, procurement and distribution procedures as well as supervision and drug quality control are all geared towards the attainment and preservation of the key elements of the objective (supply of affordable drugs of good quality on a cost-recovery basis, equity, area coverage and community participation).

2.2.1. *personality and ownership of the drug supply structure.*

The EDP is a department of the NW Fund which is a recognised legal personality under the Cameroonian law of Associations²⁰. The need to obtain a legal personality for the Fund resulted from the fact that the political and institutional arrangements were centralised. All public resources and their management were subject to the *principe de l'unicité de caisse* ('one treasury'; whereby all revenue earned wherever by the public sector, must be paid into the single national treasury). The NW Fund required for efficient management, a jurisdiction, a legal identity through which it could own property, manage it, fix appropriate rules (unlike would be the case with centralised management), sue or be sued.

The design of the institutional framework of the NW Fund was based on rights precepts embraced by the Reo. of PHC. Ownership of the Fund and therefore the drug supply system is collective; belonging in a partnership made up of the community (the NW Province), the State (represented by the Ministry of Public Health), health sector donors and denominations involved in health in the NW Province. This is in conformity with which favours respect for human rights and thus implicitly; article article 17 of the the UDHR which espouses the right in the "people to own property alone or in association with others".

2.2.2. *organisation and membership of the EDP*

The EDP is managed by the NW Fund which has three constituted organs. There is a General Assembly (G.A.) of members. This is the supreme organ of the drug supply structure at which each health district is represented by two members elected by the target community. There are 13 health districts in the province. So this formula assures the numerical majority of the community representatives over other groups of partners. This last point is of significance considering that decisions are adopted by vote. Public authorities are represented by four *ex-officio* members. The donor agency co-operating with the Ministry of health at the level of the province is also represented. Non profit-driven health operators like the denominations and charities also have representation in the G.A.. A general meeting of the G.A.

is held at least once a year to take major decisions such as to adopt the budget and approve the provincial action plan for health.

A Management Committee (M.C.) headed by a Chairman is the management and administrative organ of the NW Fund. The composition of this M.C. is still based on the partnership concept with members all drawn from the G.A. Thus public authority is represented by six *ex-officio* members. Community representatives are made up of elected representatives of users of health services and not for profit health care providers like denominations. These community representatives are classed as *active members* and an administrative mechanism is applied to cause eight representatives from the group of *active members* to sit on the M.C.. The Chief Executive Officer (CEO) of the EDP is a member of the Management Committee of the NW Fund. The M.C. normally meets at quarterly intervals to set policy and review the activities of the administrative office. Thanks to this organisation and membership structure, the target community can "take part in the conduct of public affairs, directly or through freely chosen representatives"²¹

There is an Administrative Office (answerable to the Management Committee) that is charged with the day to day running of the business of the NW Fund. It is essentially the staff at this level who manage the activities of the EDP. It is headed by a CEO who is proposed by the G.A. and appointed by the MoH. This office is operated by a small team of the CEO, a pharmacist, chief of administration and finance, an accountant, a couple of secretaries, storekeepers, supervisors and three drivers of robust delivery vans.

2.2.3. *management*

Stock procurement and management at the EDP is centred around the essential drug policy within the framework of the objective outlined above. By this, the EDP procures and offers only a limited and regionally adapted number of essential drug²² items in their generic form. This service is based on a demand driven bottom-up approach rather than on a top-down drug ration kit system hitherto offered by Onapharm. In so doing, the EDP appeals to prescribers to voluntarily apply the principles of rational drug use and change old multi-prescribing attitudes whereby the prescribers are bound to stick to preconditioned kit quantities for better or for worse²³. Resources of the drug revolving fund are subject to decentralised management²⁴ (in spite of the principle of *unicité de caisse*) and are therefore independent from those of the national treasury.

