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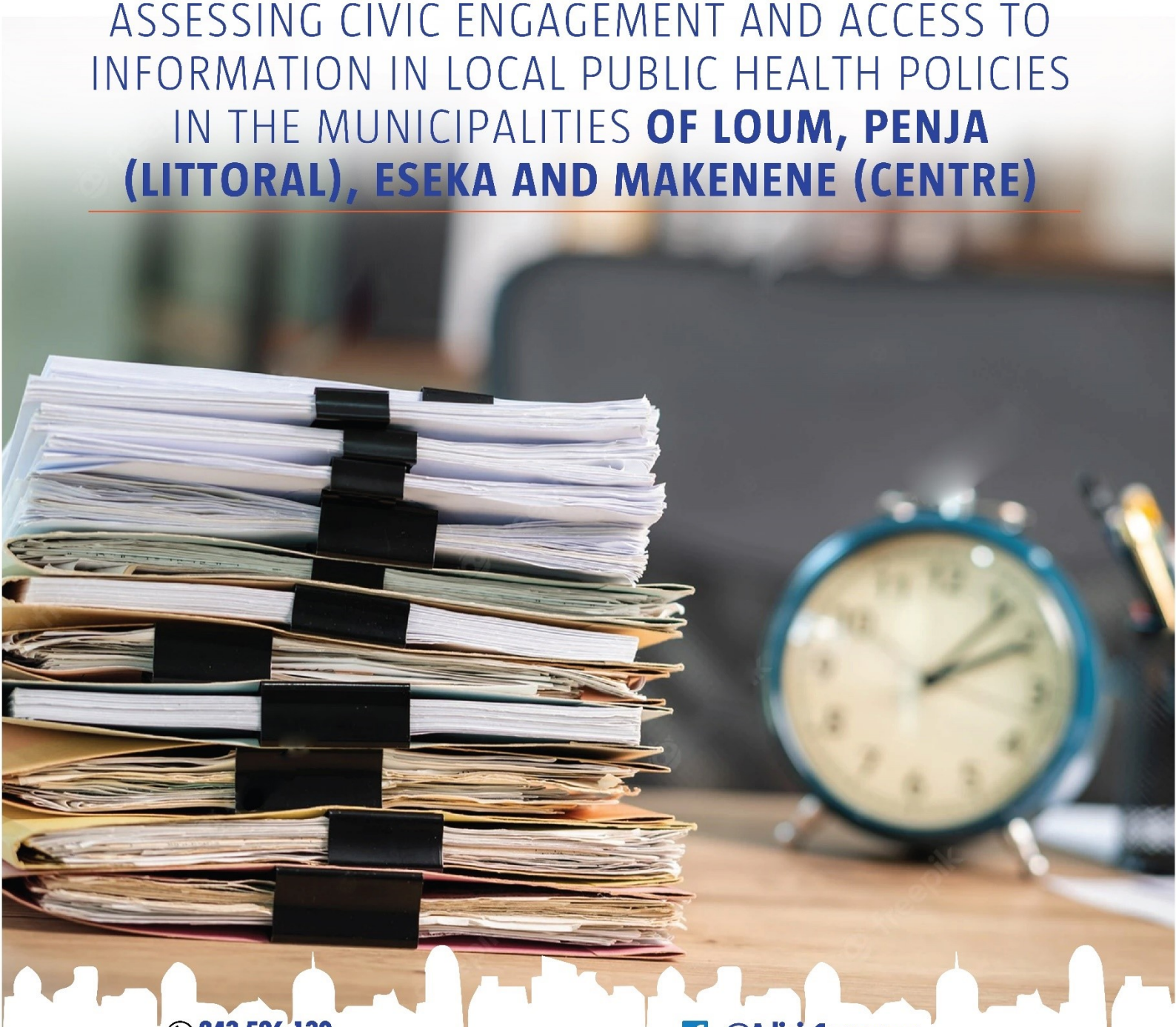
STUDY REPORT

ASSESSING CIVIC ENGAGEMENT AND ACCESS TO INFORMATION IN LOCAL PUBLIC HEALTH POLICIES IN THE MUNICIPALITIES **OF LOUM, PENJA (LITTORAL), ESEKA AND MAKENENE (CENTRE)**



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ACRONYMS AND **ABBREVIATIONS**

PIB	Public Investment Budget
CMA	Sub-divisional Medical Health Centre
COGE	Management Committee
COGEDI	District Management Committee
COGEH	Hospital Management Committee
COSA	Health Committee
COSADI	District Health Committee
CTD	Decentralized Local Authorities
IHC	Integrated Health Centre
IUHC	Integrated Urban Health Centre
DMT	District Management Team
MINDEVEL	Ministry of Decentralization and Local Development
MINEE	Ministry of Water Resources and Energy
MINSANTE	Ministry of Public Health
WHO	World Health Organization
CSOs	Civil Society Organizations

GLOSSARY ET CONCEPTS

Decentralization: The policy of transferring some responsibilities and resources from the State to local authorities or public institutions for their autonomous use.

Healthcare decentralization: The policy of transferring some responsibilities and resources from the State in the framework of health to Local Authorities for their autonomous use.

Public policies: A set of measures established and implemented by the State or one of its entities in order to solve a public problem.

Public health policy: A set of measures established and implemented by the State or one of its institutions with a view to solving a public health problem.

Civic engagement: A process of compulsory or voluntary engagement of common people, acting alone or in an organization, to influence a decision on State choices or actions. The process of involving citizens in public action.

Connectivity rate: The ability to establish a network connection.

EXECUTIVE SUMMARY

Decentralization has been the basis of the Cameroon State model since 1996. This approach was chosen to grant autonomy to local and regional authorities by transferring to them certain responsibilities and resources that were previously held by the central government. One of the key objectives of this autonomy is to boost the population' interest in development, implementation and assessment of public policies through the dual mechanism of countability and accountability of local managers.

However, on the field, this civic engagement claimed by decentralization is not fully in practice, as this study clearly shows, conducted in the municipalities of Makénéné, Eséka, Loum and Njombe-Penja, with local health care initiatives as the experimental sector.

Indeed, the data collected on the field show that the populations are marginalized and self-marginalized in public policies, despite the right granted to them by the legal system in this area. In fact, only 16% of the population concerned are aware of the existence of this legal framework. This ignorance has a major effect on the public's involvement in local public health. Very low participation rates can be observed: 20% for the health actions of the health facilities and 16% for those introduced by the municipalities. Even so, frameworks for participation exist, such as the COSA, COGE, COSADI, COGEDI and COGEH.

The situation is mainly caused by the marginalization of healthcare by local authorities, as demonstrated by the virtual absence of specific chapters in their respective budgets, but also by the lack of incentive policies that is 1% for the municipalities and 9% for the health facilities, which should not be put into perspective. However, a good number of people are willing to invest in local public health policies, as illustrated by the level of motivation to 82%, which takes to 89% the population' potential support for these policies.

The mobilizing structures expected to boost participation, especially the informational system, are either deficient or under-exploited. However, information is the primary lever for mobilizing the population in various ways. In order to helping to structure an awareness of participation, it also informs the public about the opportunities in taking part. Unfortunately, only 16% of the population is often informed of participation opportunities in public health policies.

With regard to all these limitations, it is vital for the State to proceed with genuine decentralization so that the municipalities will finally have the necessary skills and resources to increase local health initiatives that will bring the population closer to public health policies with the ultimate aim of ensuring their optimal participation in these policies. However, these efforts will not be feasible without the proper development and implementation of participation frameworks by the municipalities and health facilities, as well as the proper education of the population in the co-production of public policies. These are challenges that require the involvement of community leaders and civil society organizations, as well as a better use of digital communication systems, the usefulness of which is no longer questioned in terms of mobilizing the public.

CONTEXT AND JUSTIFICATION

Local authorities in Cameroon are subject to Law No. 2019/024 of 24 December on the general code for decentralized local authorities. This Law revolutionizes the practices of local institutional structures of 360 municipalities and 14 urban communes nationwide, most have new executives who took office in February 2020. Before then, within the framework of the transfer of skills and resources of the first and second generation, healthcare holds a prominent place. Evidence of this is the dominance of the local executives over the district hospitals, for which they are the chairmen of the management committee.

This survey aims at taking into account citizens' concerns in the design of public health policies at the local level, and in particular to understand whether the implementation of these policies meets the needs of the citizens according to the law n°2019/024 of 24 December 2019 on the general code of decentralized. The section on access to information will seek to identify and analyze local tools for promoting health and access to quality care for citizens. Health has been one of the five largest budgets of the Cameroonian state for at least 10 years. To this end, three months were spent conducting this research until its publication. As an advocacy and decision-making tool, the survey's report will be presented to the Municipal Councillors of these 4 municipalities and other local elected officials as well as to the administrations. Another advocacy will be done at the national level, especially targeting Cameroon Parliamentarians, the WHO, the Global Fund, the Minister of Public Health, Minddevel, CSOs specialized in health issues, etc. A press conference to present the project to the national and international audiences which will nutshell the activities of this phase of the project.

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Objectives

A. *Main Objective*

To assess the role of health in the design of public policies in terms of civic engagement and access to information at local level.

B. *Specific Objectives*

- To assess people' s engagement in health decision making;
- To assess the existing mechanisms for the integration of citizens in the health decision-making process;
- To verify the level of access to health information by local populations;
- Work out recommendations.

Expected results

- A comparative picture of dialogue between local governments and citizens at the local level;
- The informational and communicational system of access to health care at local level;
- The good practices observed ;
- Recommendations to improve the shortcomings identified.

Methodology

A. *The main stages of the study:*

- Understanding the different objectives of the consultation;
- The collection of data on the field. To ensure quality result, the consulting team shared the four municipalities that constitute the scope of the study, namely: the municipalities of Makénéné, Eséka, Loum and Njombé-Penja;
- Data analyses and the drafting of the report.

The scope of the survey reflected the health map of the 4 selected localities:

Table 1 : Scope of the survey

Localities	Regions	Divisions	Surface area	Population	Health District	CMA	IHC
Makénéné	Centre	Mbam et Inoubou	885 Km²	16.564	/	Sub-divisional Medical Health Centre	-IHC of Nyokon -IHC of Kindjing Ndjabi
Njombe-Penja	Littoral	Moungo	260 Km²	31 792	/	Sub-divisional Medical Health Centre	-IHC of Njombe -IHC of Pendja -IHC of Bouba
Eséka	Centre	Nyon-et-Kellé	965 Km²	44.825	District Hopital of Eséka	IUHC (urban) of Eseka	-IHC of Manguegues -IHC of Nguibassal -IHC of BOGSO
Loum	Littoral	Moungo	430 Km²	37.707	District Hopital of Loum		-IHC of Manengwassa -IHC of Loum -IHC of Bonabélé -IHC of Babong

Sources: 2020 administrative reports of the different municipalities and the survey of this study.

1. Data collected during field research

- The level of transfer of responsibilities and resources to the local government in terms of health since 2010, the year healthcare decentralization came into effect in Cameroon;
- The extent to which local populations are integrated and involved in the design, development and monitoring of public health policies at local level;
- The normative framework for the integration and involvement of local populations in public health policies at local level;
- The institutional mechanisms established at local level to inform citizens on health offers and campaigns;
- The budgets allocated for health at the national level (state budget) and at the local level in the 4 municipalities, the sites of the study, over the past 10 years.

1. The targets of the survey

Les investigations de terrain ont été l'occasion de se rapprocher des populations afin de cerner les contours de ce problème. Among those reached by the field research were:

Table 2: Targets of the survey

Targets / Localities	Loum	Njombé-Penja	Makénéné	Eséka	TT
Municipal officials	06	03	04	01	14
Local population	400	400	400	400	1200
Managers of the decentralized services of the Ministry of Health	03	04	04	03	14
Leaders of dialogue structures	05	03	02	3	13
Religious leaders	03	2	02	03	10
Local traditional leaders	03	03	03	03	12
Decentralisation specialists	01	01	01	1	03
Managers of civil society organizations specialized in health	01	/	01	01	03
Local elected representatives	06	04	04	6	03
Community health workers	3	7	2	5	17
Members of the local media	01	01	/		02
Community health specialists	01	04	/	02	07
Decentralisation specialists	01	01	/	01	03
Others	3 staff from Minddevel 2 regional staff from the Ministry of Public Health 1 health economics specialist				06
	TOTAL				1307

Source: Investigation of this study

2. Data collections techniques :

- Desk research ;
- Observation ;
- Interviews ;
- Questionnaires.

CHAPTER I :
PICTURE OF CIVIC ENGAGEMENT IN PUBLIC HEALTH POLICY AT THE LOCAL LEVEL

I. The normative framework of the population engagement in public health policies at local level

The normative framework refers to all the legal, administrative and practical measures taken to ensure the proper integration and involvement of the population in local public health policies, both in their development and in their implementation.

Normative framing of population engagement in local public policies in the light of health decentralization

- Law N°96/03 of 04 January 1966 on the framework law in the field of health;
- Decree N°93/229/PM of 15 March 1993 to lay down the modalities for the management of revenues allocated to public health facilities for their operation;
- Decree N°0001/AMSP/CA of 16 November 1994 specifying the attributions of management committees of public health facilities;
- Decree N°95/040 of 7 February 1995 on the organization of basic health services into health districts;
- Decree N°003/CAB/MSP of 21 SEPTEMBER 1998 setting the modalities for the creation of community dialogue structures in health districts;
- Law n° 2004/017 of 22 July 2004 on the orientation of decentralization;
- Law n° 2004/018 of 22 July 2004 to lay down rules applicable to Communes;
- Circular No. 001/CAB/PM of 11 January 2008 on taking into account decentralization in sectoral strategies;
- Order No. 00136/A/MINATD/DCTD of 24 AUGUST 2009 making enforceable the standard tables of communal jobs;
- Decree n°2010/0246/PM of 26 February 2010 fixing the modalities of exercise of certain powers transferred by the State to the municipalities in the field of public health;
- Order n°2010/0000298/A/MINEE of 01 September 2010 laying down the conditions and technical modalities for the exercise of responsibilities transferred by the State to Municipalities in areas not covered by the public water distribution network conceded by the State;
- Order No. 0821/A/MINSANTE of 01 April 2011 laying down the conditions and technical procedures for the exercise of the powers transferred by the State to Municipalities in the area of drinking water supply in areas not covered by the public water distribution network conceded by the State to the Municipalities for construction, equipment, maintenance and management of Integrated Health Centres and District Medical Centres;

- - Order n°2010/3702/A/MINSANTE/CAB of 09 September 2011 on the specifications specifying the conditions and technical modalities for the exercise of the power transferred by the State to the Municipalities in terms of public health;
- - Health sector strategy 2016-2027; Decree No. 2018/190 of 2 March 2018, amending and supplementing certain provisions of Decree No. 2011/408 of 9 December 2011 on the organization of the Government;
- - Law No. 2019/024 of 24 December 2019 on the General Code of decentralized local authorities;
- National Development Strategy 2020-2030 (SND30) for structural transformation and inclusive development.

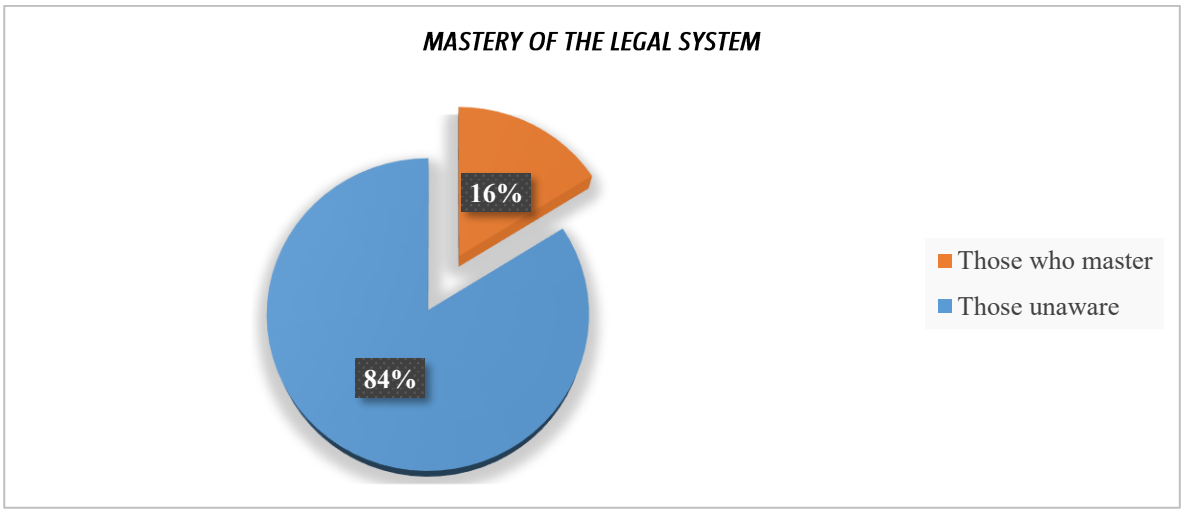
This normative framework is to be inserted in the various responsibilities released by the State to the benefit of the communes. According to article 160 of Law N°2019/024 of 24 December 2019 on the General Code of Decentralized Local Authorities, the following specific responsibilities have been transferred to the municipalities in terms of health.

- The creation, equipment, management and maintenance of health centres of communal interest, in accordance with the health map;
- The recruitment and management of nursing and paramedical staff in integrated health centres and district medical centres;
- Assistance to health and social establishments;
- Sanitary control in manufacturing, packaging, storage or distribution factories for food products, as well as in facilities for the treatment of solid and liquid waste produced by individuals or companies.

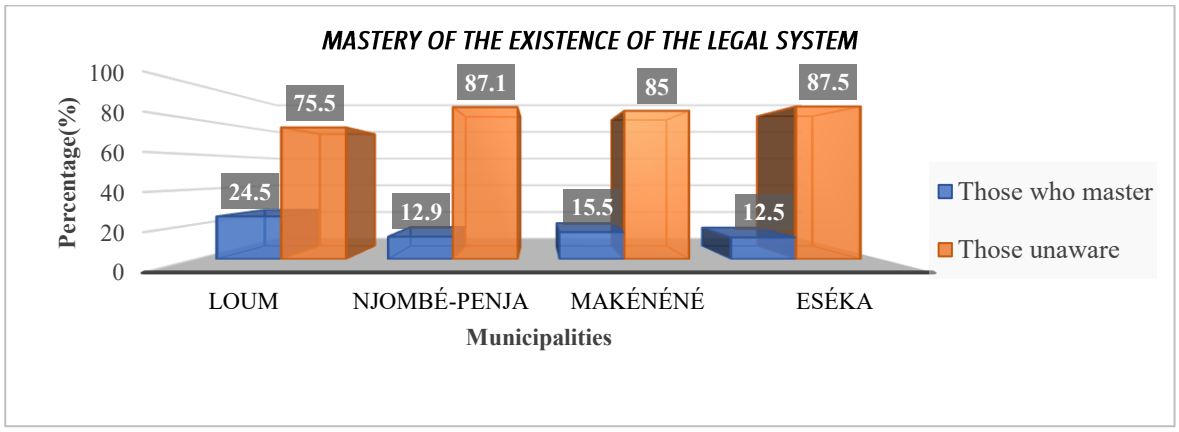
However, the population in its vast majority is unaware of the existence of the said system.

CHART 1: Awareness levels of the existence of the legal instrument on decentralization

Share within the total population:



Share per municipality :



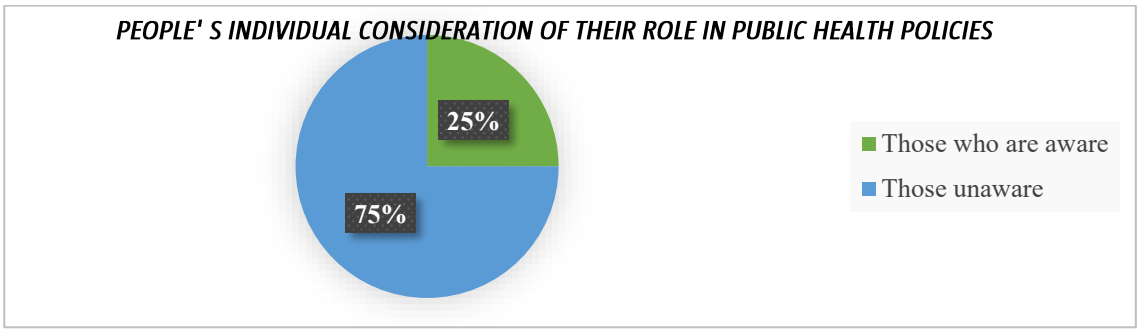
This chart is the result of a number of factors, including:

- The educational deficit of a number of populations;
- The lack of popularisation of models for the functioning of the state and the legal and administrative dynamics that frame them;
- The non prioritisation of state management by the population highly concerned with their daily tasks;
- The lack of structures for popular consultation at the local level;
- The very noticeable absence of municipal councillors from their constituencies;
- The lack of a political culture that leads to a loss of interest in the actions of the State.

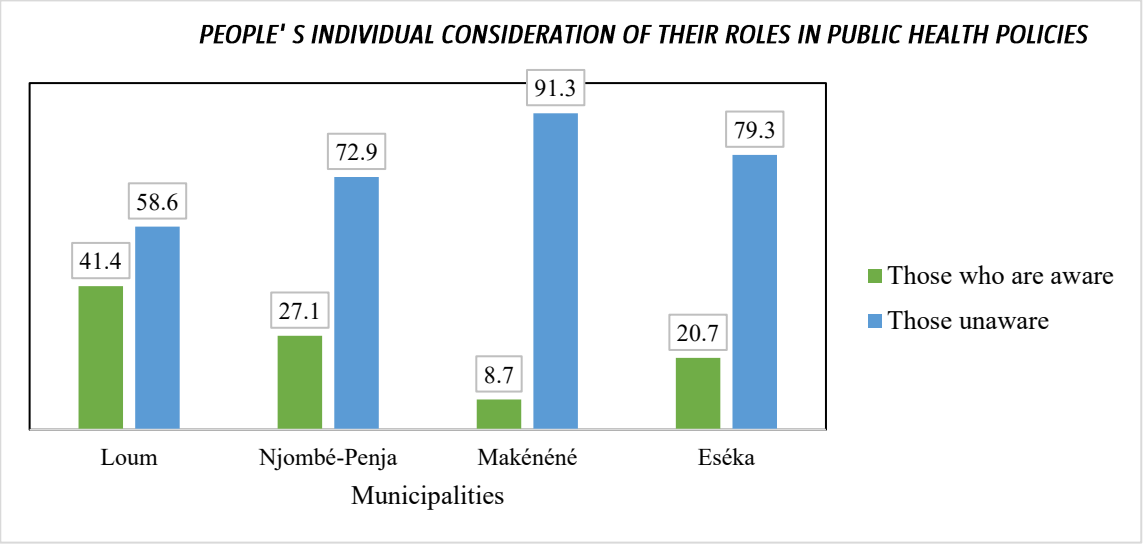
This ignorance of the legal framework of decentralisation explains the population's lack of information about the different responsibilities assigned to the municipalities in regard to health. However, it also has a major impact on the relationship between the municipalities and their role in public health policies in their respective localities.

CHART 2: Population' levels of individual consideration of their role in public health policies

Share within the total population:



Share per municipality :



The limited awareness of the population of their responsibility in the design and implementation of public policies implies their total absence from the process of designing and implementing the various health policies: between marginalization and self-marginalization, as shown by the comparative picture of the framework for dialogue between the administrations of the public health policy chain and citizens at local level.

II. Comparative picture of the dialogue framework between local government and citizens at local level

Local public health policies provide the public with two levels of co-production frameworks for action. The first is decentralized local government, while the second is community investment through local public health structures.

Table 3: Dialogue frameworks in local public health policies

	Health Committee (COSA)	Management Committee (COGE)	District Health Committee (COSADI)	District Health Committee (COGEDI)	Hospital Management Committee (COGEH)
LEVEL	HEALTH AREA		HEALTH DISTRICT		
Composition	It is composed of a board and a general assembly made up of: - The Manager of the health area - A nurse or care assistant from the health area team - The Chairman of the management committee of the health centre - **Two representatives of associations and non-governmental organizations** - One representative from each non-profit medical organization - One representative from the private for-profit sector - **Two elected representatives from each village in the area** - Representatives of other administrations concerned	The Management Committee, called COGE, is a sub-committee of the COSA. The members of the COGE are elected by the COSA	COSADI is made up of: -Representatives of the health areas, with two representatives per health area. - The Chairman of COGE, who is an ex-officio member of COSADI, along with one other member elected by COSA.	The COGEDI: - The head of the district health service - The Chief Medical Officer of the district hospital - The Head of BAAF and active members who are - The chairpersons of COGEs are ex-officio members of the COGEDI. - For health areas that do not have health facilities, an election is organized to elect a representative from each area concerned to COGEDI among their two COSADI members.	The COGEH includes - The head of the district health service - The Chief Medical Officer of the district hospital - The Tax Collector - The Mayor -A representative of the paramedical staff elected by their peers - The general supervisor and 4 active members who are elected from within the community to represent the community on the hospital's management committee.
Missions	- Assist the health team in identifying key health issues - Participate in the development of a health action plan - assist with prevention or promotion activities - Raise community awareness for better participation in activities Mobilize the necessary material and human resources Take part in the monitoring and evaluation of activities	The main functions of the COGE are to: - Manage all financial and material resources of the health centre - Control the community pharmacy Develop and present the budget for the next	Approve the District Action Plan - To elect the members of the COGEDI - Elect the district representative to the General Assembly of the special fund - Adopt the budget	- Develop the district joint action plan - Develop the combined budget of the district - Manage all the resources of the district health service in collaboration with the district management team (DMT) - Identify priority areas for health intervention dans le district - Mobilize the necessary resources.	Develop the hospital's action plan - Develop the hospital's budget - Budgeting for earmarked income - Monitor the community pharmacy - Monitor the community cash box

	- Raise awareness, inform and mobilize the population for a better use of health facilities.	year to the General Assembly - Monitor the community fund recruit and pay the community staff - Develop the cash flow plan.	Ruling on conflicts not resolved by COGEDI - Raise awareness and mobilize community members for health activities.	- Resolve existing conflicts - Participate in the supervision of district activities - Monitor and evaluate district activities. COGEDI reports to COSAD	Develop the hospital's cash flow plan - Hire and pay the hospital's community staff - Manage all hospital resources - Assess the hospital's activities.

Source: Manual for trainers of mutual health insurance in Cameroon. Supporting text n°4: The different dialogue structures and their role.

Table 4: Dialogue frameworks in local public health policies

Frames	Loum	Njombé-Penja	Makénéné	Eséka
At the level of the municipalities	Not available	Not available	Not available	Not available
At local health unit level	01 COSADI 05 COSA	01 COSADI 03 COSA	03 COSA	01 COSADI 03 COSA

Source : Investigation of this study

The table above shows that the municipalities do not have any frameworks for exchange with the population during the development and implementation of their health activities. This is due to the barely unnoticeable importance of health in the public policies of the municipalities, although Order No. 00136 of 24 August 2009, which makes the standard tables of municipal jobs enforceable, provides for the Health and Social Action Unit in the organization chart of the municipalities.

On the other hand, at the level of the health units, the framework for participation in the decision-making process and in the implementation of public policies is more complete, even if these structures are not fully operational on the field. Various problems constrain their implementation:

- Landlockedness ;
- The lack of an operating budget;
- Lack of working materials (android phones, data collection materials, working equipment, etc.);
- Lack of transportation ;
- Administrative hassles ;
- Time constraints due to bad weather;
- The size of the area is not proportional to the number of staff due to the very small number of staff;
- Unavailability due to the multiple life-saving tasks of volunteers.

Nevertheless, among these different formal spaces of exchange between the insiders and outsiders of health policy, the COSA are much more practical in scope. This is due to their lower level on the scale of dialogue structures. They are therefore closer to the people.

But roughly speaking, whether in Makénéné, Loum, Eséka or Njombe-Penja, the dialogue structures play a dual role of participation and integration. On one hand, they are frameworks for the involvement of local populations through their representatives in the dialogue and health intervention structures, with a view to the co-production of health decisions and their implementation. On the other hand, they are structures that encourage the population to participate in public health policies.

These different dialogue structures are assisted by community health agents who are real belts in the decision-making process and in the implementation of public health policies. They are the link between the population and state public health actors. These community health workers are responsible for passing on health information to the health structures in order to improve the development of action. The same approach is used to convey health information from health structures to the population. Sometimes, they go beyond the simple work of information carriers to position themselves as carriers of health services to their communities through their basic health interventions.

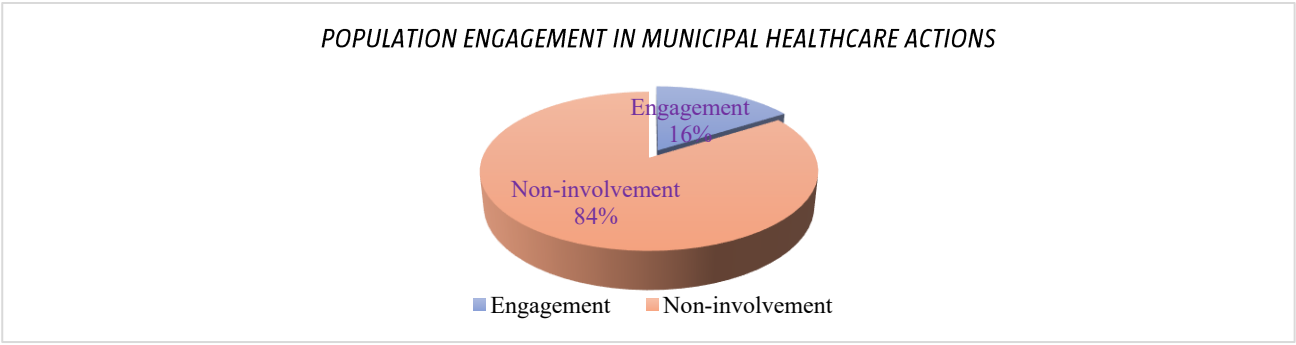
III. Levels of integration and of local populations' involvement in public health policies at the local level

Despite the availability of these frameworks and participants for dialogue, the contributions of the population in the development and implementation of public health action are nevertheless very limited in the four municipalities.

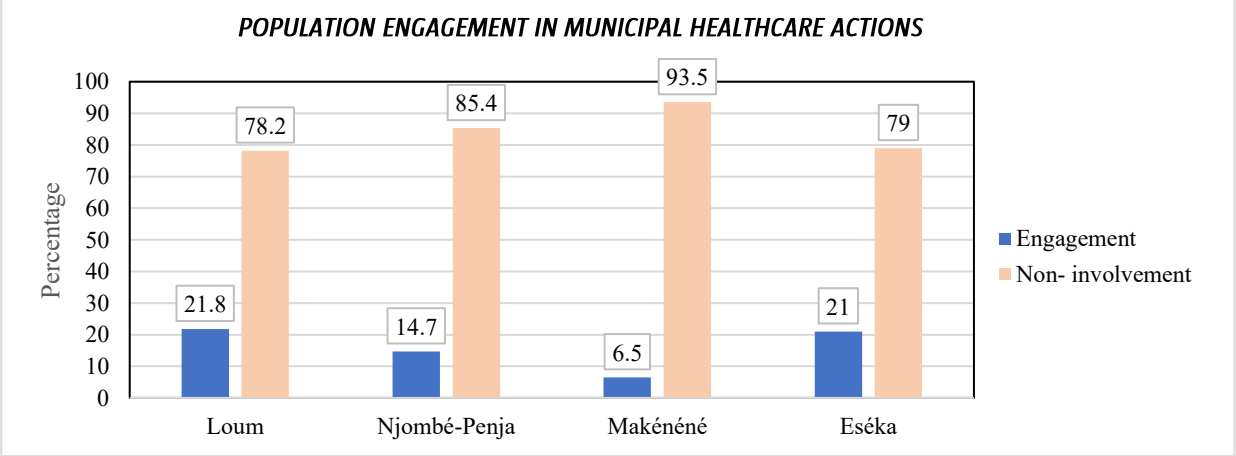
Within the framework of health actions organized by the municipalities.

At this level, the situation seems to be more difficult because of the lack of local governance, which is based on democratic and transparent management of public affairs. As seen in the following charts, engagement rates and incentives to participate are very low.

CHARTS 3: Population engagement rate in municipal healthcare actions



Share within the total population:

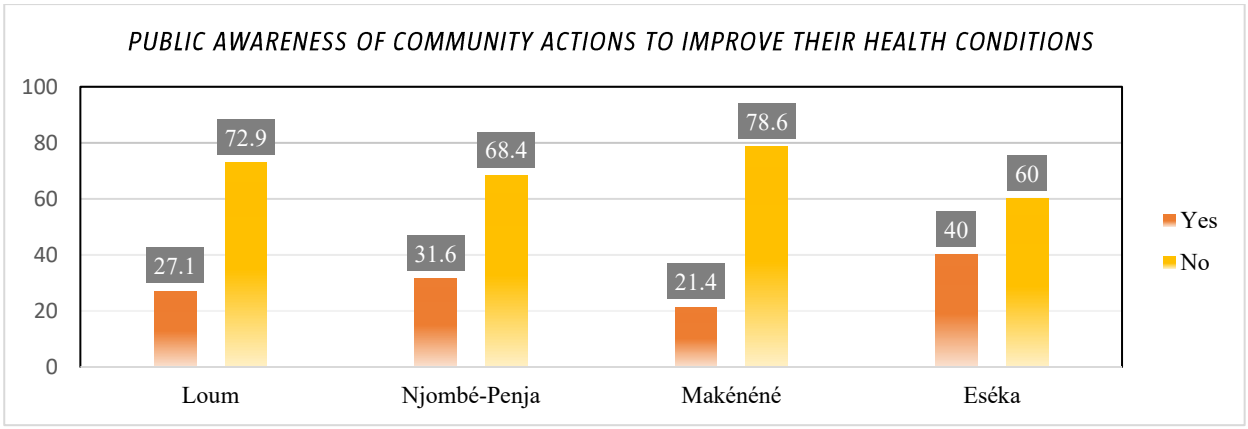


Another reason for the low numbers is that the masses are not even aware of the existence of municipal health policies.

CHART 4: Public awareness of municipal actions to improve their health conditions

Share within total population:

Share per municipalities :



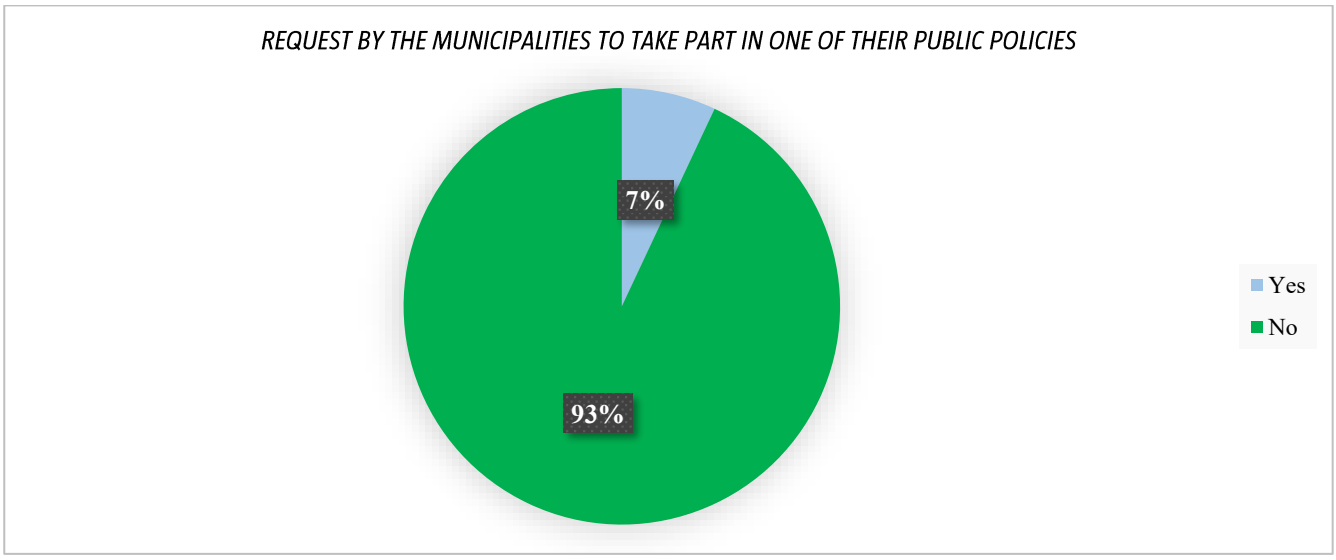
The health actions on which this measure is based are much more "health-related", "quasi-health" actions, i.e., actions that are not directly related to health, such as hygiene and sanitation, since the municipalities, in their budgetary lines, do not yet invest sufficiently in health activities in the proper sense.

However, the observed gaps in participation should be mitigated because there are a few passive participations here and there. Passivity is defined here in terms of simple adherence of the populations to initiatives in which they have only the status of beneficiaries without any real contribution or impact on the decision-making and implementation process.

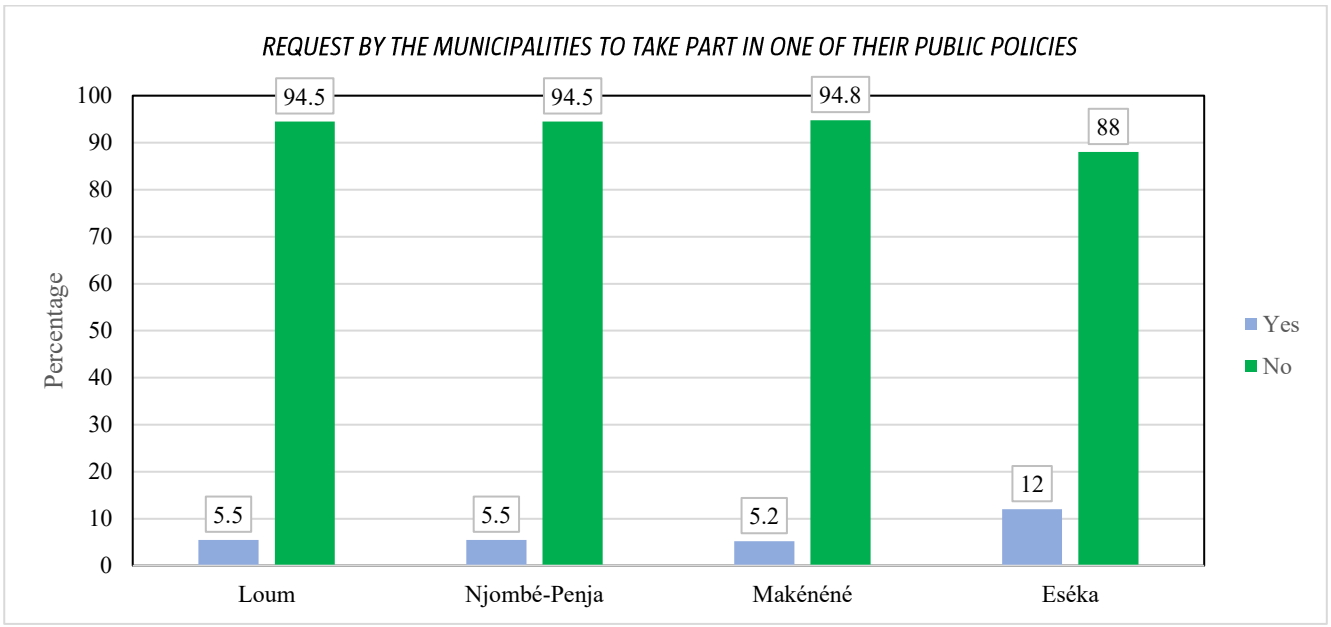
These gaps in participation and involvement in health initiatives are simply the result of a global situation observed in almost all municipal policies such as economic, cultural or environmental initiatives.

CHARTS 5: Number of requests from municipalities to take part in public policies

Share within the total population:



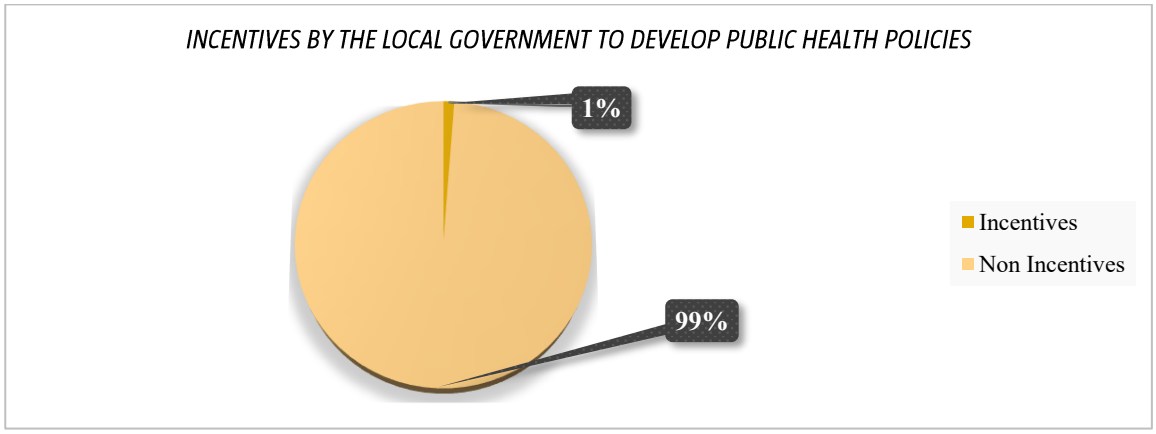
Share per municipalities :



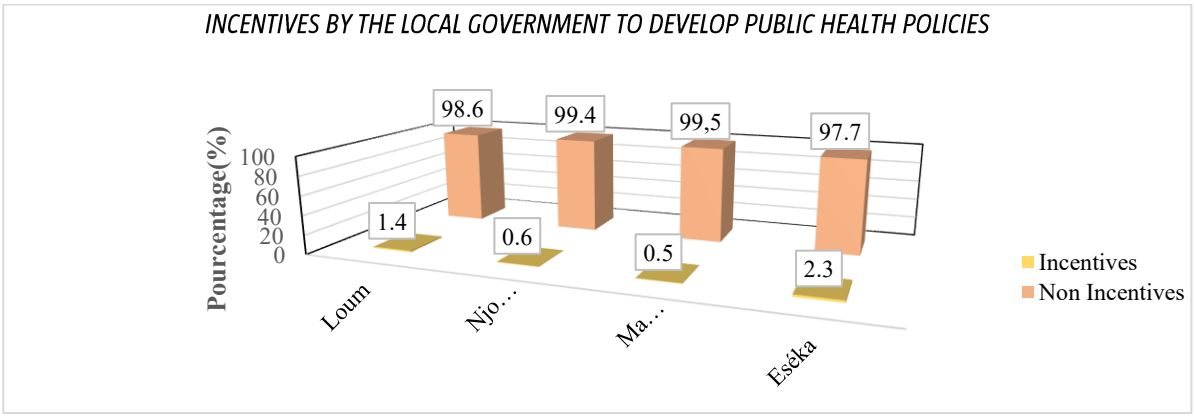
The above weaknesses are certainly linked to the reluctance observed in the transfer of powers and resources and also to the biases and crises of legitimacy of the communal executives, but it must be admitted that several municipalities are conspicuous by their flagrant lack of policies to encourage the masses in the domain of health. This is true both in terms of participation, as shown in the previous chart and in the decision-making process, expressed here in terms of the development of the action.