To assure continuity of supplies within the framework of the Bamako Initiative²⁵, drug supply management is on a "qualified" full *cost recovery* and *social equity*²⁶ basis. This brand of full cost recovery is a qualified one because it excludes costs for investments such as buildings or depreciation but budget estimates take precaution against all overheads. On this basis, all costs are averaged and apportioned per drug item. This procedure results in an average price margin per drug item for all users within a geographical area - the Province. Drug prices are calculated with varying mark-ups so that relatively cheap and high in demand formularies like *Acetylsalicylic acid* (aspirin) carry mark-ups that permit cross subsidisation of other essential and low in demand but relatively expensive drugs. The result is some measure of social equity: (in application of Decree N° 93/228 of March 15 1993), prices of the same drug items are uniform all over the province; irrespective of whether a community pharmacy is accessible by air, road, river, or cattle tracks. As a consequence, villages in remote areas

do not incur extra costs for the transportation or other overheads inherent in making the drugs available in the area.

Each year, whenever risks for which certain mark-ups were set aside are not incurred, the sums so realised are distributed to the health committees proportionately to their purchases in the course of the previous year. It might be useful to state here that in spite of the mark ups, the prices of drugs cost some 40% less than they would in private pharmacies. Moreover, the vast majority of the population of the NW Province lives in rural areas where private pharmacies do not exist.

2.2.4. *Sources of finance*

The memorandum and articles of association governing the NW Fund provide methods of raising funds. These include donations, proceeds from sales of drugs, rallies, government subventions, and gifts and legacies. For example it is :

- donor support in the form of drugs that provided the seed stock of the NW Fund,
- MoH subventions cater to salaries of senior staff and the use of some State-owned real property is gratuitously ceded to the Fund. This is what currently houses the offices of the EDP.
- cost recovery from sales of drugs feeds the revolving fund and in turn enhances the sustainability of the structure and the renewal of stocks.

2.2.5. *procurement procedures*

Procurement procedures of the NW Fund for drugs vary according to the total financial value of the drug quantities earmarked for procurement.

All purchases up to or exceeding CFA 50 million Frs²⁷. per order are as a rule made by open tendering. All purchases above CFA five million Frs. but under CFA 50 million CFA per order are mandatorily made through a negotiated procurement with the supplier. In this case contacts are made with at least three possible suppliers. Supply terms and conditions of the three are compared on a scale of those that are most favourable in terms of quality, price and time of delivery to the EDP. The procurement contract is then made at the end of this . All purchases under CFA five million Frs. per order, follow a direct procurement procedure. Here, the manager of the EDP after comparing going prices for the drug items of other suppliers selects and contracts with one.

Irrespective of the procedure followed, all purchases made by the essential drug programme respect the terms of a standard form contract of the NW Fund carrying specific conditions on labelling, drug information, quality, packaging and transportation and a penalty clause. There is a 'Tenders Board' (sub-committee of the Management Committee of the NW Fund). This Board is charged with ensuring and overseeing the practice of a transparent purchase policy by management.

2.2.6. *distribution, supervision and drug control procedures*

The EDP owns and uses all-season vans for drug delivery and supervision of community pharmacies and pharmacies serving public health units. Though deliveries are normally done every three months, the intervals between distribution and supervision and control rounds by the EDP are largely determined by:

- i. requisitions from the community pharmacy, health centre or health unit,
- ii. the state of the mostly seasonal roads of the NW Province,
- iii. the distance from the health facility and the regular route of the delivery van.

Supervision and control procedures are carried out within the framework of the primary health care activities of the province. This subjects drug sales outlets to a four-tier supervision and control.

There is "technical supervision" of the sales outlets by the staff of the EDP during their drug supply rounds. This team looks for compliance by the pharmacy attendant with set prices for drug items, the keeping of stock cards, retention of drugs in their original batch, turn over, abidance by the rule to keep and sell only drugs supplied by the EDP. etc. These technical supervisors are empowered to make on-the-spot appreciation of problems that their visits reveal. They are further empowered to resolve, in the best interests of the NW Fund, those that fall within their competence before reporting the matter to the CEO of the NW Fund.