CHART 6 : Incentive levels of the municipal administration in the development of public health policies

Share within the total population:

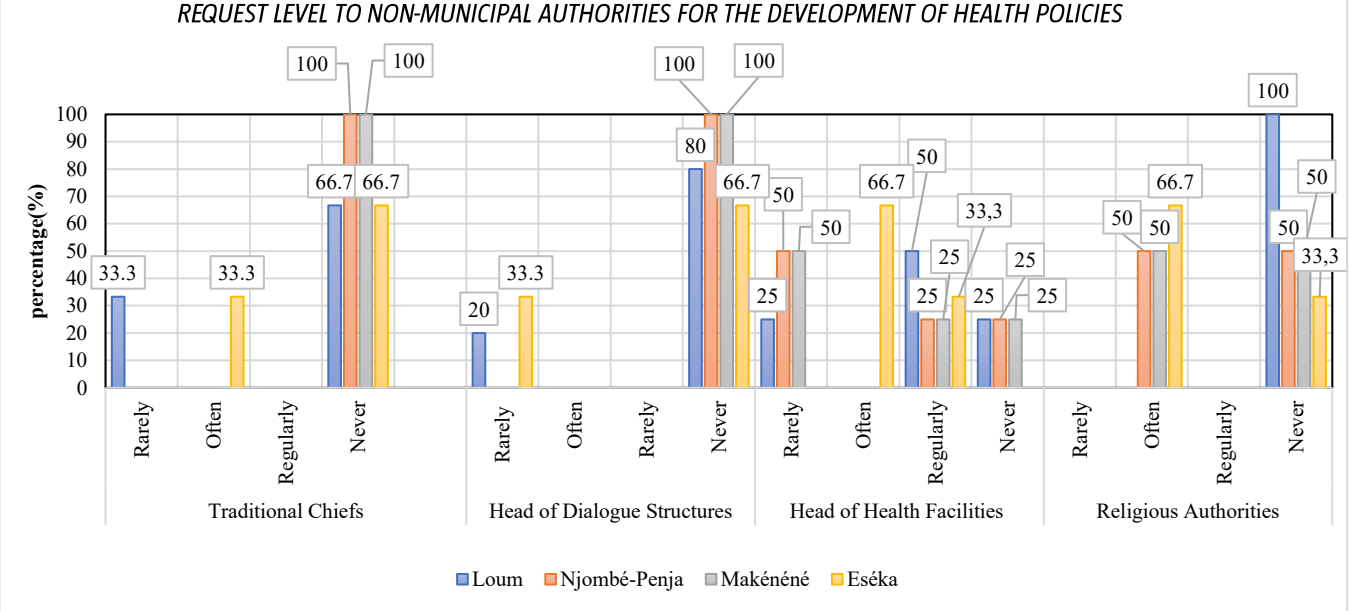


Share per municipalities:

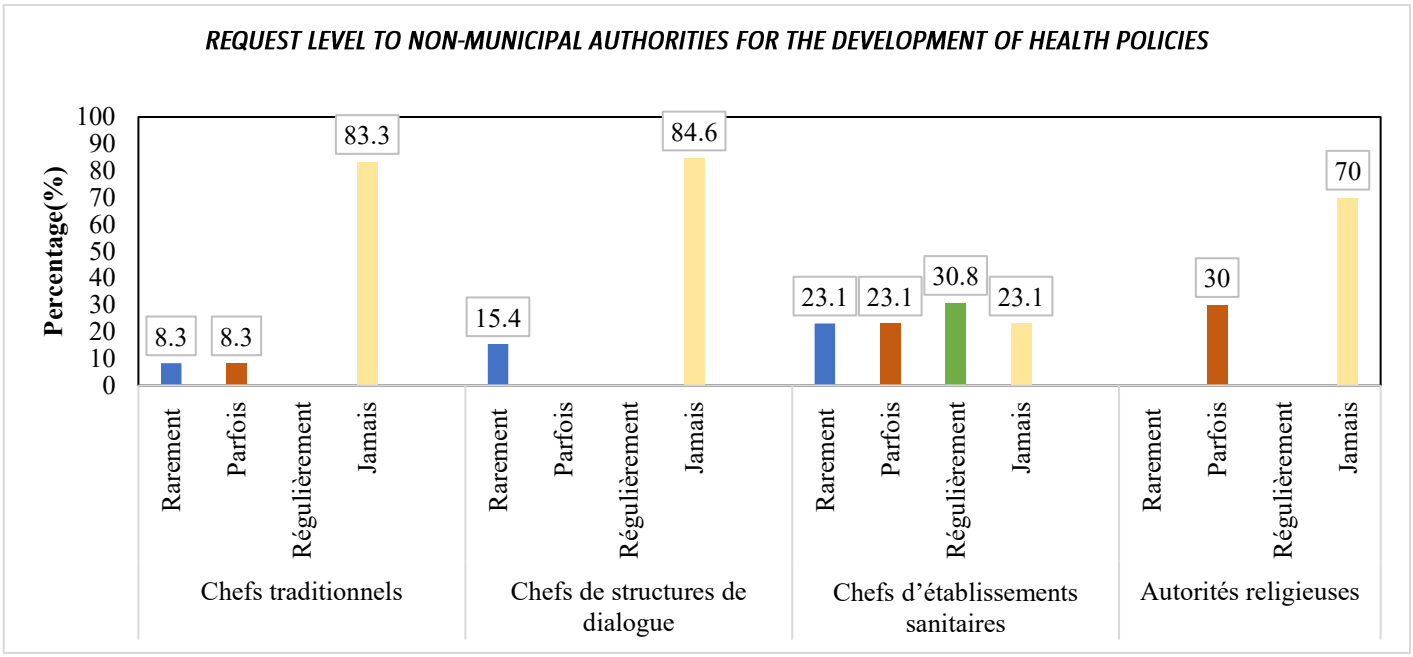


A similar comment is made by other potential participants in the chain of public health policy development who acknowledge the isolated approach of city councils in the development of the few health or para-health actions. In fact, among the non-municipal participants interviewed, few have often been invited by their municipalities to participate in discussions on health.

CHART 7: Request level to non-municipal authorities for the development of health policies
Share within the total population:



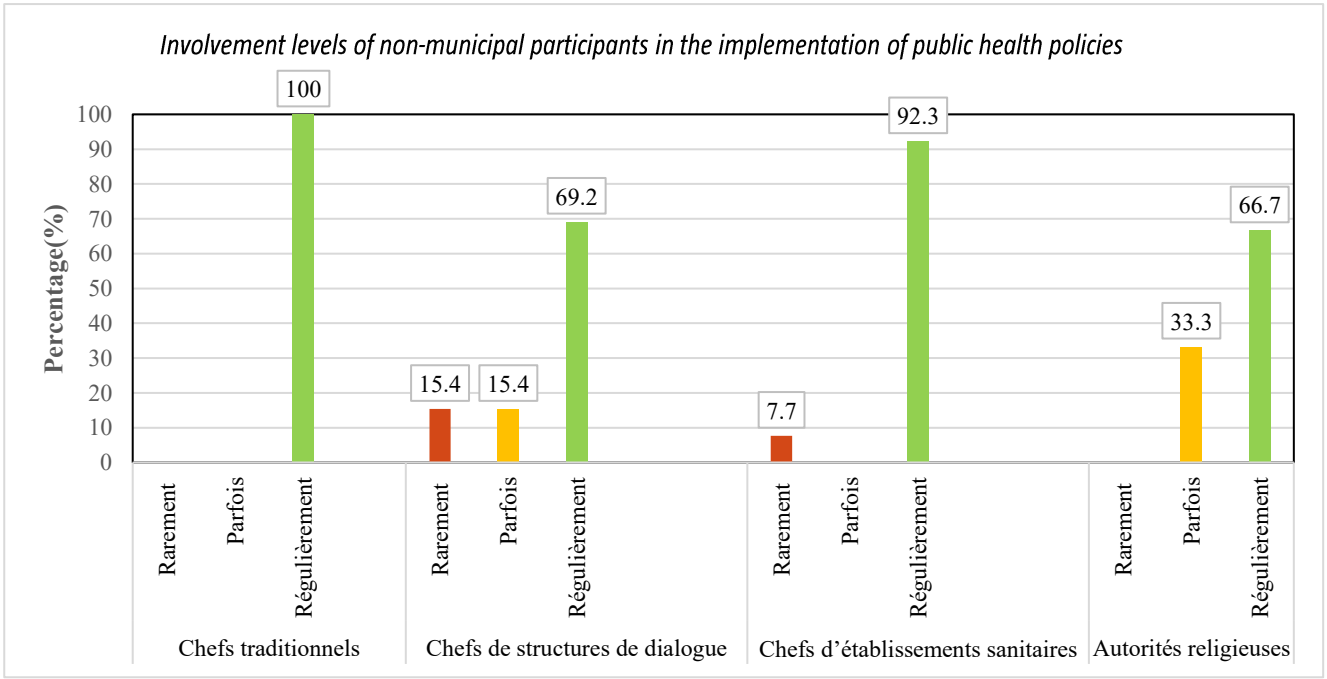
Share per municipality:



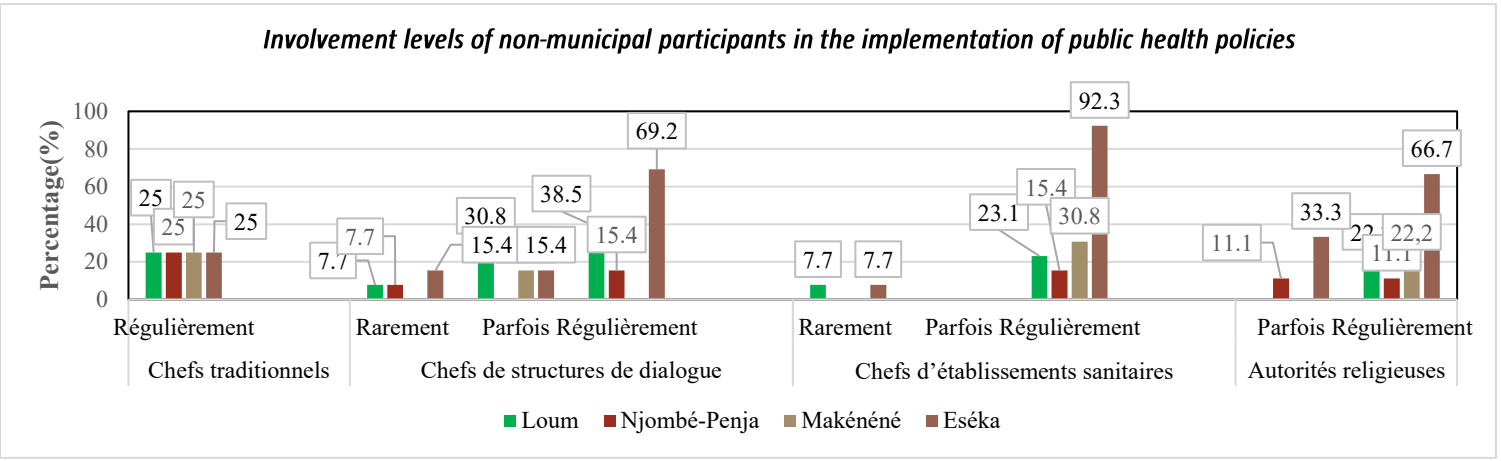
But unlike the case of development, the request levels of non-municipal participants in the implementation of public health policies are admirable.

CHART 8: Involvement levels of non-municipal participants in the implementation of public health policies

Share within the total population:



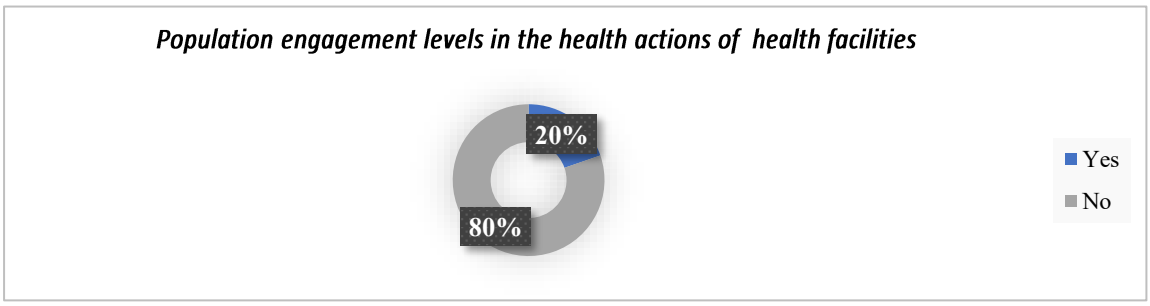
Share per municipality:



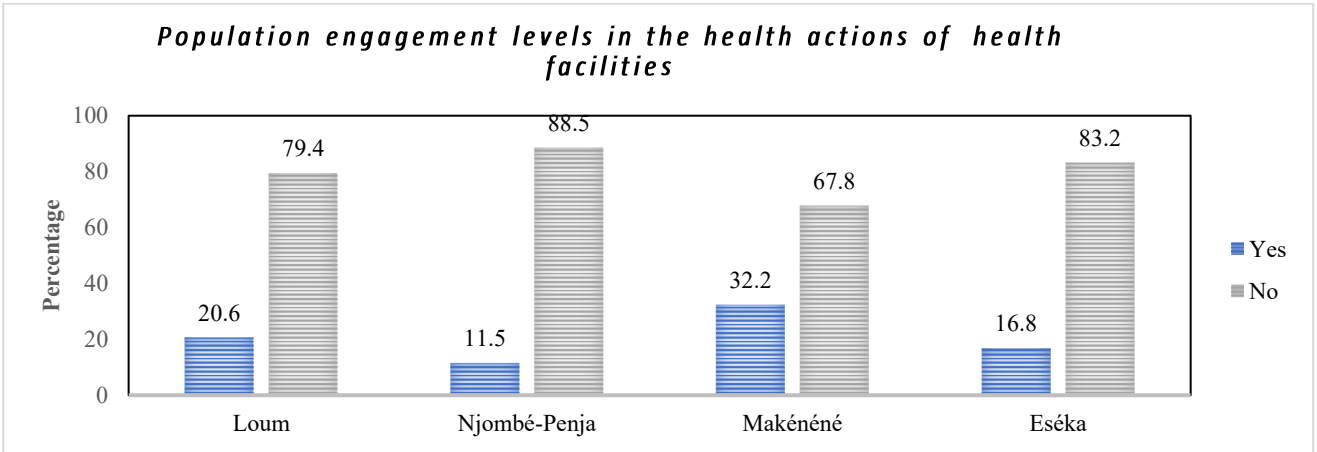
Within the framework of health actions organized by the health facilities.

It is worth noting that, although clearly improved compared to the public health policies designed and managed by the municipalities, the participation rates of the populations in the health actions organized by the health administrations also remain poor.

CHART 9 : Population engagement levels in the health actions of health facilities
Share within total population:



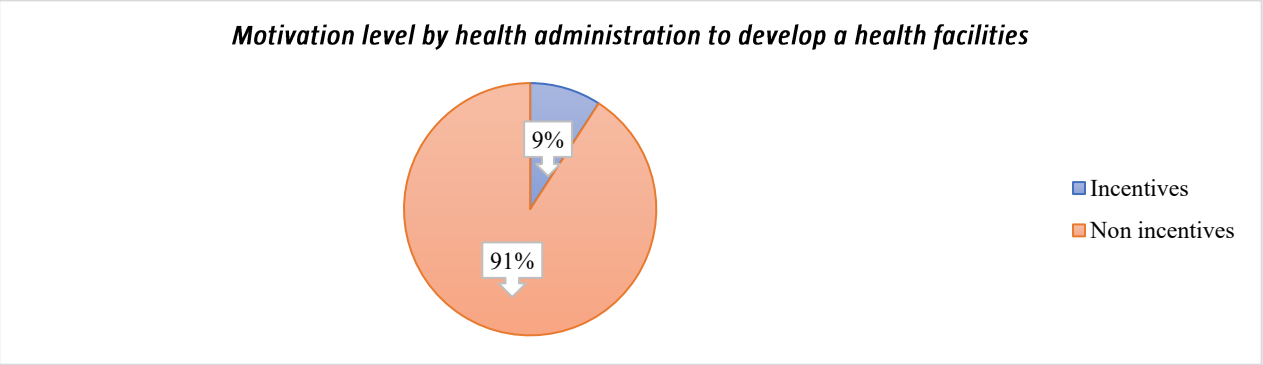
Share per municipality:



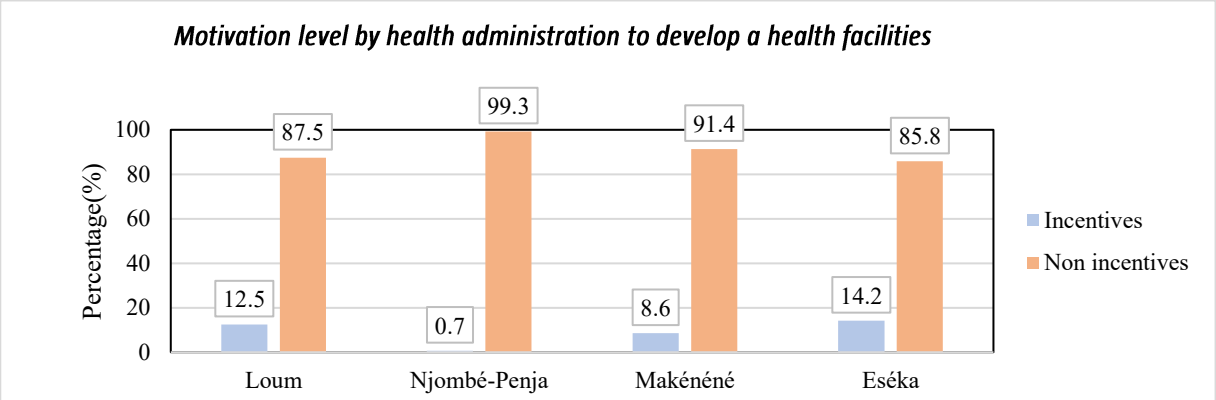
As in the case of municipalities, low engagement rates are a consequence of low population incentive levels.

CHART 10: Motivation level by health administration to develop a health facilities

Share within the total population:



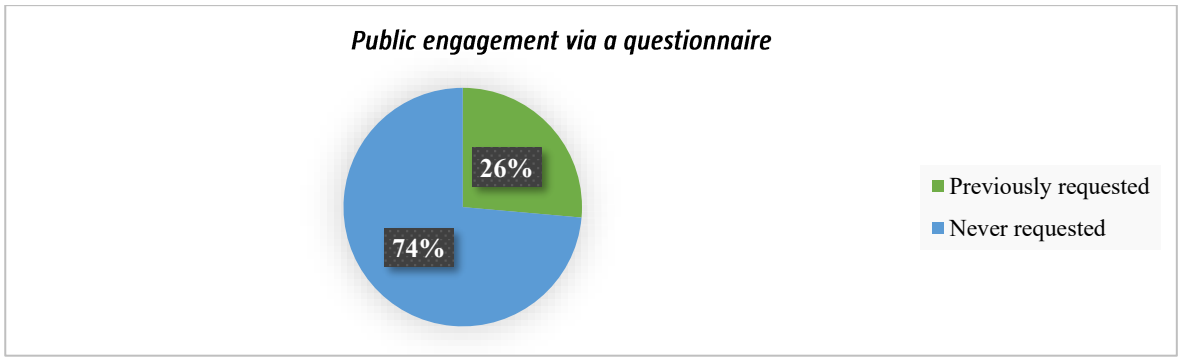
Share per municipality :



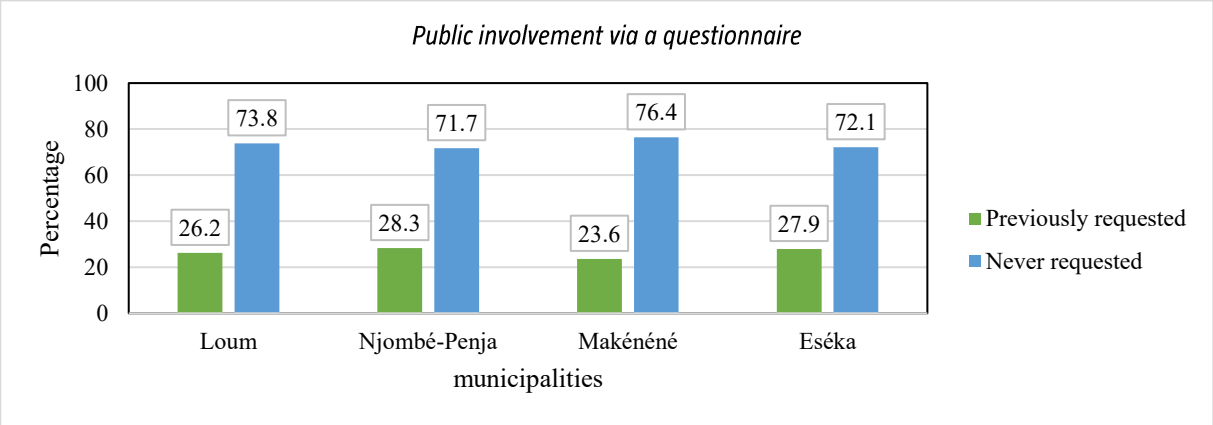
In addition, instruments for involving the population in the elaboration of policy options, such as questionnaires, which assess and collect the opinions of the population, remain under-exploited.

CHART 11: Level of population engagement via a questionnaire

Share within the total population:



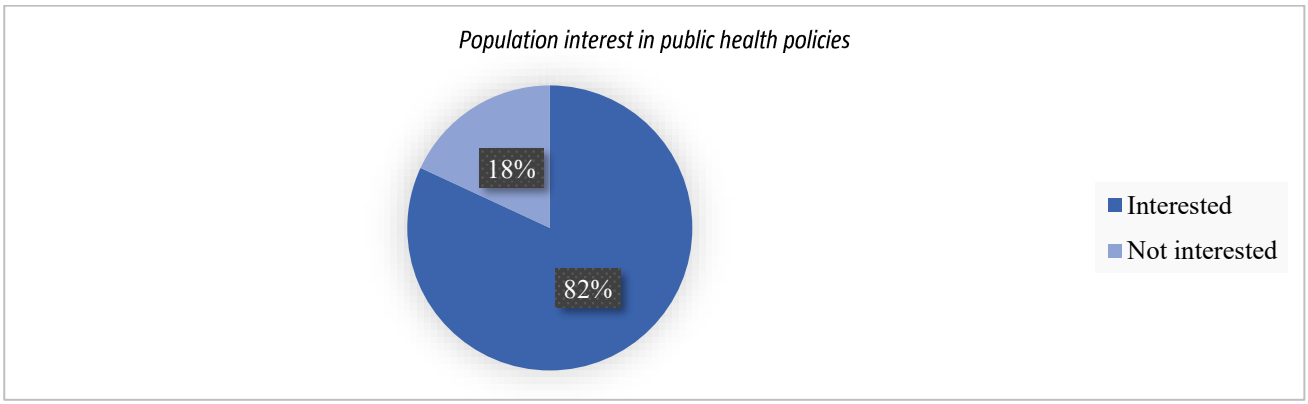
Share per municipality :



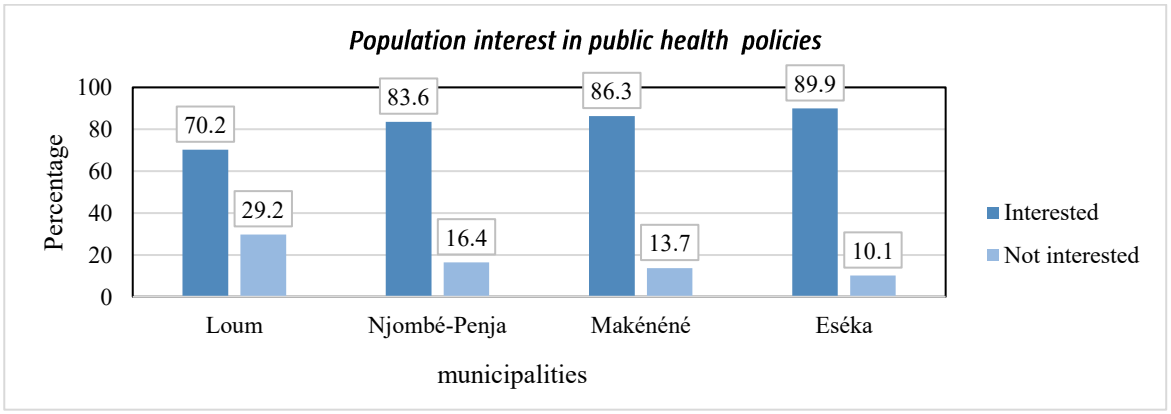
However, several respondents still show great interest in health activities at the local level.

CHART 12: State of population's interest in public health policies.

Share within the total population:



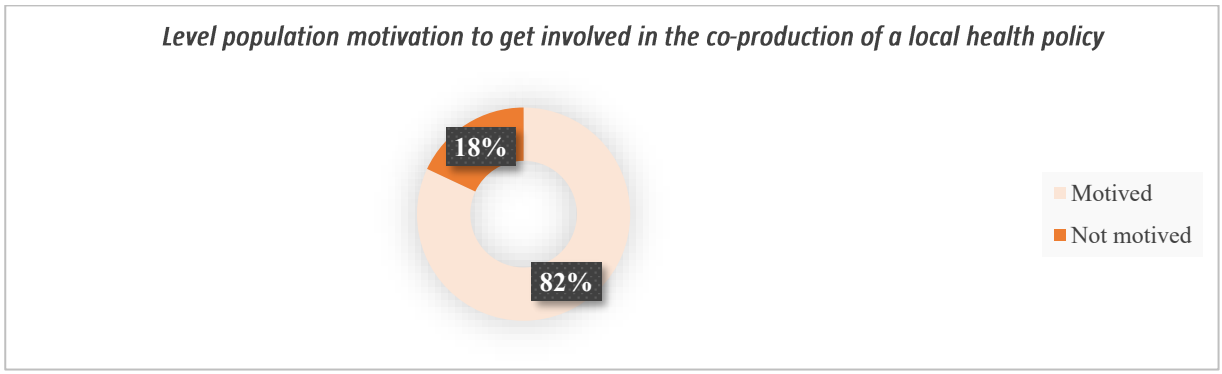
Share per municipality :



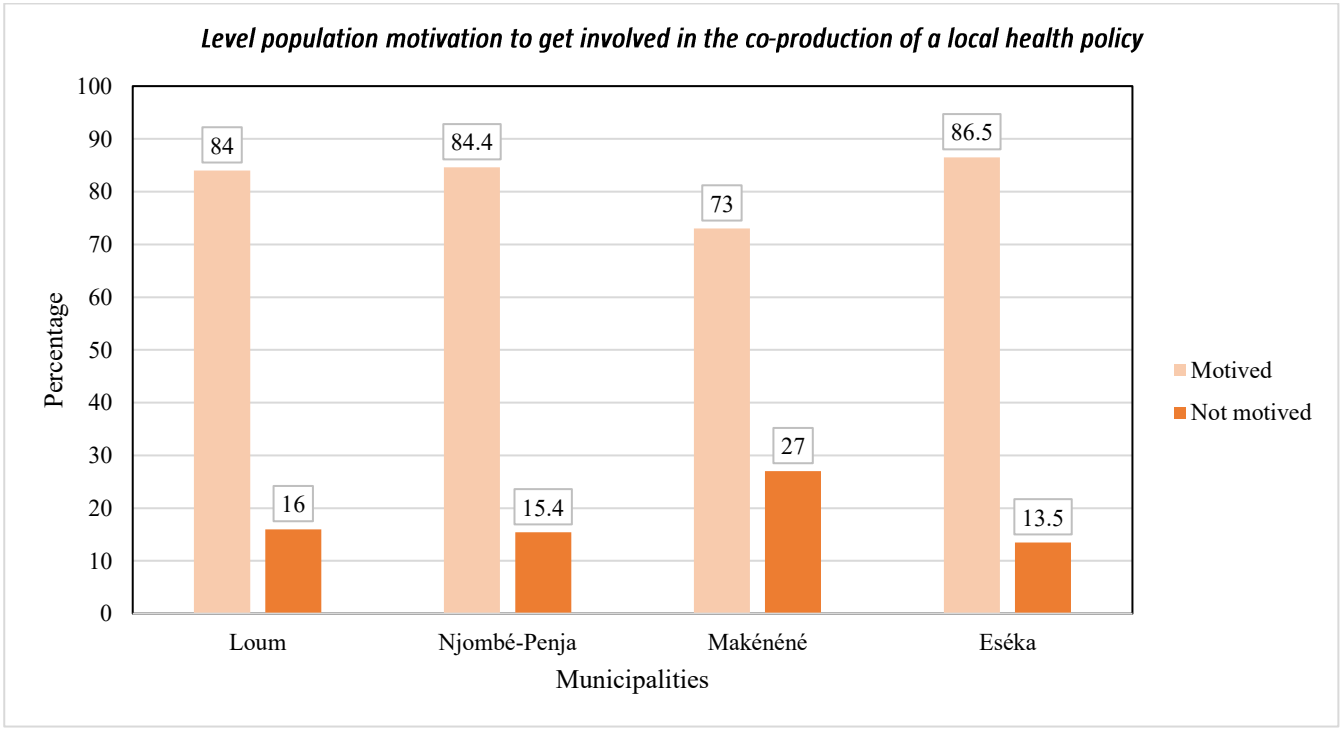
Many of them are also willing to invest in local public health policies

CHART 13: Level population motivation to get involved in the co-production of a local health policy

Share within the total population:



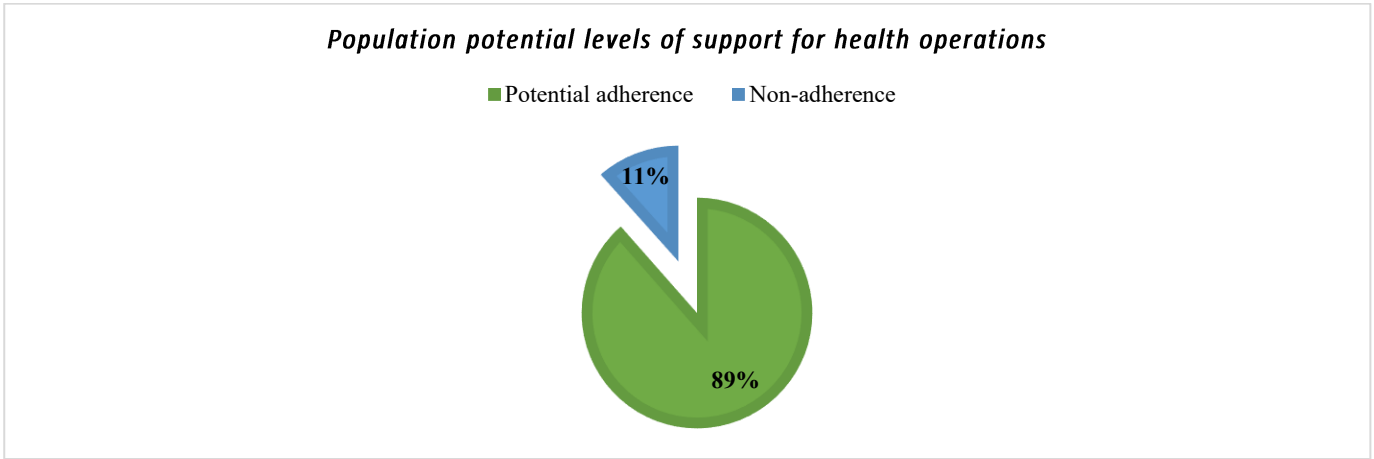
Share per municipality :



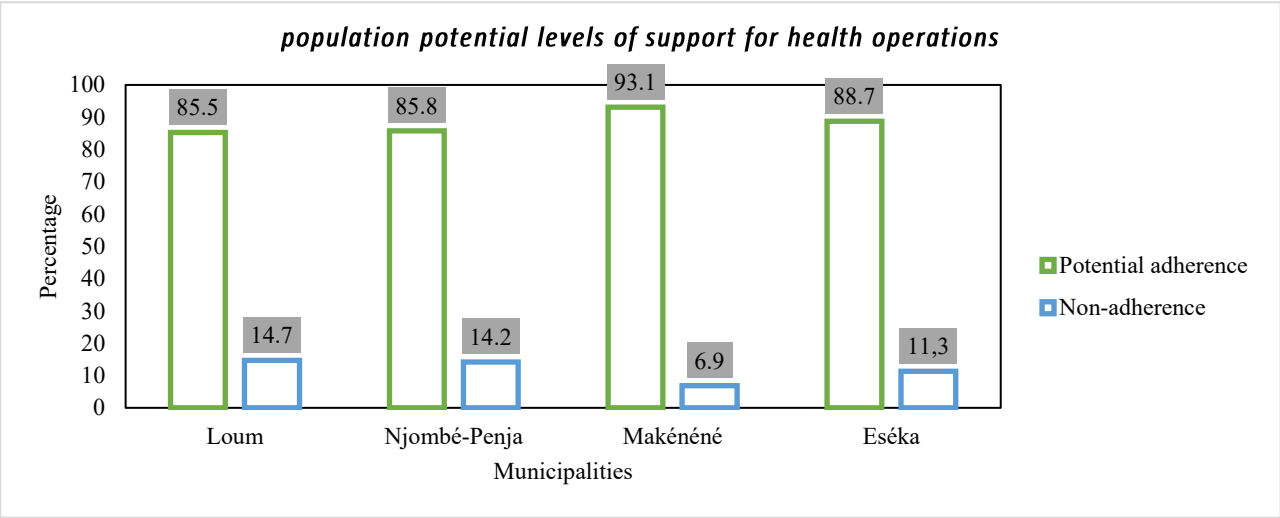
A clear illustration of this interest is the unavailability of many to get involved in local health activities.

CHART 14: Population potential levels of support for health operations.

Share within the total population:



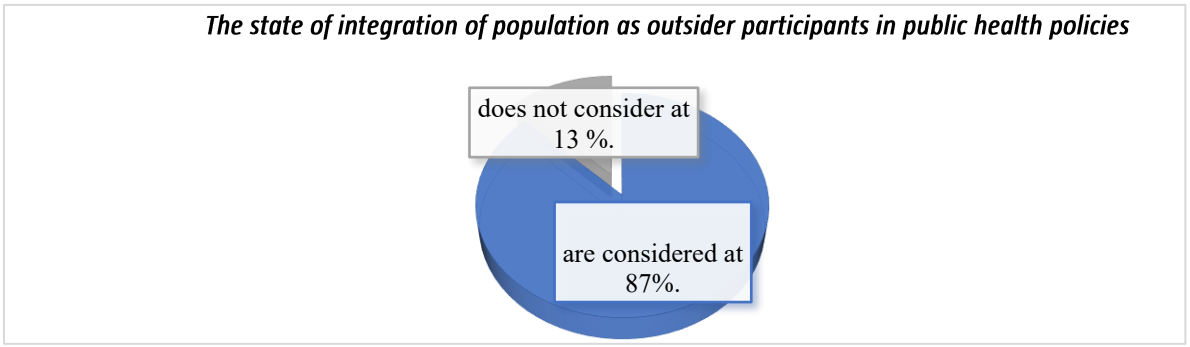
Share per municipality



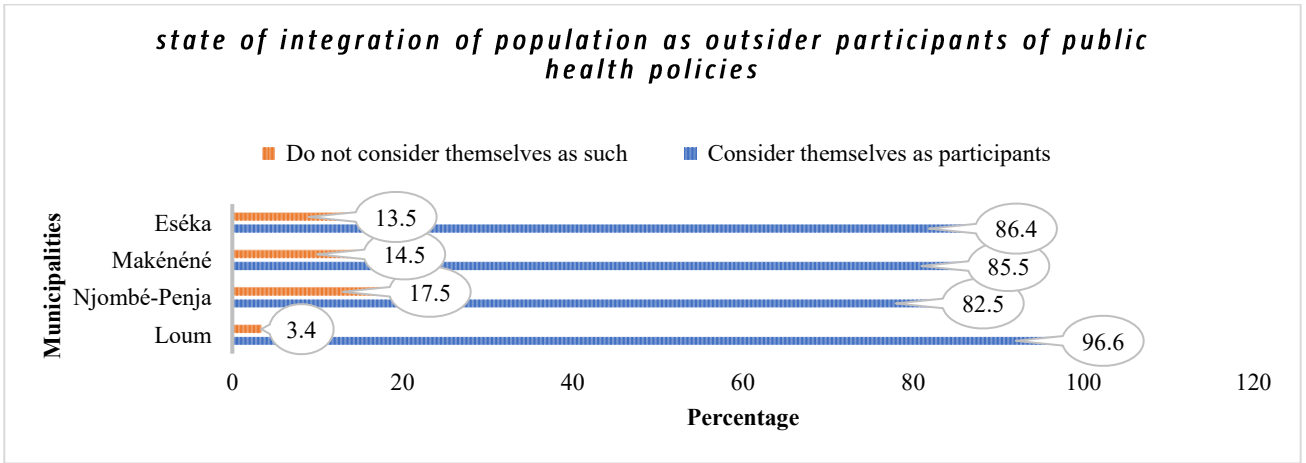
Unfortunately, it should be noted that the potential for membership remains under-exploited, as shown by the engagement rates in health activities (CHART 10).

As a result, many end up resigning themselves, concluding that they are marginal actors in public health policies.

CHART 15: The state of integration of population as outsider participants in public health policies
Share within the total population:



Share per municipality :



In addition, apart from the first elements of disinterest and marginalization of the population and other outsider participants in the chain of public health policies at local level already mentioned, the lack of

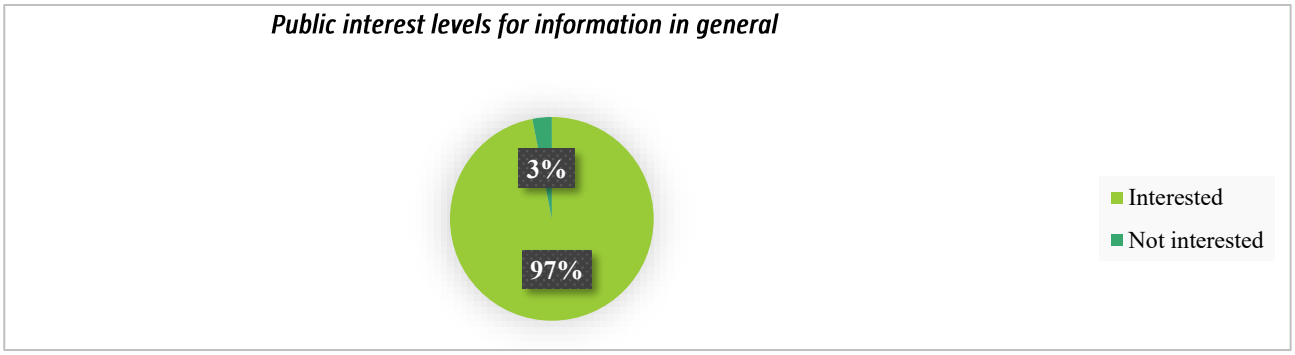
will on the part of the designers of public policies, the lack of incentive and mobilization resources, the lack of a culture of citizen participation and wilful self-marginalization, these shortcomings are also linked to the limits of the information and communication systems and mechanisms in the municipalities

CHAPTER II: INFORMATIONAL AND COMMUNICATIONAL MECHANISMS TO ACCESS PUBLIC HEALTH POLICIES AT THE LOCAL LEVEL

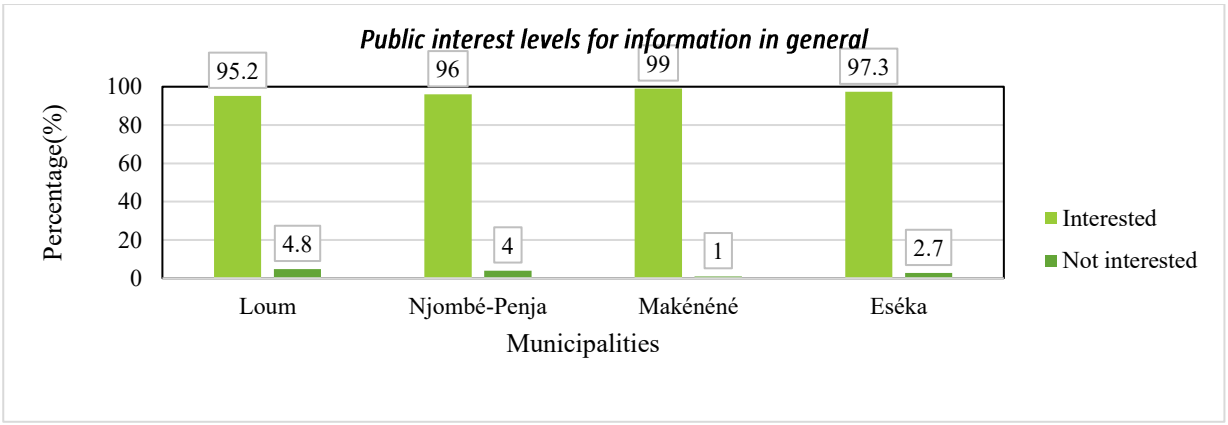
The four municipalities surveyed all have a population that is generally interested in information.