"Pharmaceutical supervision" which deals especially with drug quality control is done by the pharmacist of the EDP. The pharmacist at the central store of the EDP checks for compliance with drug quality norms, respect by suppliers of legal norms governing pharmaceuticals, and updating of the essential drug list. The pharmacist also undertakes surprise checks of the peripheral pharmacies. During these visits, attention is focused on issues like prescribing practices of consulting nurses and GPs, drug dispensing practice by the pharmacy attendant, informal drug sales in the periphery, the degree of drug sales in the pharmacy in relation to the consultation rates of the health unit in accordance with prescriptions.

Community pharmacy attendants chosen by the user community receive training from the EDP on handling and control of stocks in their respective pharmacies. Using techniques learnt at training seminars for elected community health representatives,²⁸ the various health committees also exercise such day to day observatory control over the activities of the pharmacy attendant as to avoid or reduce embezzlements and abuse.

Yet another level of supervision and control of the peripheral pharmacy is called "medical supervision". This occasionally done by the medical team of the area. The medical team assures that the community pharmacy remains at the service of community health.

All supervision visits culminate in the preparation of a report, copies of which are made available to the pharmacy attendant, the head of the community health pharmacy or health unit and the representative of the relevant health committee of the area. Findings of supervision tours are discussed regularly and solutions sought during provincial co-ordination meetings involving all responsible officers of health units and services in the province and the NW Fund.

2.2.7. mechanisms for community participation of partners

Mechanisms for participation are important in institutional arrangements for the management of public affairs because, properly defined and implemented as pertains to health, they permit health education of

the people²⁹ in self determination³⁰ as they seek, receive and impart information through formal and informal involvement³¹ in the management of health affairs. It is submitted that all of these contribute to the tenacity of the institution and in the enhancement of health.

In the EDP, these mechanisms vary according as the partner is the beneficiary community of health services in the NW Province, donors, denominations, or the state³². Each partner in their own way participates materially, through the provision of know - how, exchange of health information, decision making (hence collective responsibility) and use of public health facilities through formal fora for participation.

On the basis of the partners participating each according to their means³³, under the partnership model of the NW Fund:

- *public authority* participates through the provision of buildings, heavy equipment, salaries of senior staff, training of cadres. The representatives of the Central services of the MoH are expected to present quarterly reports of their activities to the MC .
- *donors* provide cash especially for the seed-stock of the revolving fund, and/or drugs, technical assistance/ know-how on drug procurement, management and distribution.
- *communities* participate by payment³⁴ for drugs from the EDP, (unlike in the Onapharm era when drugs were given for free), salaries of community employed pharmacy attendants, community mobilisation for participation in health education, making of donations into the paupers fund, benevolent attendance of and participation in meetings, defence of the health realities and views of the population and the filing of written feedback by way of quarterly reports from the community (on health needs, health difficulties, drug supply problems).
Community pharmacy attendants are chosen by the user community. They receive training from the EDP on handling and control of stocks in their respective pharmacies. Again, elected representatives of the community participate in community health training seminars at which various basic public health issues are treated.

Participation by the community (through payment for drugs), has for example, sustained the drug revolving fund, assured continuity of supplies and their availability. It has enhanced health information dissemination especially as the community representatives speak the local dialect (which the health worker may not), they trek to otherwise inaccessible places (where the health worker would expect a car or motorcycle to accede to), they have access to traditional fora which the health worker (often alien to the culture) does not have access to. Health assets in common ownership have been protected from subversion through the setting up by local communities of vigilante groups to guard premises that house community pharmacies.

2.3. Results

This partnership model has allowed the population to "take part in the conduct of public affairs, directly or through freely chosen representatives"³⁵ A sense of ownership is evident as involvement in community health meetings is vibrant. The attendance records of meetings³⁶ by members of the

Management Committee of the NW Fund during the period under study is indicative of the level of commitment to the concept by members representing specific partners.

By the said records, most members record a 100% attendance rate throughout the period under study. Nevertheless, on the *active* member side, a 96.25% attendance rate is recorded while on the *ex-officio* member side, the central services (Representative of the Minister) of the Ministry of Public Health, record a 50% attendance rate for the period.

These attendances are significant because, under the rules governing the NW Fund, decisions are taken by vote. The rules require representatives of the community to present reports relating to the health situation in their health district at the MC meeting. Moreover, the records consulted indicate that these *active* members are not passive at meetings! In 1992 for example, community representatives used their voting rights to outvote a motion of health workers that would have made a gift from the NW Fund of 50% (instead of a 33%) to a sister Fund. User-participation in the cost of essential generic drugs and the management of the revolving fund exposes management to the eyes and ears of the user. This was not the case under the previously centralised and deconcentrated drug supply system. For example, minutes of MC meetings of the NW Fund for the period under study record several cases where health workers have been successfully indicted for mismanagement at the behest of community representatives on the board. Under the previously centralised drug supply structure, only the state could litigate in such instances against a health worker. The complex procedure involved to trigger this was painfully slow (to the extent that little or nothing was ever recovered from those who otherwise would have been charged with an offence). Participation has therefore forced or caused a kind of transparency and accountability that was hitherto absent. This has greatly enhanced the sustainability of the NW Fund.

As a community participation/partnership model, the NW Fund has been generalised by the MoH and is currently being implemented in other provinces of Cameroon with some differences that depend on the approach of the co-operating agency charged with implementation³⁷. It is for this reason that for example, there are structures of the same name in the South and the Adamaoua Provinces.³⁸ The latter structures differ specifically from the NW Fund in their strategies to procurement and distribution. For example, community pharmacies of the NW Fund pool their resources at the level of the EDP and thereby benefit from economies of scale, financial management skills that the central EDP office and the banks provide at the provincial headquarters. These facilities are otherwise not available in the periphery. The Special Funds of the South and the Adamaoua did not adopt this approach until after it became clear (through a spate of losses) that community pharmacies and related institutions had not yet acquired the expertise and infrastructure that could ensure shrewd management and adequate security of stocks and resources.

Thirdly, a 90% coverage of the public health units in the NW Province by the EDP has been achieved³⁹. The affordability of essential drugs that are now available is yet to be measured. Nevertheless, compared to specialties (available mainly in urban areas and more expensive than generics), it can be stated that essential generic drugs are available on a continuous basis at 'affordable

system cost some 40% less than they do in private pharmacies which generally sell mostly brand name drugs)⁴⁰

Without implying that the 'Fund' concept is dependent solely on the provision of medicines in health units, it is clear that the provision of medicines is the backbone of the Reo. 'Besides the obvious therapeutic role of medicines, they ... provide the driving force for the utilisation of health services'⁴¹ It is submitted that this strength is attributable to the change in organisational arrangements .

3. Conclusions /lessons learned

One lesson stands out clear from the Cameroonian experience in drug procurement and distribution through public private partnership. Economic realities of the late eighties as they prevail today demonstrate the need for some measure of partnership for user participation in cost sharing and management of public health structures. The centralised solely partnership-free public sector drug supply institutional arrangements *prior* to the Reo. i.e. the Onapharm model of centralisation, failed to adequately serve health interests for reasons of policy (extrinsic to Onapharm) and reasons intrinsic in the design of the Onapharm network (absence of procedures for needs assessment, drug management, distribution etc.). Health policy prior to the Reo. and governing a centralised Onapharm embraced free drug supply to the population served by public health units. The success of this policy was based on the premise that the national treasury will perpetually be in a position to grant subventions that will assure procurement of pharmaceuticals and their free distribution to patients.

Partial ownership of public health structures in the beneficiary through partnerships seems to constitute one sound base for assuring their sustainability. The drug supply organisational and institutional arrangements prior to the Reo. show that centralised health institutional arrangements of the type described create an unhealthy monologue especially of management, information flow and the decision - making process as well as hinder, or even at times, erode broadly based human development⁴². This spectre turns the client community into mere recipients; stifling social and mental well-being which otherwise could come from participation; collective ownership and access to information and health care. By contrast, fee - for - service health care based on the decentralised drug supply institutional arrangements as *under* the Reo of PHC (the NW Fund model) is built on a national finance law that permits decentralised management of pharmaceutical revenues. Thus there is community participation in the financing of health and its management. There are internal procedures that base management on sound business principles and assure availability of stocks and the continuity of health care services.