CHART 16: General interest levels of the population in information

Share within the total population:



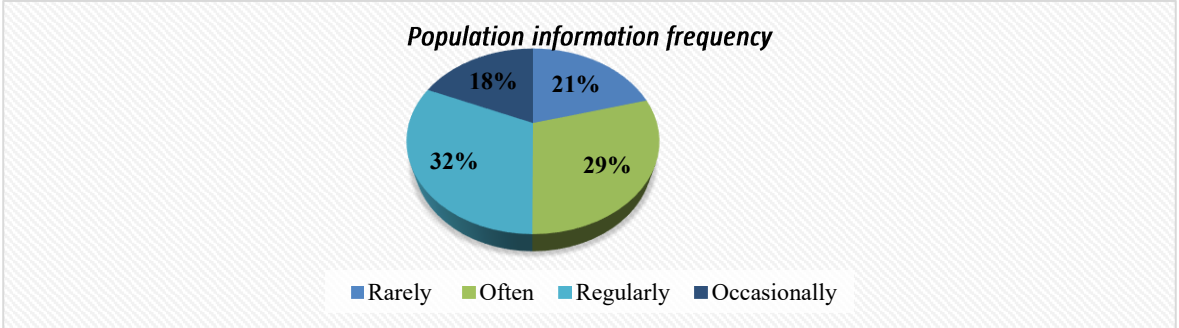
Share per municipality :



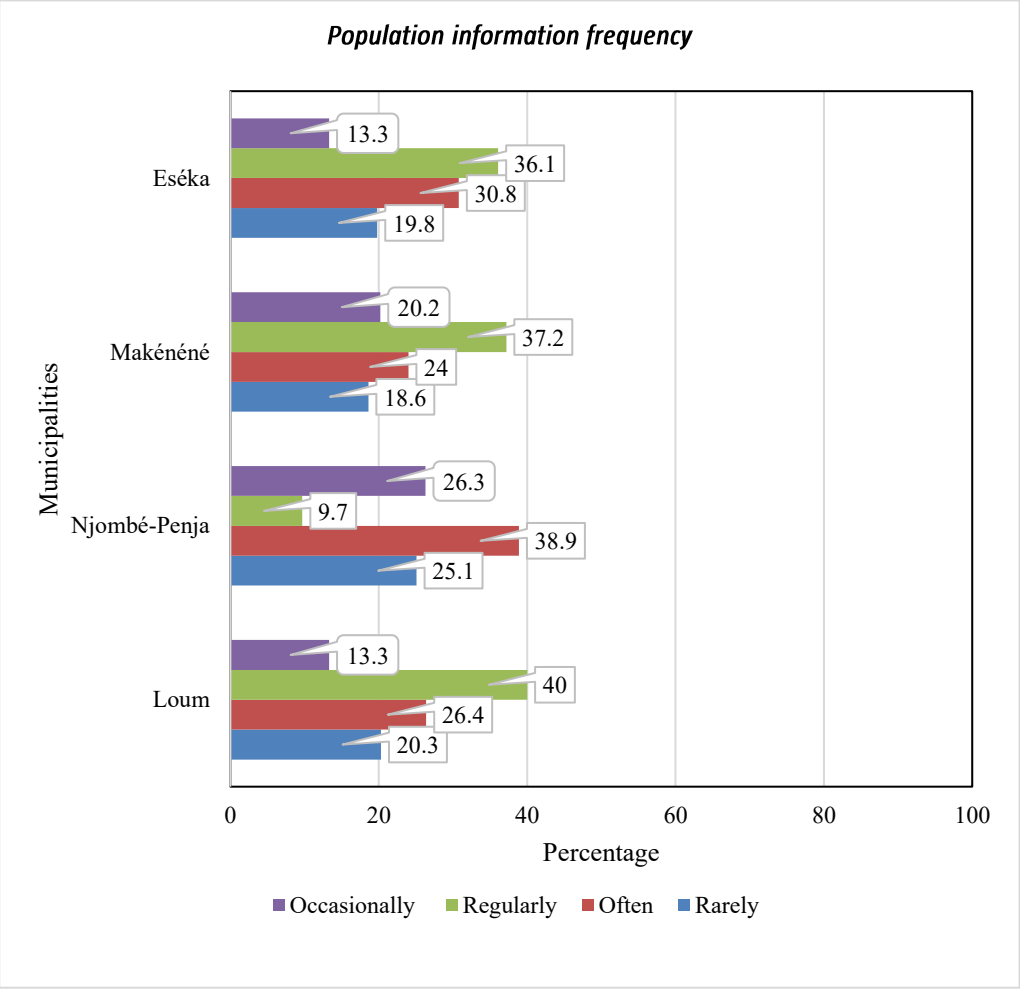
The consistency with which people follow up on the information is also bearable

CHART 17: Population information frequency

Share within the total population:



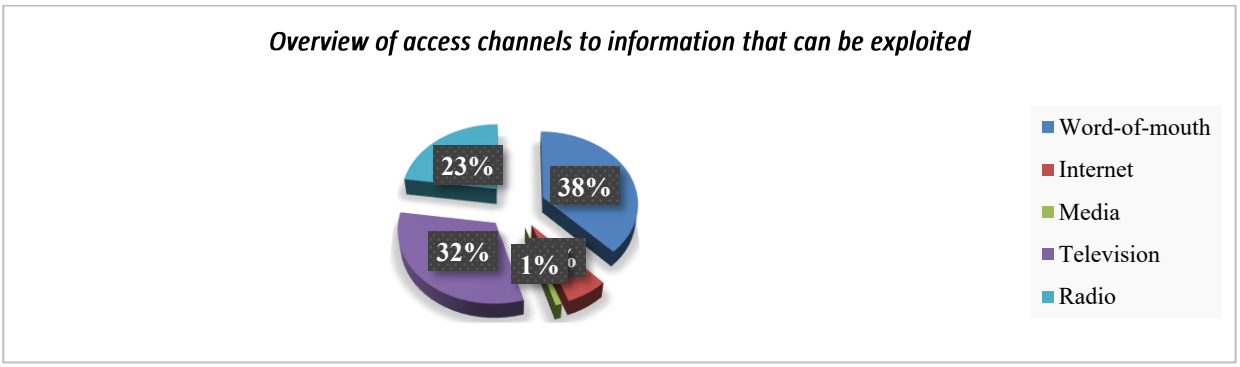
Share per municipality :



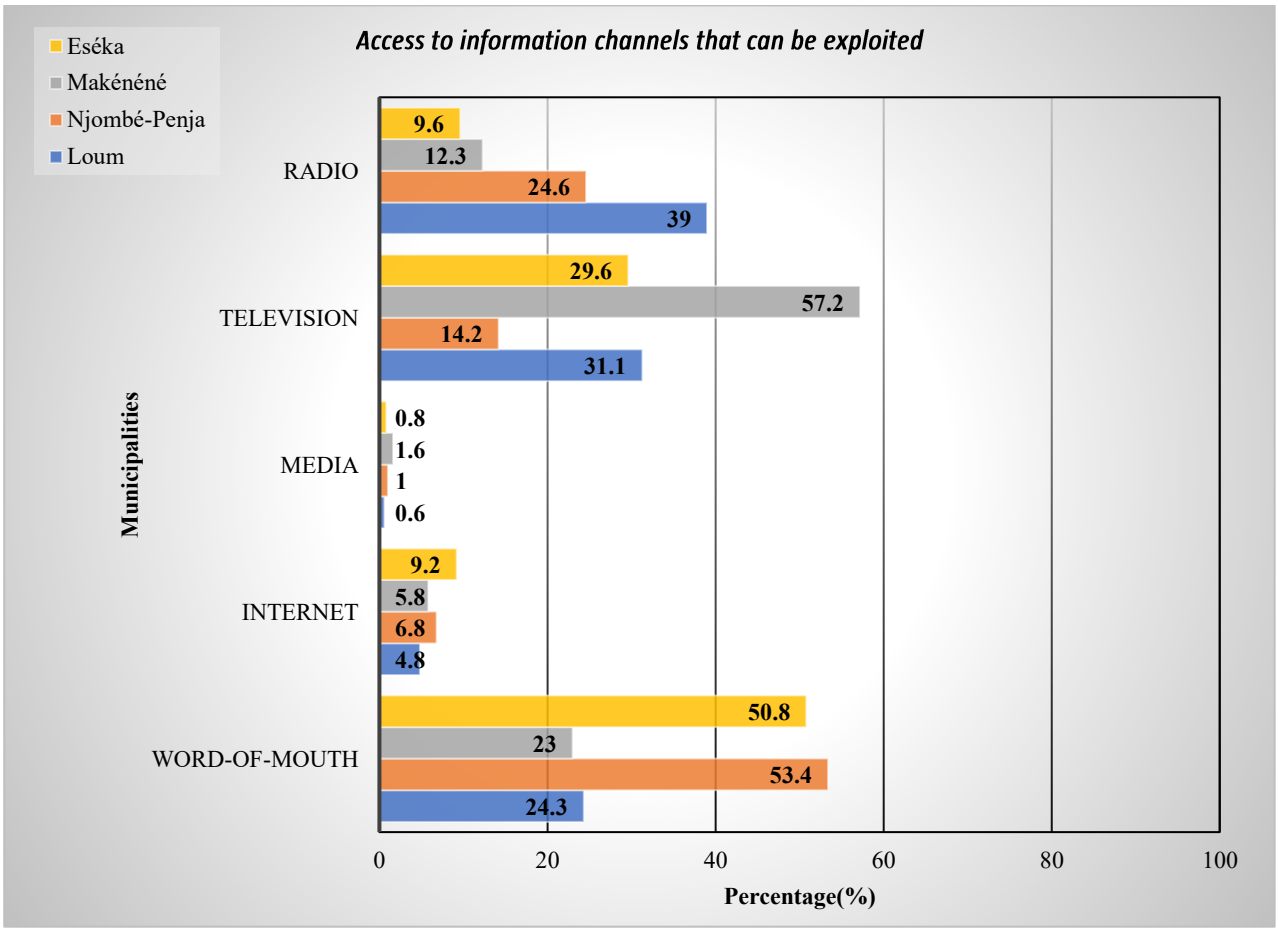
However, the instruments and channels of access to information continue to be a serious challenge to accessing information, even if we must add to this the willingness of the population to follow the information.

Many people continue to obtain information by word of mouth, for example.

CHART 18: Overview of instruments for accessing information according to their level of use
Share within the total population:



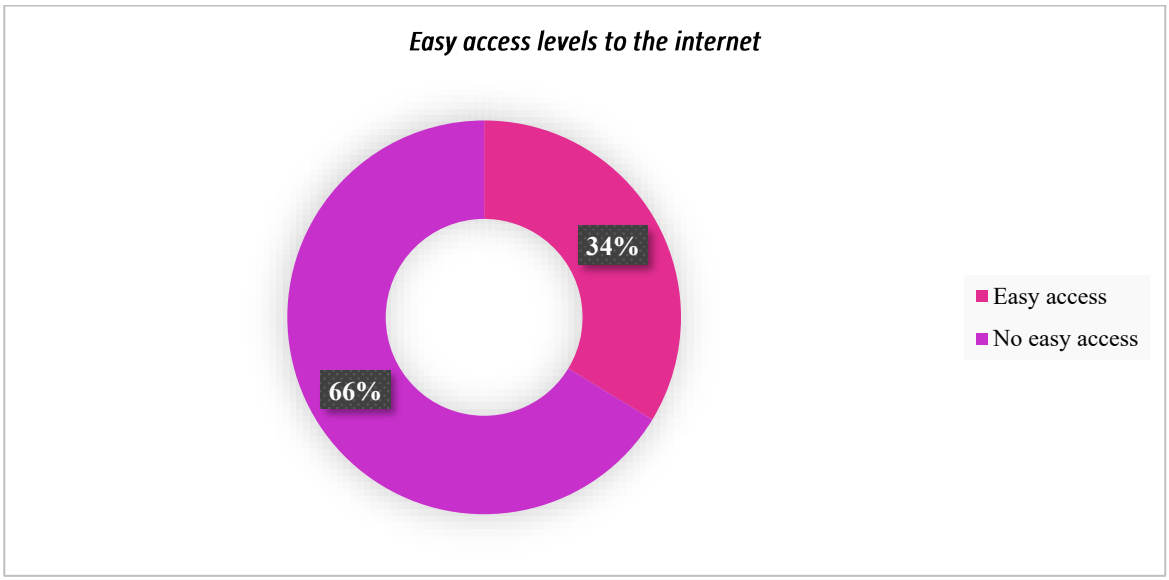
Share per municipality:



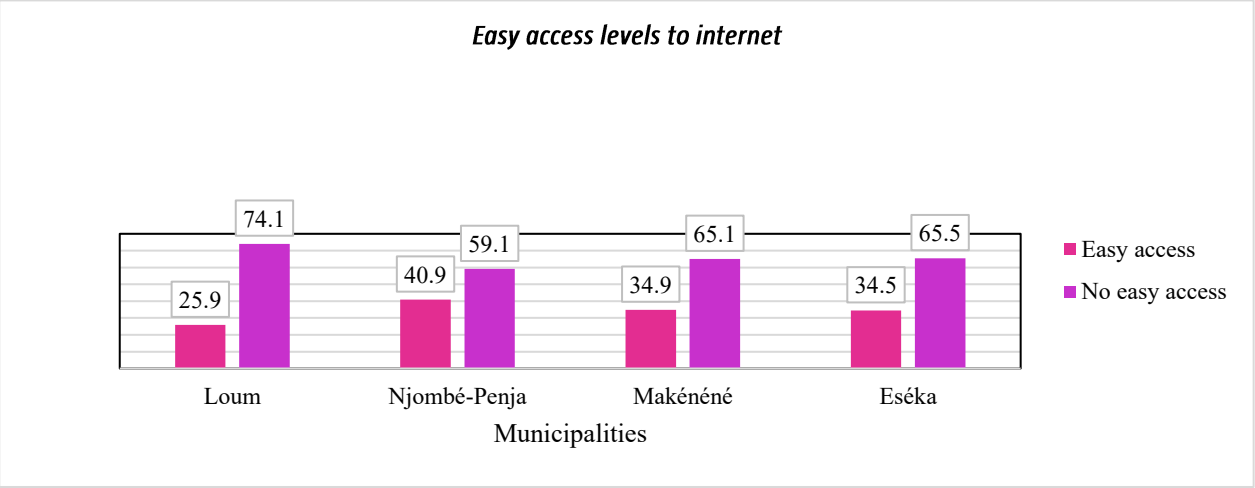
The use of new information technologies that should address the issue of access to information is not affordable for many. For example, the use of android phones and the internet tool for local and fast information is poor because access to the internet is still difficult.

CHART 19: Easy access to internet

Share within the total population:



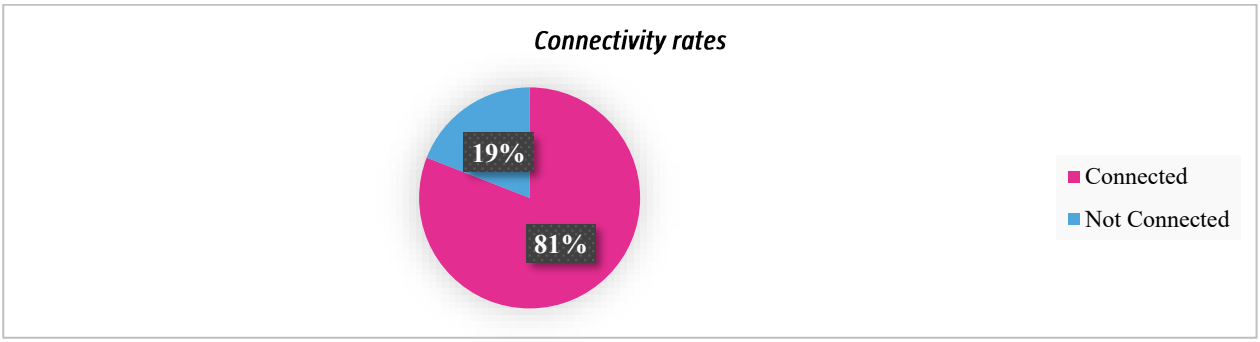
Share per municipality :



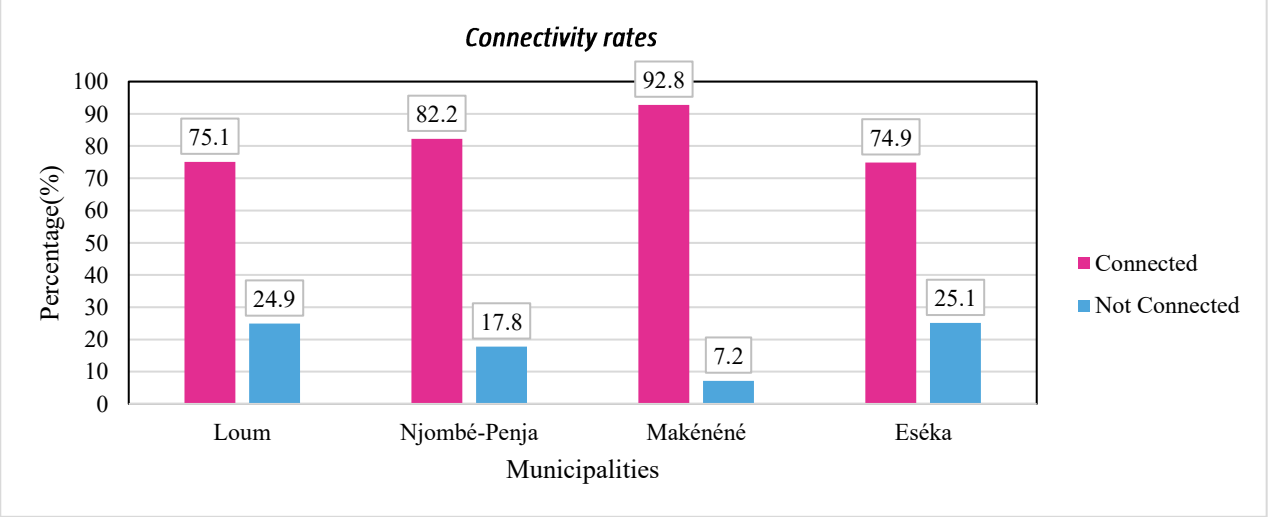
Connectivity rates remain low.

CHART 20: Connectivity rates

Share within the total population:



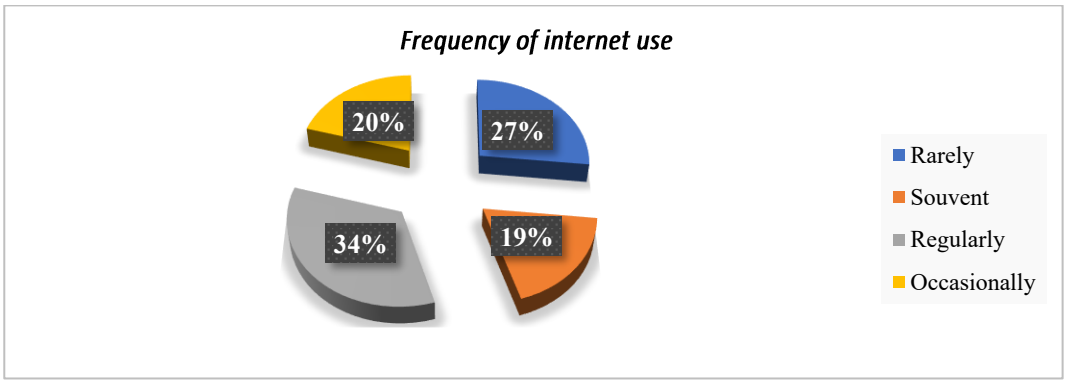
Share per municipality :



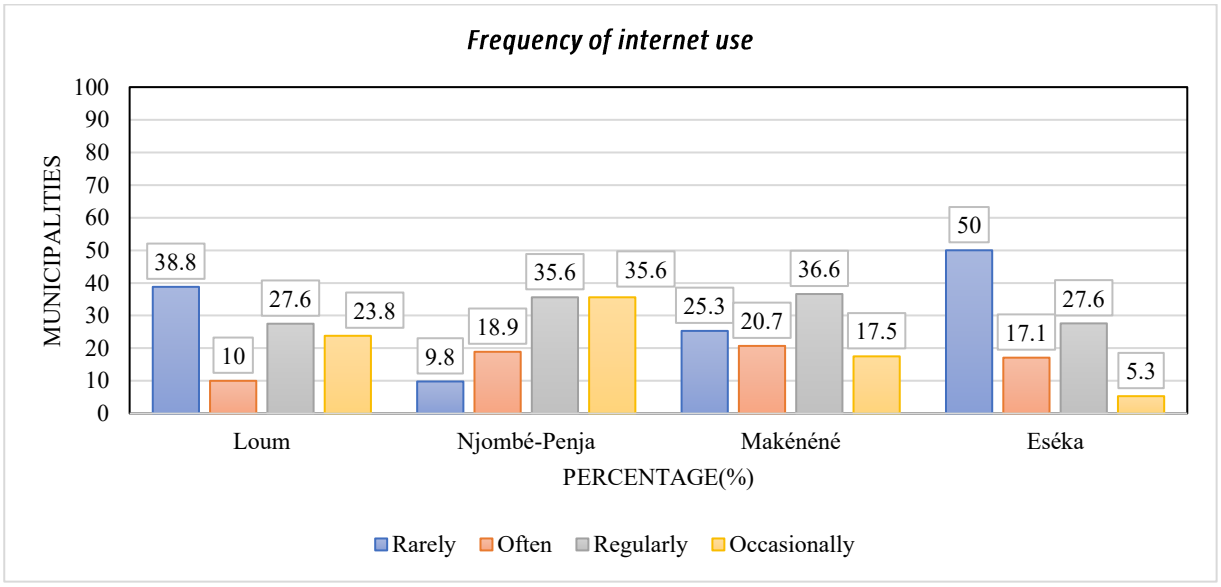
The frequency of internet use also remains low.

CHART 21: Frequency of internet use

Share within the total population:

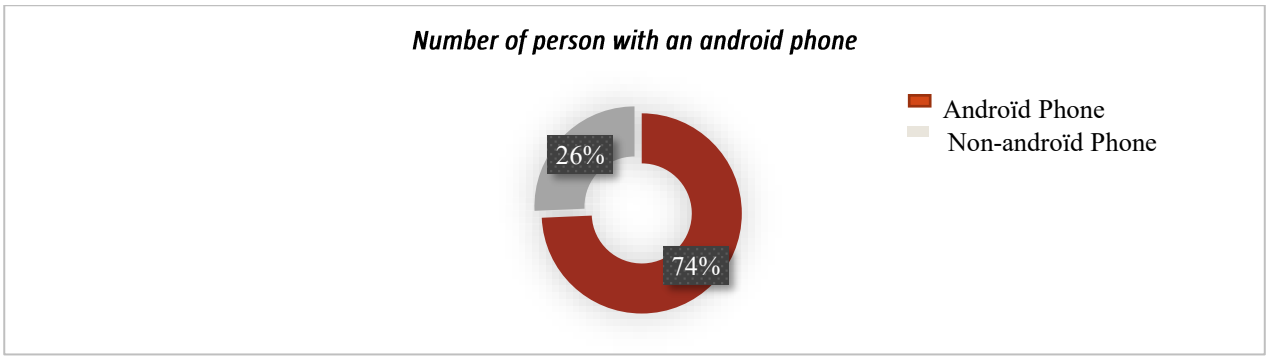


Share per municipality :

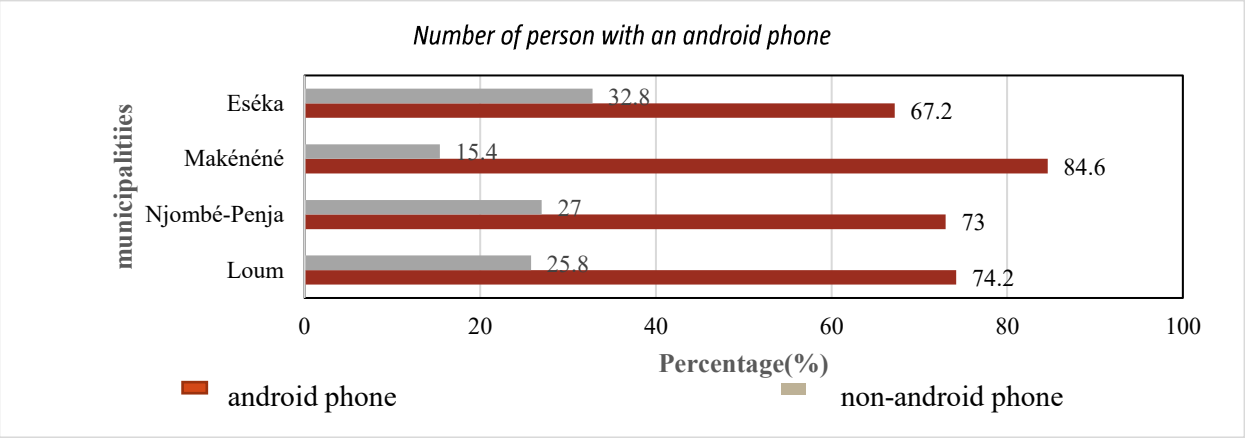


This is mostly due to the poor quality of the internet connection, its instability and its high cost for rural areas. However, most phones of the populations surveyed are android.