Again, within the current Cameroonian context, the NW Fund model has while on the one hand showing

system cost some 40% less than they do in private pharmacies which generally sell mostly brand name drugs)⁴⁰

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Again, within the current Cameroonian context, the NW Fund model has while on the one hand showing that the community can best assure the security of health assets once they are brought to understand that it is theirs, by the same token, it has highlighted a security problem that is attributable to the high poverty levels, limitations of the capacity of stretched forces of law and order, and the slow speed with which justice is dispensed when community pharmacies suffer embezzlements or are burgled⁴³. There is now a tendency for communities to 'participate' in the assurance of the security of 'their' community

pharmacy by relying on vigilante groups . If this effect of decentralisation remains unbridled, it might result in conflict between vigilante groups and established forces of law and order with unpredictable consequences on further manifestation by central authorities of the state of the political will to decentralise institutions and empower the people.

Otherwise, the NW Fund model underlines the usefulness and place of institutional and organisational determinants of health to the conception, design of decentralised health structures and their implementation. This in turn emphasises the need for interdisciplinary and intersectoral collaboration in the interest of health. The relevance of organisational arrangements to the attainment of health goals means that statesmen and politicians should build law and health policy *on partnerships*. Health technocrats and project planners should include public private partnerships in the conception by them of health projects and in their implementation .

The NW Fund model reduces avenues that enhance the flourishing of the informal drug supply sector. This is achieved through the sale of good quality drugs at affordable prices, a distribution mechanism that directly assures transportation of pharmaceutical products from the central warehouse to the community pharmacy⁴⁴, only serves known community pharmacies manned by trained pharmacy attendants and supervision control procedures that oversee quantities held by the pharmacy attendant.

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- ** The authors wish to record their sincere thanks to Mme Helen TATA (chief pharmacist and CEO) of the NW Fund for invaluable assistance.
1. Address of the World Bank at the *Deuxième Rencontre des Ministres de la Santé des Pays de la Zone Franc et des Pays Associés sur la Politique du Médicament* Bruxelles 4-7 avril 1995; publié par le Ministère de la Santé de la Côte d'Ivoire et la Direction Générale du Développement de la Commission Européenne avec l'assistance de l'OMS.
 2. *ibid*
 3. **Cameroon:** National Declaration on the implementation of the Reorientation of Primary Health Care, signed by the Minister of Public Health on May 15, 1992. This declaration is now imperfectly reflected in Law N° 96/03 of January 4, 1996 laying down the legal framework in the health domain.
 4. A consultancy report made by AEDES and financed by the European Union for the Cameroonian Ministry of Public Health was completed in September 1995 with a view to putting in place a National Central Store for the Procurement and Distribution of Pharmaceuticals in Cameroon.
 5. Decree N° 85/1126 of 08.08.85 creating l'Office National Pharmaceutique du Cameroun (Onapharm); *cf. infra* note 35.
 6. The Universal Declaration of Human Rights (UDHR) (G.A.Res. 217, 3 GAOR, U.N. Doc. 1/777 (1948) adopted by the UN General Assembly on December 10, 1948), art. 3; *cf.* the International Covenant on Civil and Political Rights (ICCPR) (Annex to G.A. Res. 2200, 21 GAOR, Supp. 16, U.N. Doc. A/6316, at 52 (1966), adopted by the U.N. G.A. on December 16, 1966; opened for signature on December 19, 1966; went into force on March 23, 1966), art 6.
 7. Constitution of the Republic of Cameroon, as modified, adopted on May 20, 1972, promulgated into law on June 2, 1972; recently revised by Loi N° 96/06 du 18 janvier 1995 portant révision de la Constitution du 02 juin, 1972.