CHART 22: Number of persons with an android phone
Share within the total population:



Share per municipality :

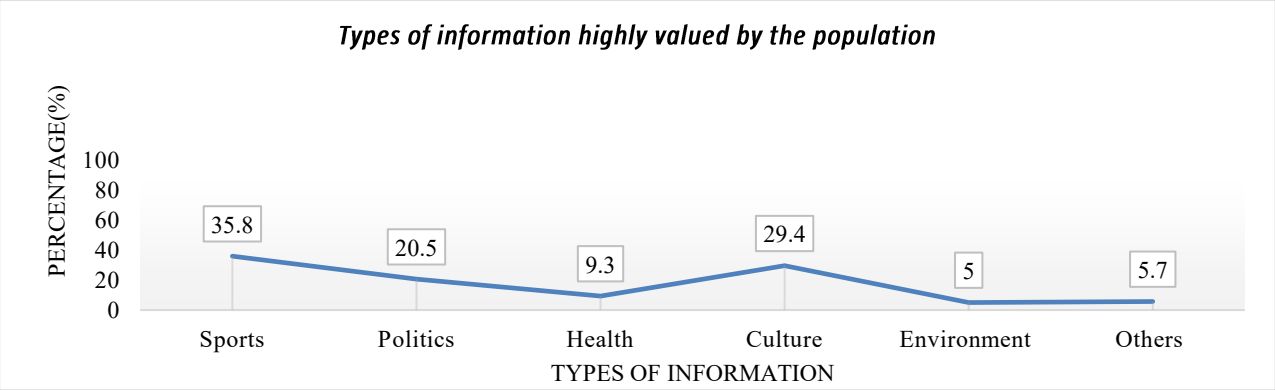


However, it should be noted that health information is not the most widely shared and available.

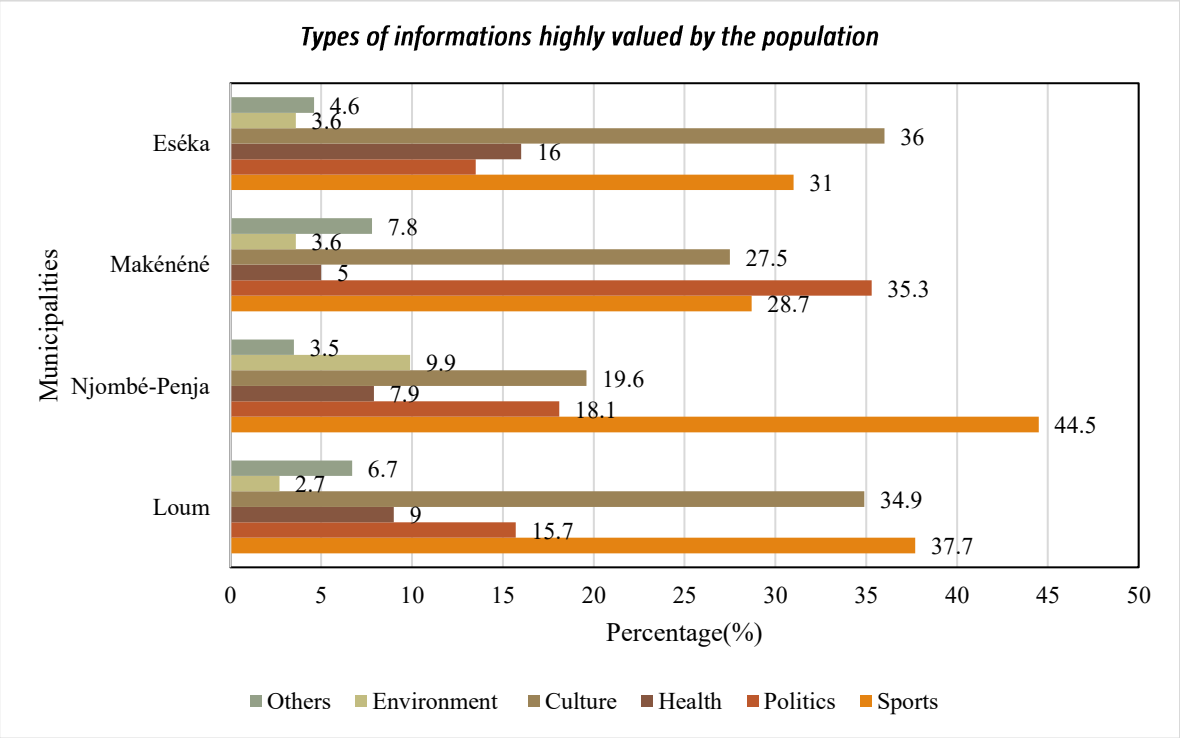
Indeed, it is not one of the most valued by the local masses:

CHART 23: Types of information highly valued by the population

Share within the total population:



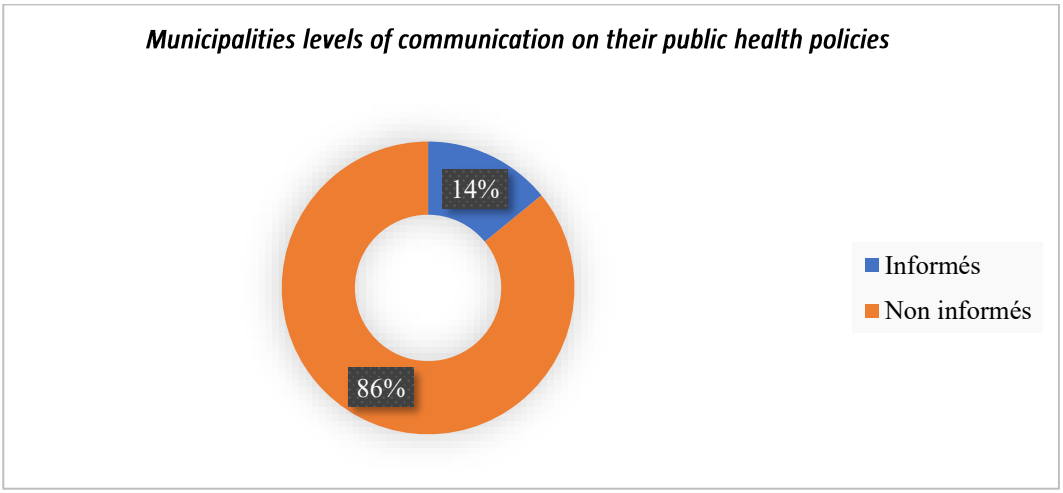
Share per municipality :



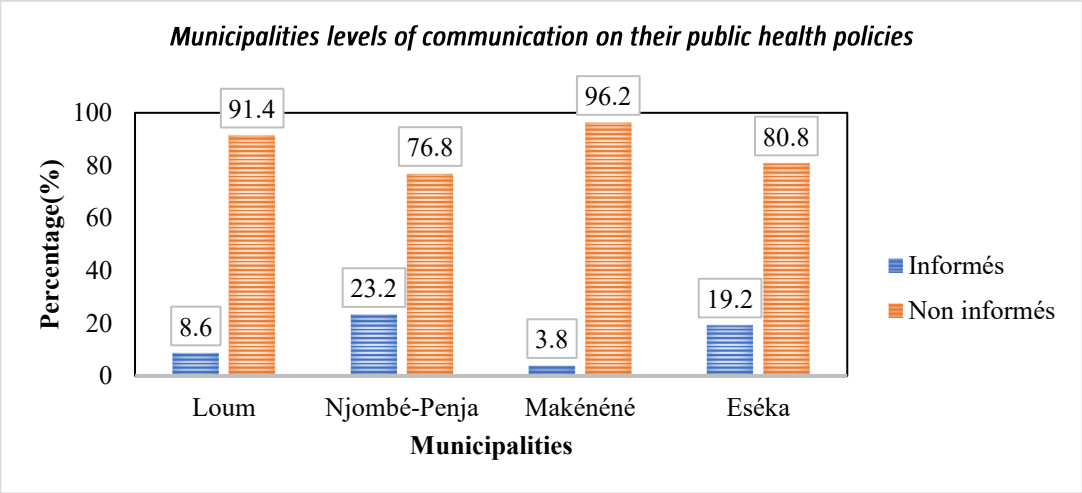
Next, local authorities, especially Mayors whose superiors are ex-officio chairpersons of the COGEH, fail to communicate much about their public health policies, both at the design and implementation stages.

CHART 24: Municipalities levels of communication on their public health policies

Share of the total population:



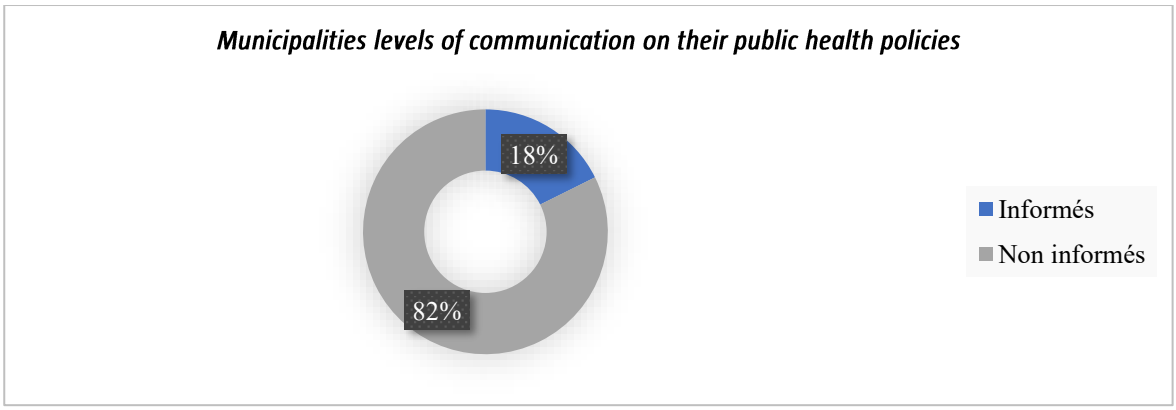
Share per municipality :



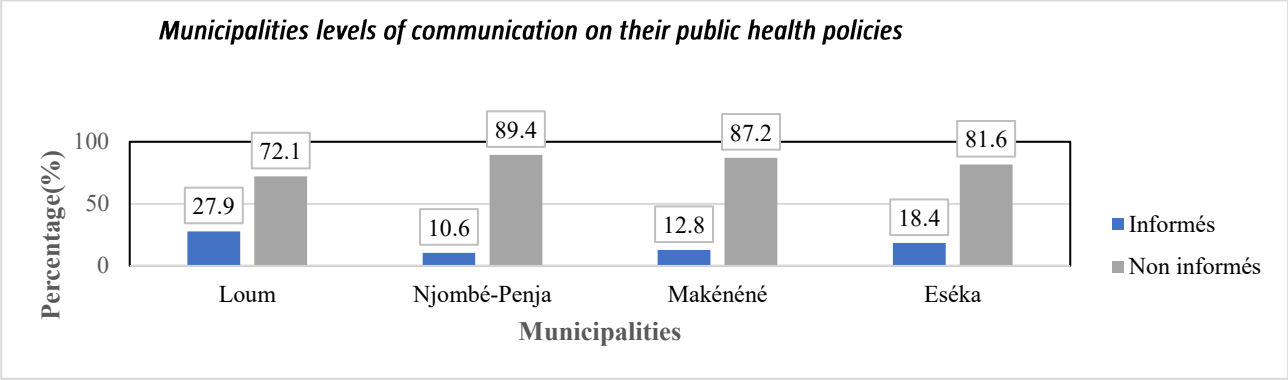
Indeed, this is almost the case with the rest of their public policies.

CHART 25: Municipalities levels of communication on their public health policies in general

Share within the total population:

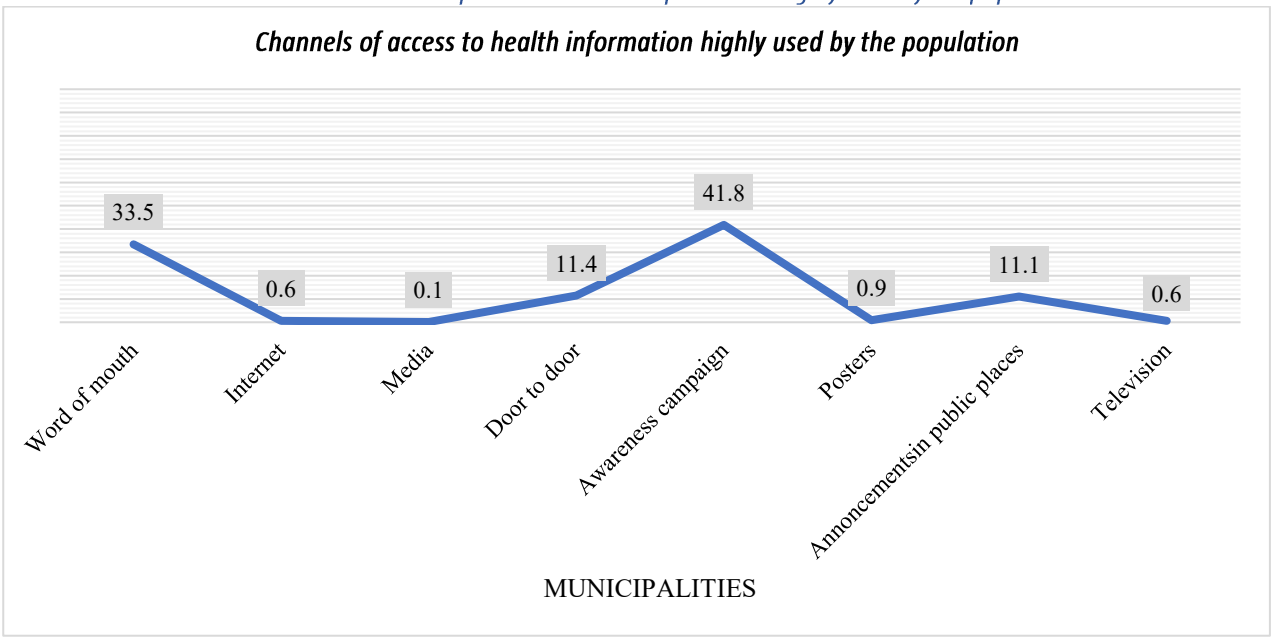


Share per municipality :

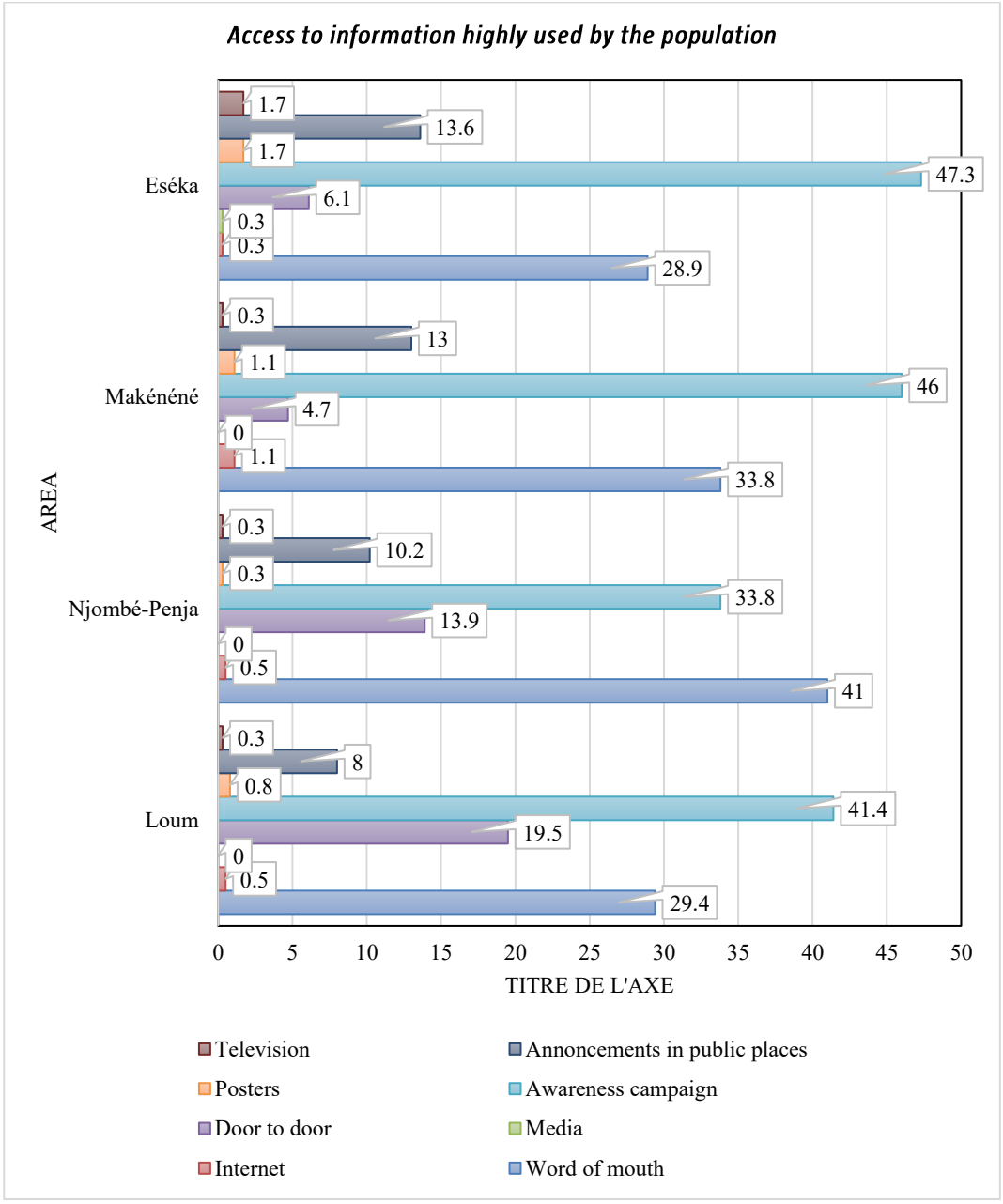


Even when they do communicate, they make mistakes in using rudimentary information channels.

CHART 26: Channel of access to health information highly used by the population



Share within the total population:

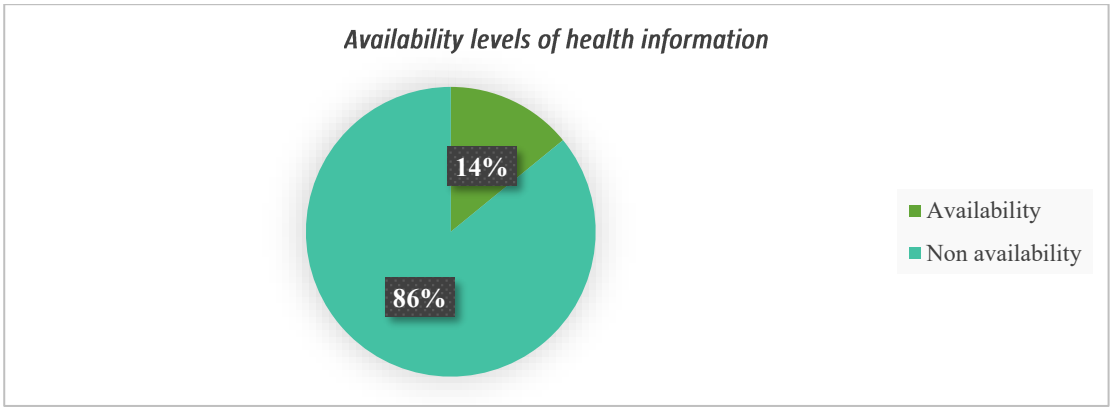


Share per municipality:

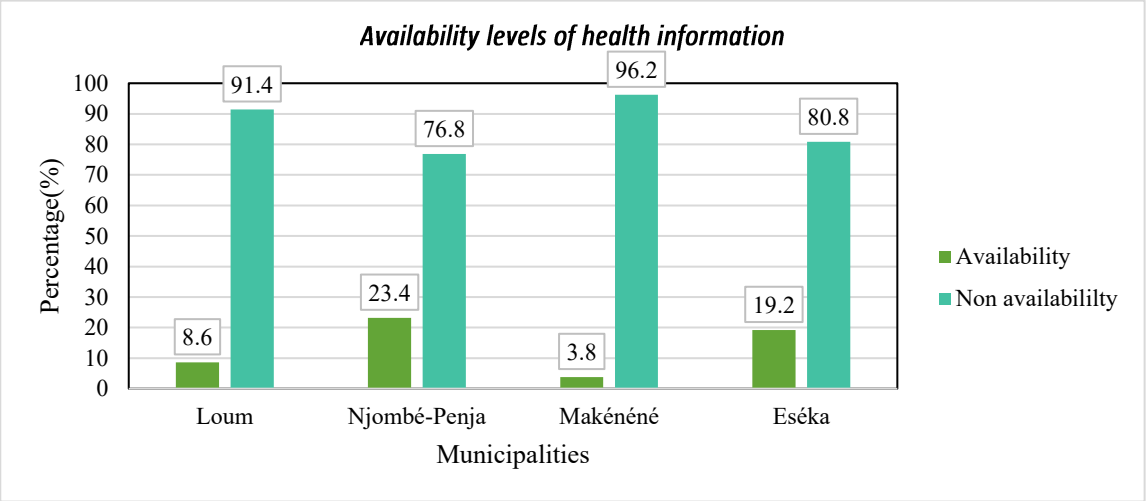
The same applies to the levels of availability of health information, which remain alarming.

CHART 27: Availability levels of health information

Share within the total population:



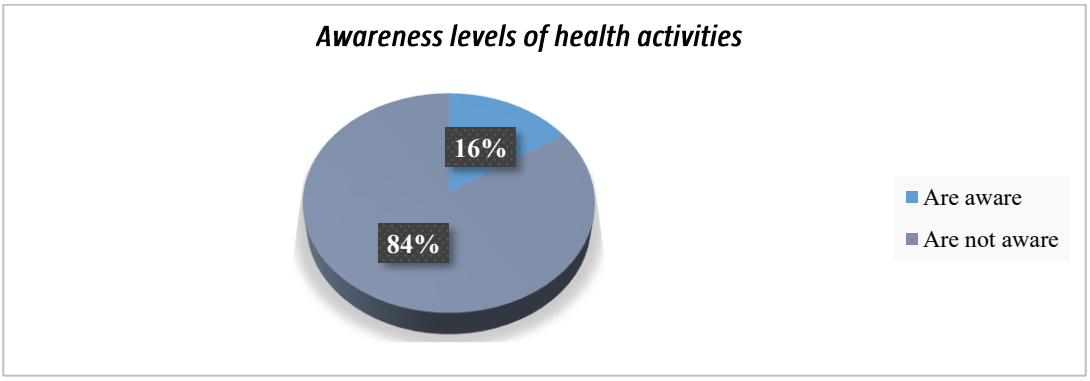
Share per municipality :



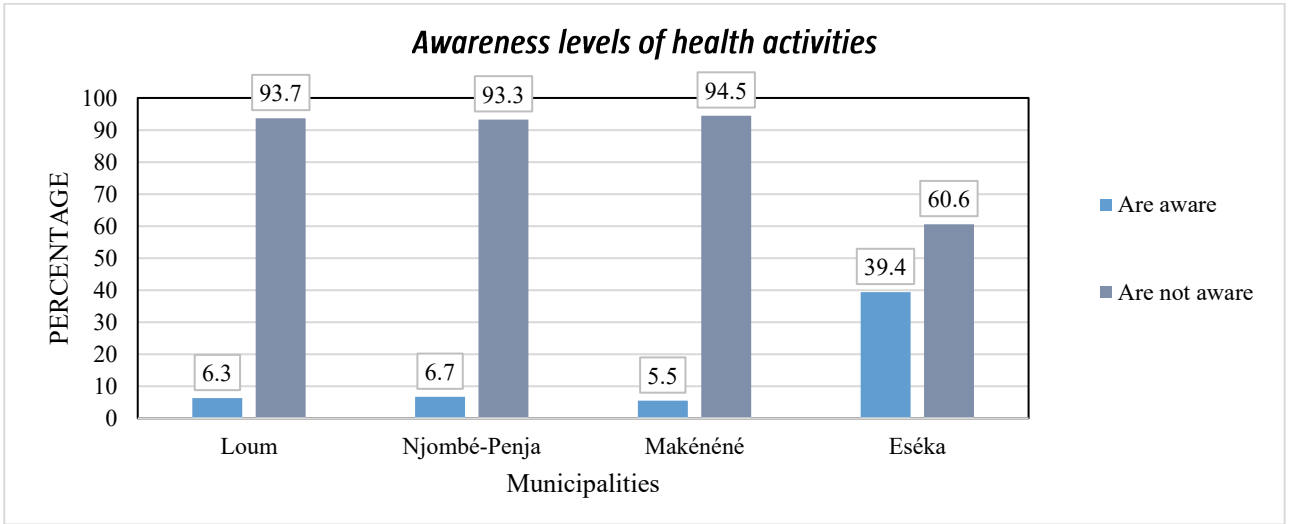
The various limitations thus identified end up contributing to the under-information of the population about local public health policies.

CHART 28: Awareness levels of health activities

Share within the total population:



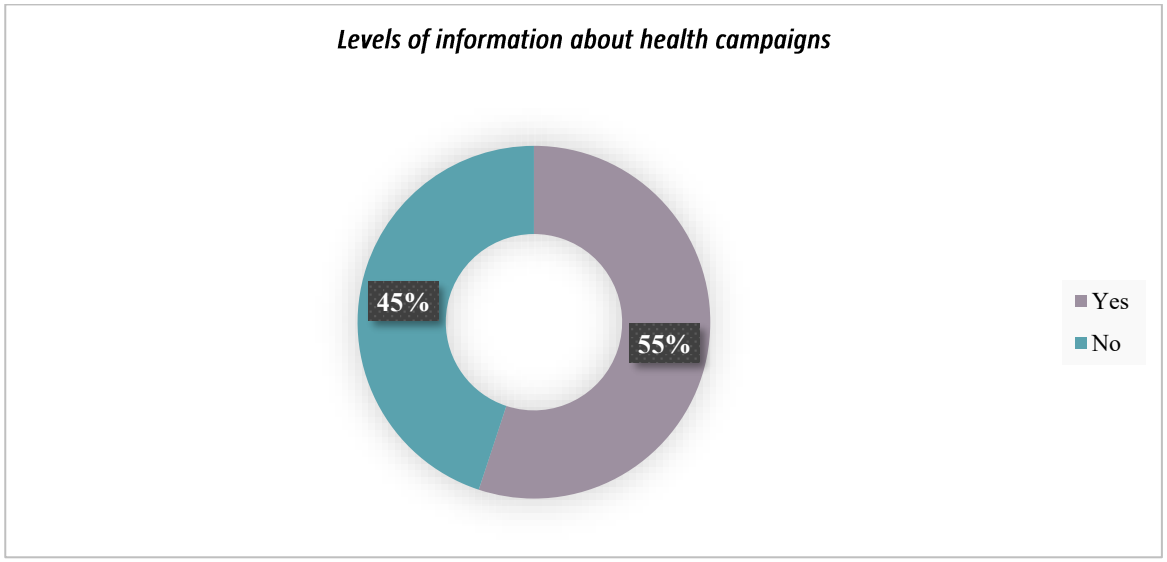
Share per municipality :



This is the case for health campaigns, which are affected by the unavailability and non-regular frequency of health information from municipalities:

CHART 29: Levels of information about health campaigns

Share within the total population:



Share per municipality :

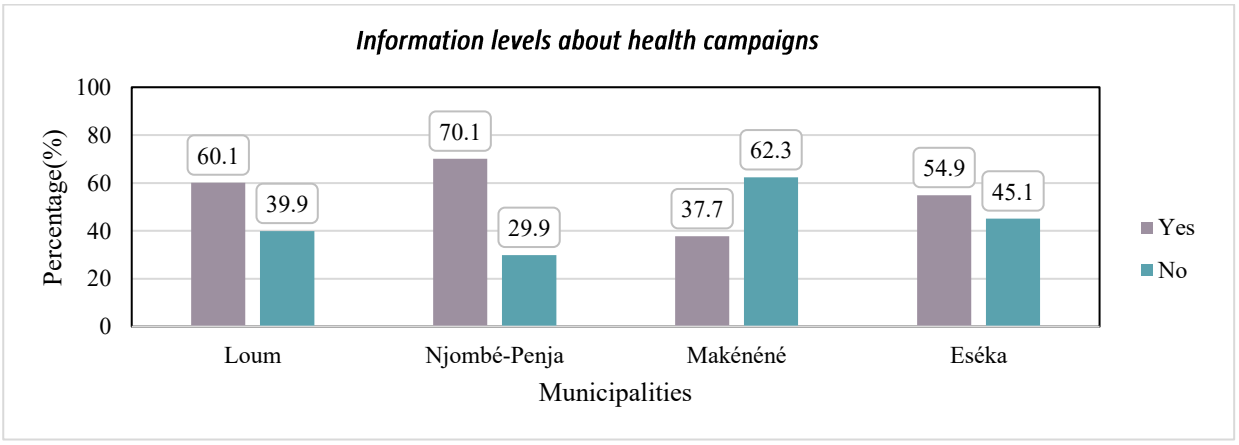
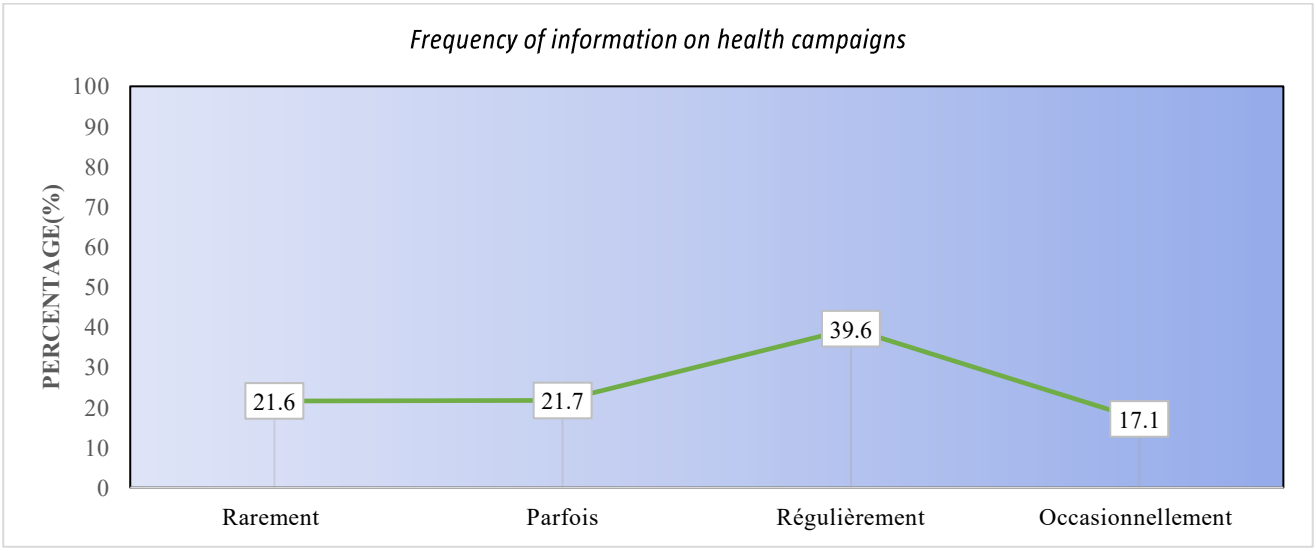
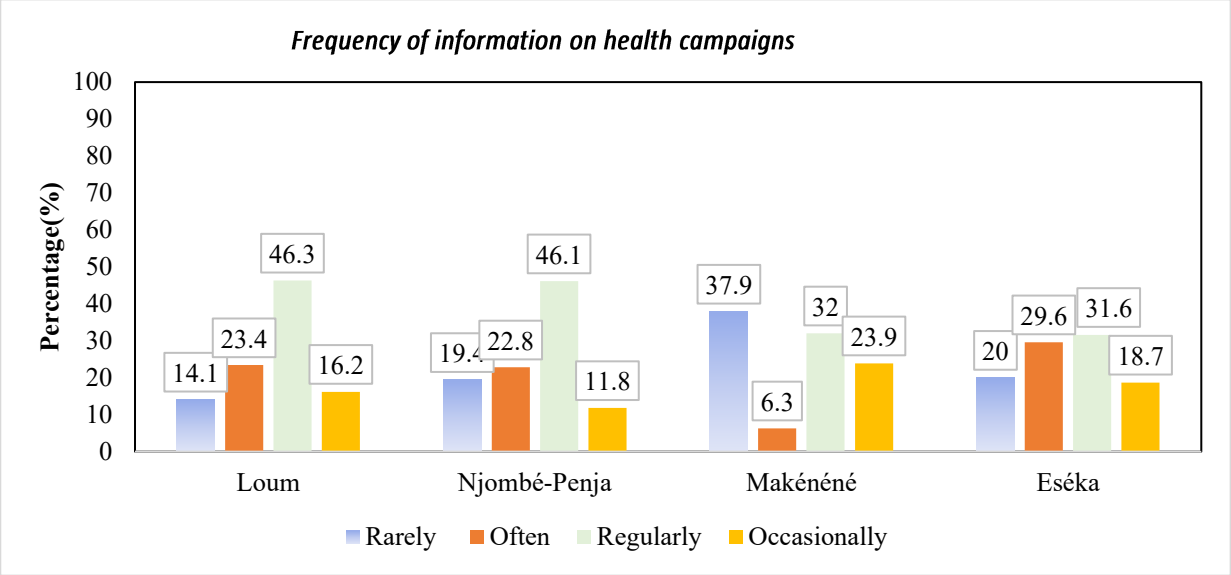


CHART 30: Frequency of information on health campaigns

Share within the total population:



Share per municipality :

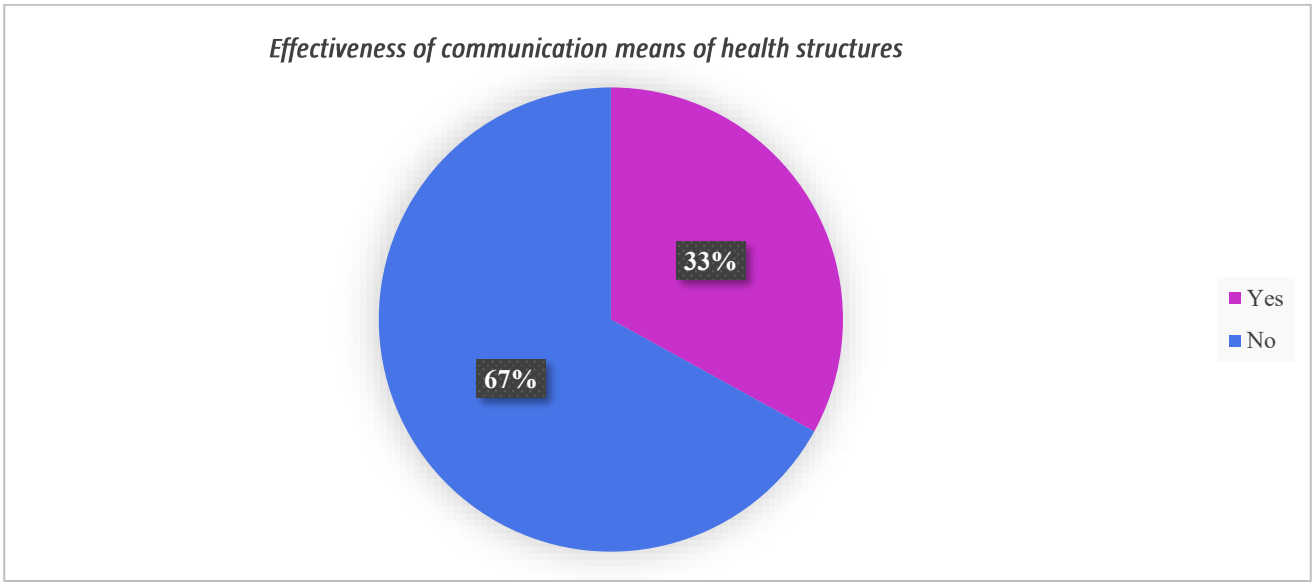


However, it must be acknowledged that when it is necessary to communicate on public health policies in order to encourage adhesion and involvement, participants do their best with the means available, including

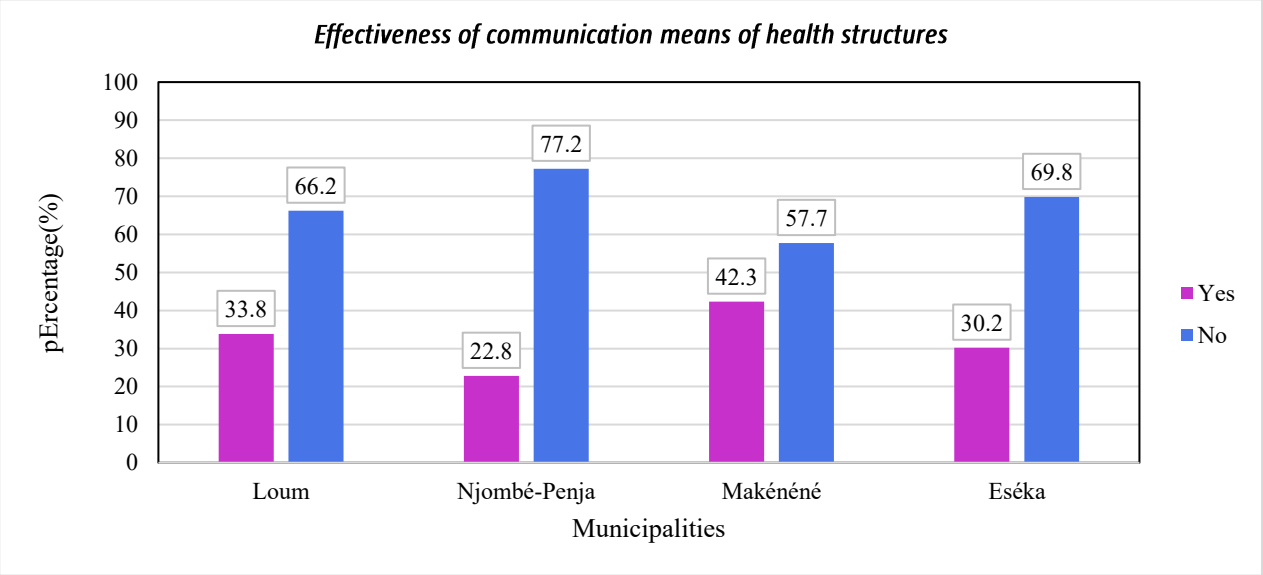
- Communicating in places of worship and mosques;
- Alerts by human and modern loudspeakers
- Radio announcements;
- Door to door campaigns;
- Mass awareness campaigns;
- Posters.

Although many find these ineffective, as the charts below illustrate:

CHART 31: Levels of effectiveness of health facility communication
Share within the total population:



Share per municipality :



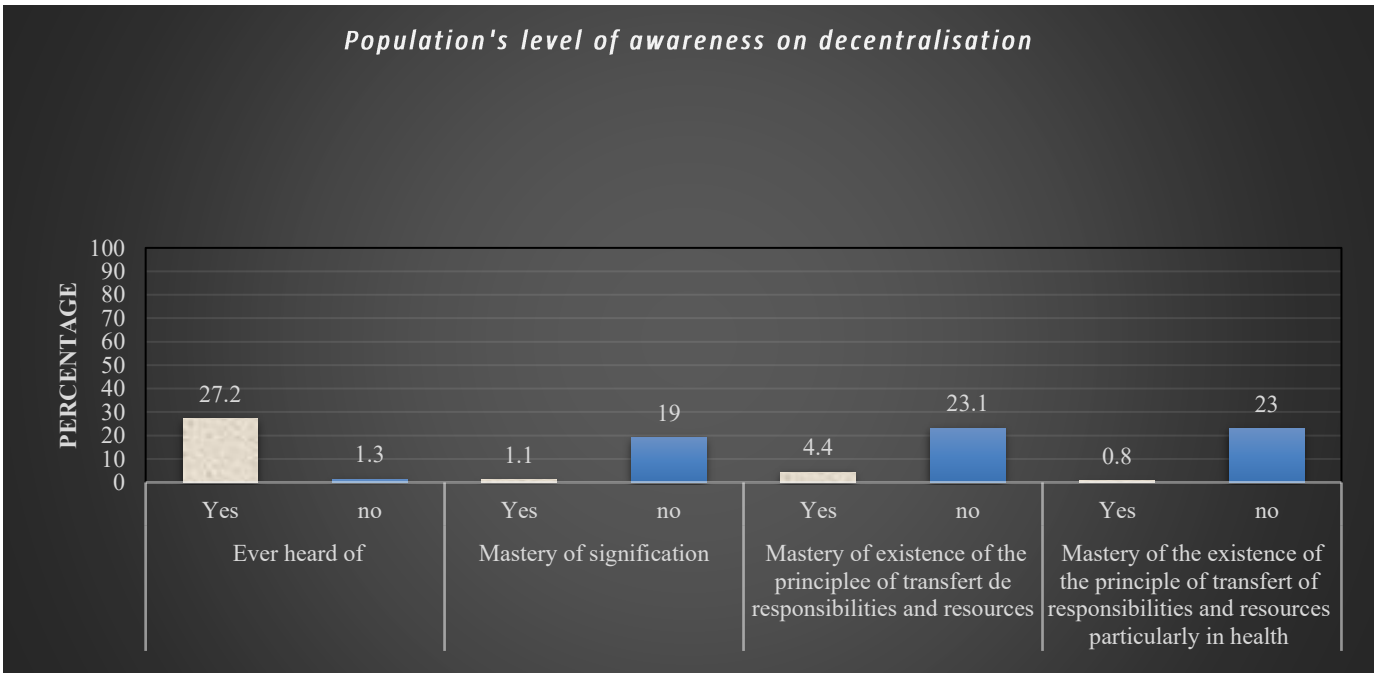
CHAPTER III:

THE STATE HEALTH DECENTRALISATION SINCE 2010, THE YEAR HEALTH DECENTRALISATION CAME INTO EFFECT IN CAMEROON

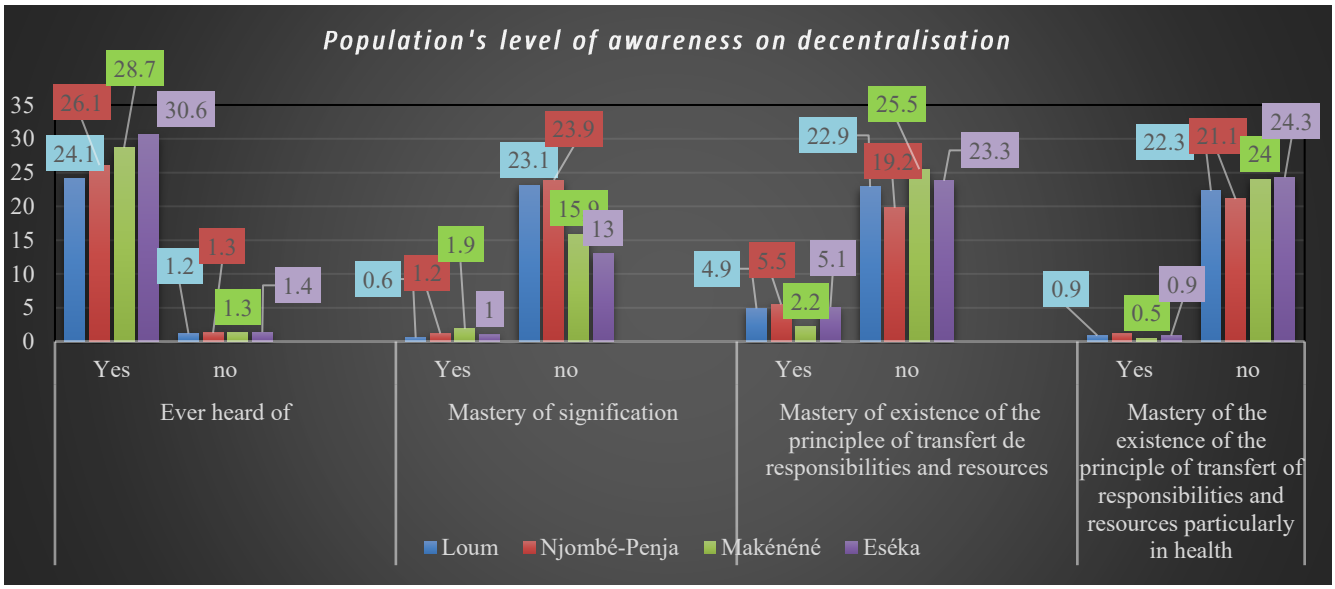
All the shortcomings in the integration and engagement of local population in local public health policies are not to be dissociated from the question of the responsibilities and resources available to municipalities, alongside the democratization of the management of communities, underpin the bedrock of decentralization promoted by the State since 1996. This is the issue of the effectiveness of decentralization and its adoption by all local actors, which should lead to the co-production of local public policies in general and health policies in particular. In any case, the issue is that of health decentralization, with the additional issue of the role of health at the heart of local public policies as expressed in the various budgets.