8. See : Cameroun: *Loi N° 90-035 du 10 août 1990 portant Exercice et Organisation de la profession de pharmacien, art. 63,* and *Lettre Circulaire N° D23/LPOACEP/MSP/SG/DPH/SIVIP/BI du 12 août 1991 portant liste des pièces à fournir pour obtention d'un agrément de création d'établissement pharmaceutique.*
9. per Decree N° 89/011 of January 5, 1989.
10. per Decree N° 95/040 of March 7, 1995.
11. For further detail see Robert Murray, *Etude sur l'approvisionnement en médicaments essentiels et produits pharmaceutiques au Cameroun.* (19 avril au 24 Mai 1989) Document de Travail non publié du FNUAP. See also, Théophile Sogodandji " *Le Médicament au Cameroun. Pour une Politique Pharmaceutique Cohérente*" Janvier 1992. Rapport non publié d'une consultation de la Banque Mondiale.
12. This model of centralised drug supply structures is not unique to Cameroon. It seems to be the model for public sector drug procurement and distribution in former French colonies of the Central African Sub-region for example, see for the case of the Congo a similar structure called "Pharmacie d'Approvisionnement" (with the specificity that this structure is a service of the Directorate of Pharmacy in the Ministry of Health and Population per Decree N° 91-953 of December 18 1991), for Gabon, the structure is known also as "Pharmacie Nationale" which is attached to Direction Generale de la Santé et de la Population at central level by Decree N°1406/PR/MSPP of November 6, 1982 reorganising the Ministry of Health and Population.
13. in spite of an operational W.H.O. funded structure in place.
14. Sogodandji, op. cit. page 33.
15. No indepth hospital management Information System (HMIS) records for the period under consideration exist, so the enormity of the problem cannot be graphically represented.
16. Source: Records of HMIS, at the Provincial Delegation of Health, Bamenda, Cameroon.
17. Thanks to Ordinance N° 90/004 of June 22, 1990 (which set criteria relating to the privatisation of public enterprise), Decree N° 90/1257 of 30.08.90 established rules governing the application of the latter Ordinance and Decree N° 94/125 of 14 July 1994 (relating to the admission of certain public and semi-public enterprises into the procedure of privatisation; which listed Onapharm for privatisation.), on February 2 1995, Onapharm was declared qualified for dissolution by Decree N° 95/032. See also, Fondation Friedrich-Ebert Stiftung : "*Les Privatisations au Cameroun, bilan et perspectives*" par Theodore K. Eyangue.

18. The Essential drug list applicable in Cameroon is set by Ministerial Order N° 0381 of 15 June 1993.
19. See: *The Memorandum and articles of Association of the NW Provincial Special Fund for Health* conferred legal personality by the government of the Republic of Cameroon per ref. N. E29/1599/S.1/400 on June 6th, 1991 as well as the subsequent modifications thereof. Because of antecedent less liberal laws governing the creation of not for profit associations, it took two years for the first draft partnership rules for community participation to give birth to a legal person and this only after a new law of associations was passed in 1990 .
20. Cameroon: Law N° 90-53 of 19.12.90 on Freedom of Associations.
21. UDHR art. 21.1, ICCPR, art 25 (a), see also the Alma Ata Declaration of 1978 N° 1 Health For All Series, WHO (Geneva), 1978, art. IV
22. According to WHO in 'L'Utilisation des Médicaments Essentiels', (OMS, 1990), these are drugs that satisfy the health needs of the majority of population and must always be available in sufficient quantities and appropriate pharmaceutical form. Cameroon Decision N° 0381 of the Minister of Public Health of 15 June 1993 instituted a National Essential Drug list which, taking local therapeutic specificities into consideration, constitutes the basis for the elaboration of the Provincial essential drug list.
23. Friedrich Von Massow, Cheka Cosmas, Meinolf Kuper, Helen Tata, Bergis Schmidt-Ehry (1998) 'A financially independent primary health care drug supply system in Cameroon', *Tropical Medicine and International Health*, Vol. 3, N° 10, (October 1998).
24. See Decree N°90/062 of 19 December 1990 granting a special waiver to public health units in financial matters
25. Commitment made by African Health Ministers assembled under the auspices of the WHO and endorsed by the 24th Summit Meeting of the OAU, Bamako Mali, (1988), see also; WHO (1985, 1987), Report of the 35th and 37th sessions of the Regional Committee for Africa; UNICEF (1988) Report of the UNICEF Executive Board.
26. But *cf.* Gilson L. (1988) " Is Equity being abandoned?" a discussion paper published EPC N° 15, London School of Hygiene and Tropical Medicine.
27. The FCFA (franc de la communauté financière d'Afrique) has, as from January 12 1994, a fixed exchange parity of FCFA 100 to one French franc.

28. See (unpublished) Reports of GTZ Health Projects in Cameroon. "Community Health Training Workshop for elected health district representatives of the NW and SW Provinces of Cameroon," Bamenda September 12 - 16, 1994.
29. UDHR *ibid.* art 26.1., ICESCR *ibid.* art. 13,
30. ICCPR *ibid.* art.1; ICESCR *ibid.* art. 1.
31. UDHR *ibid.* art 19; ICCPR *ibid.* art. 19.2.
32. See (unpublished Reports of GTZ Health Projects in Cameroon. "Community Health Training Workshop for elected health district representatives of the NW and SW Provinces of Cameroon," Bamenda September 12 - 16, 1994.
33. See J. Midgley, A Hall, M Hardman and D Narine "**Community Participation, Social Development and the State**" London Methuen & C° (1986) (for an introduction into the concept of community participation and especially the relationship between the state and community); but see (for practical constraints to achieving participation) Ralph Diaz "*Community participation in Urban projects with emphasis on health and family planning*" paper presented at "Community Health & Urban Poor" a Workshop organised by the London School of Hygiene, Oxfam and UNICEF, Oxford, (1985).
34. For other methods that have been used to mobilise community support, see W. Stinson: *Community financing of primary health care, Washington DC: American Public Health Association (1982) (P.H.C. Issues, Series 1, N° 1); cf. A Ugalde "Ideological Dimensions of Community participation in Latin American health programs" Soc. Sci. Med. 21: 41-53 (1985) (for a critical treatment of the ideological implications of participation in the health sector).*
35. UDHR, art. 21.1.; ICCPR, art. 25 (a).
36. See Records of Meetings of the Management Committee of the North West Provincial Special Fund for Health from October 10, 1991 to October 1995.
37. This is for example the structure referred to by J I Litvak and Claude Bodart in "User fees plus quality equals improved access to health care: Results of a field experiment in Cameroon" *Soc. Sci. Med. Vol. 3, pp. 369 -383, (1993).*
38. J I Litvak and Claude Bodart in "User fees plus quality equals improved access to health care: Results of a field experiment in Cameroon" *Soc. Sci. Med. Vol. 3, pp. 369 -383, (1993).*

39. This was made public in the report of the Chairman of the Management Committee of the NW Fund to Senior Divisional Officers of the NW Province at an intersectorial training Seminar for which: See: unpublished Reports of GTZ Health Projects in Cameroon. "*Provincial Public Health Training Seminar for Senior Divisional Officers, Municipal Councillors and Provincial Delegates of the NW Province*," Bamenda April 27-28, 1995.
40. Friedrich Von Massow, Cheka Cosmas, Meinolf Kuper, Helen Tata, Bergis Schmidt-Ehry (1998) 'A financially independent primary health care drug supply system in Cameroon', *Tropical Medicine and International Health*, Vol. 3, N° 10, (October 1998).
41. René Owona Essomba, Malcolm Bryant and Claude Bodart, "The Reorientation of Primary Health care in Cameroon; rationale, obstacles and constraints" *Health Policy and Planning*; 8(3); (1993) 232-239.
42. J.S Wunsch and Dele Olowu (eds) *The Failure of the Centralised State* Westview Press (1990).
43. Cheka Cosmas and Bergis Schmidt-Ehry "Human Rights and Health in Developing Countries: Barriers to Community Participation in public health in Cameroon" *Harvard Journal of Health and Human Rights*, Vol 1, N° 3, (1995).
44. Thus avoiding the ills of , for example, the centralised public sector procurement and distribution model currently in operation in Cotonou, Benin. Under the Cotonou model, the client assures removal of pharmaceutical Products from the "Centrale d'Achats" and transportation from this warehouse to the client's destination. It is submitted that this model creates multifarious avenues for replenishing stocks of the informal sector in pharmaceutical products especially franc CFA countries where pharmaceutical inspection is inefficient or well-nigh inexistent.

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