- Here, several problems have been noted.
- The first is awareness of decentralization in general by the population

CHART 32: Population's level of awareness on decentralization



Share within the total population:



Share per municipality:

- The second point is the lack of ownership of this functional approach of the state by local actors.

- The last issue is the unwillingness of the central government.

Nonetheless, the law specifies the responsibilities conferred on the municipalities in the field of health:

- The creation, equipment, management and maintenance of health centres of communal interest, in line with the health map;

- The recruitment and management of nursing and paramedical staff in integrated health centres and district medical centres;

- Assistance to health and social institutions;

- Sanitary control in manufacturing, packaging, storage or distribution factories for food products, as well as facilities for the treatment of solid and liquid waste produced by individuals or companies.

Yet when we examine the various local budgets - the ultimate tool for assessing the level of importance of a public policy, as it shows that it has been scheduled, valued by the decision-maker, and provides the framework for its implementation - **we discover that the health chapter does not exist in these budgetary plans, more specifically in 10-year 2010-2020 period for the four municipalities targeted by the study. However, since 2010**, the date of the start of the effective transfer of responsibilities and resources to the decentralized local authorities, many resources (the level of communal budgets) - although below expectations - have been managed by the municipalities if one sticks to the 2010-2020 range, to refer only to this period.

In fact, in addition to the financial availability of State budgets reserved for health at the national level,

Table 5: National budgets allocated for health from 2010 to 2020

Financial years	Over all budgets in FCFA	PIB In FCFA
2010	123 701 000	30 150 000
2011	151 810 000	77 173 000
2012	141 420 000	58 800 000
2013	162 448 000	71 500 000
2014	165 870 000	74 500 000
2015	207 066 000	100 370 000
2016	236 167 000	132 452 000
2017	208 195 000	135 109 000
2018	175 240 000	90 990 000
2019	206 712 000	103 559 000
2020	213 651 000	80 698 000

The municipalities have a wide margin for public health policies in their own budgets.

Table 6: Initial budgets of the 4 surveyed municipalities from 2010-2020

Years / Locations	Loum in FCFA	Njombé-Penja FCFA	Makénéné FCFA	Eséka FCFA
2010	294 454 310	239 003 210	488 797 639	215 672 231
2011	294 454 310	300 573 873	611 385 132	182 273 810
2012	323 749 900	287 201 66	327 229 456	259 286 813
2013	350 000 000	344 216 414	350 818 224	310 890 630
2014	360 000 000	412 945 309	266 375 700	956 375 502
2015	422 978 724	529 735 393	655 650 000	990 556 370
2016	578 803 000	766 351 350	572 600 000	789 227 941
2017	588 201 160	650 000 000	634 125 709	783 268 275
2018	563 035 113	634 386 480	570 000 000	627 003 305
2019	640 642 968	599 646 104	743 860 000	804 232 080
2020	594 461 361	676 683 649	740 500 000	1 650 9 62 760

Source: *The various budgets and administrative accounts of the municipalities targeted by this study.*

Unfortunately, on examining the budgets of these municipalities and their administrative accounts, it is clear that none of them has so far allocated a chapter to health. Even the various autonomous expenditures planned or reflected in the administrative accounts do not show any heading explicitly and exclusively devoted to health, even though investments in certain social needs of lesser importance such as the financing of associations and sports and cultural activities are clearly stated.

The few health expenditures or achievements (setting the agenda and implementing health policies) of the different municipalities discovered reveal two ambiguities:

1) These rare, scattered and marginal expenditures are financed by the budgets of the Central State and not of the communities, the Public Investment Budgets (BIP), sometimes co-piloted by the latter or its local branches. These include

- Equipping health centres with health equipment (microscopes, beds, technical platforms);
- The supply of generators;
- The construction of hospital buildings;

- Maintenance of the IHCs' equipment;
- The payment of salaries to health centre staff, such as in Penja in 2022, nearly 24 million distributed among the three health centres in the commune
- The recruitment of paramedical staff.
- The recruitment of paramedical staff.

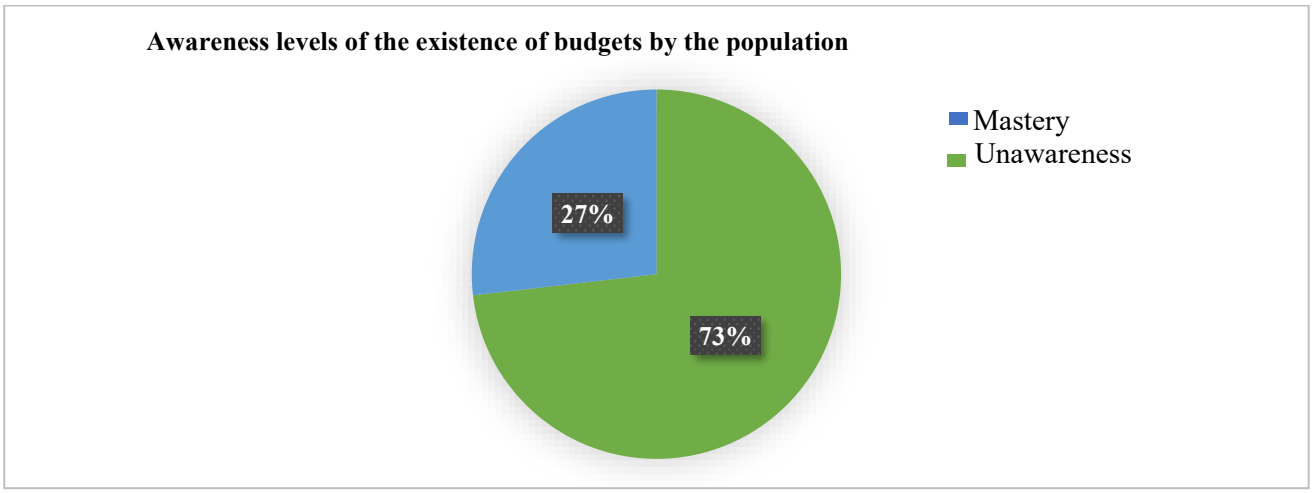
1) The initial budgets do not greatly cover, from the quantitative and qualitative point of view, the four main lines of competence recognized to the municipalities. It is more a question of par-sanitary achievements such as:

- Creation and maintenance of roads;
- Development of roads and networks;
- Hygiene and sanitation;
- Assistance to populations following natural disasters;
- Maintenance of communal buildings housing health services;
- Burial of abandoned bodies;
- Water services equipment Drinking water supply;
- Destruction of harmful animals;
- Collection of household waste;
- Purchase of waste removal equipment.

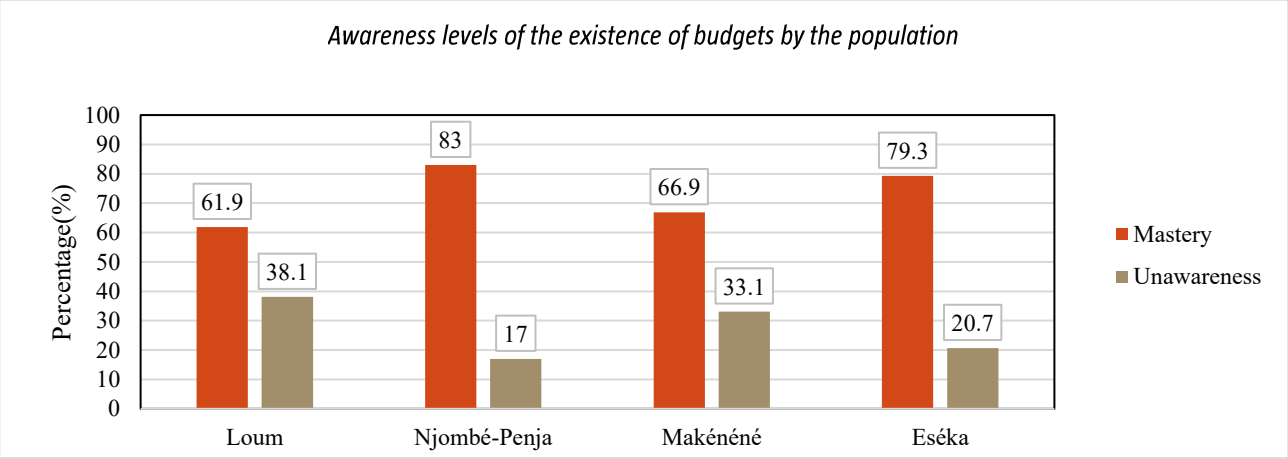
However, the issue of engagement and integration of outsiders at the local level remains a great one, both in terms of public policies within the framework of primary and total budgets.

Also, the popularization of municipalities functioning is not in favouring the quick engagement of the local masses. Unawareness of the existence of specific communal budget to city hall remains very high.

CHART 33: Awareness levels of the existence of budgets by the population
Share within the total population:



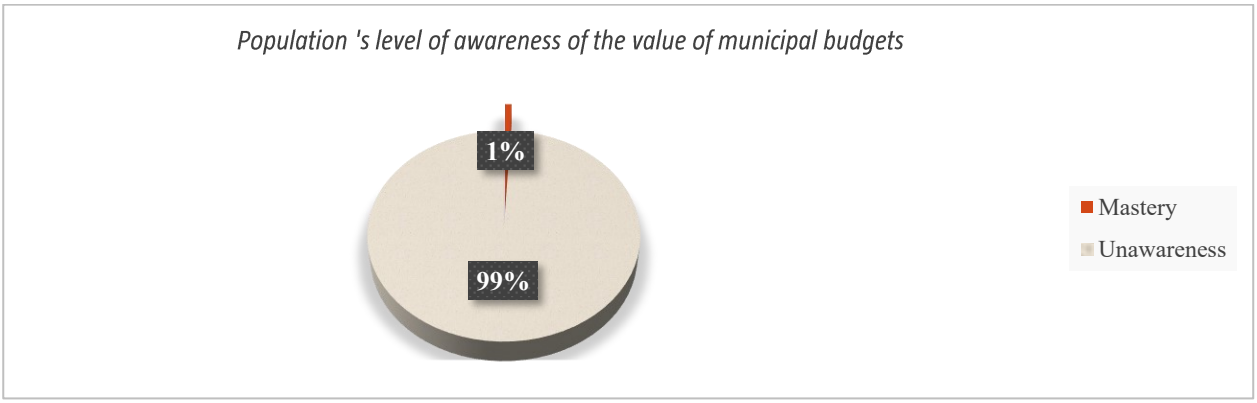
Share per municipality :



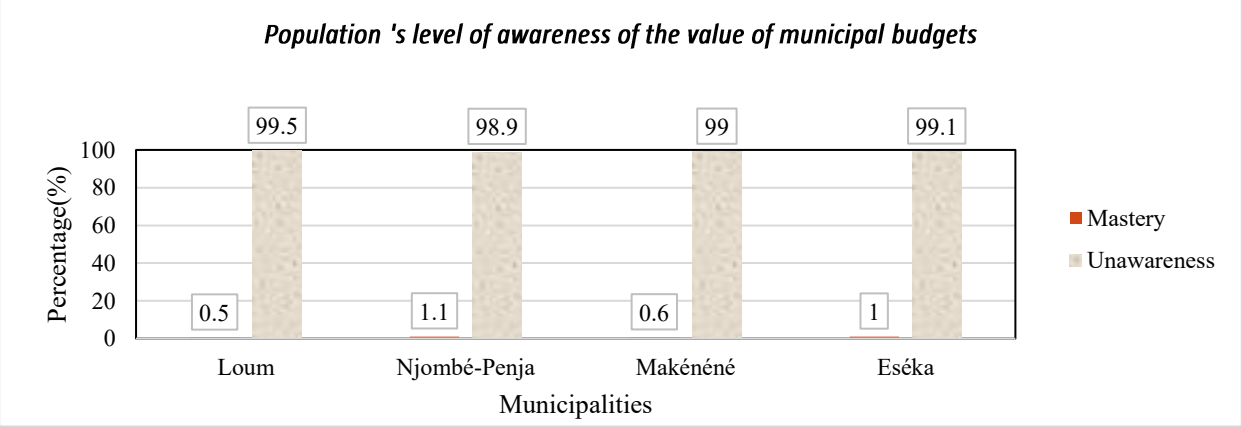
The levels of awareness of the amounts adopted by the municipalities also remain, as a result, very low.

CHART 34: Population's level of awareness of the value of municipal budgets

Share within the total population:

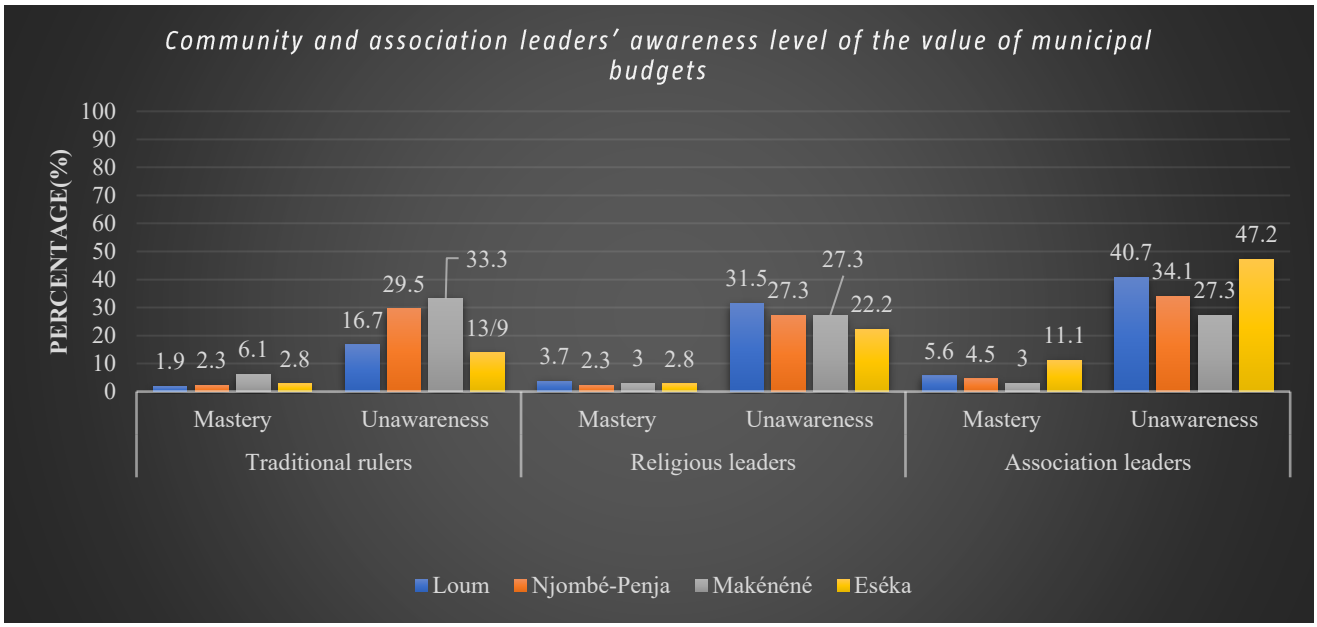


Share per municipality :



Even among the community leaders, who are the link to the makers of public policy:

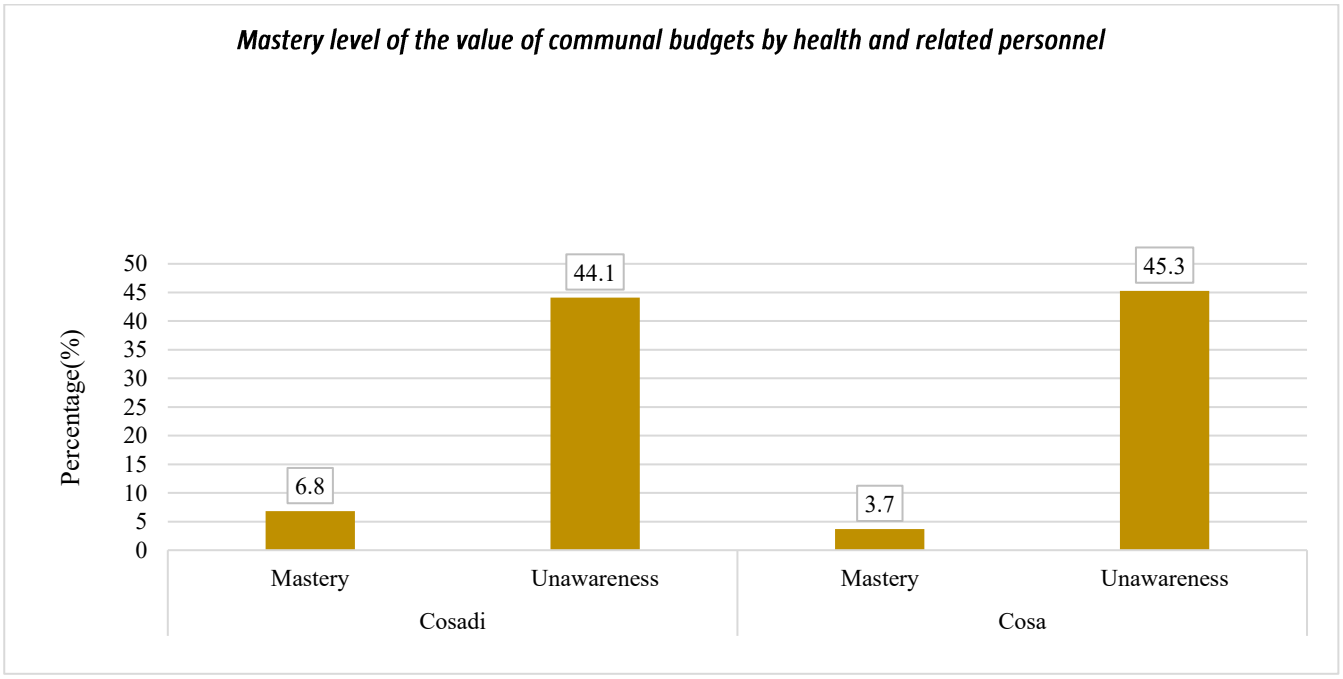
CHART 35: Community and association leaders' awareness level of the value of municipal budgets



Percentage explanations [1]

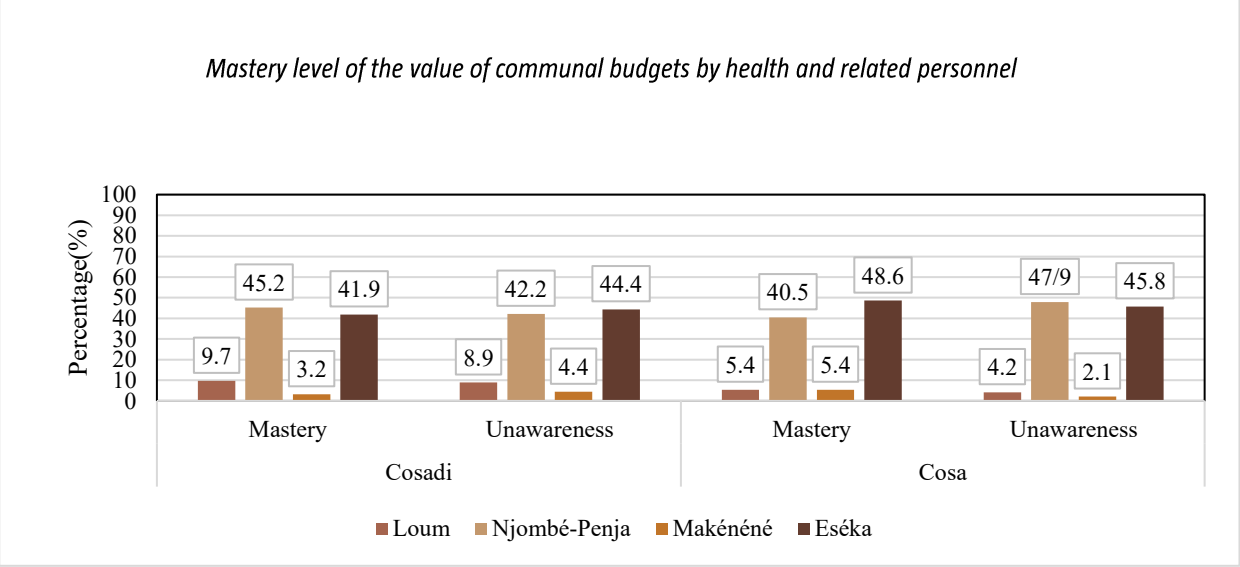
The same unawareness is noticed among the health facilities' management and related staff:

CHART 36: Mastery level of the value of communal budgets by health and related personnel
Share within the total population:



Share per municipality :

[1] In the case of Loum, for example, 1.9% of traditional chiefs, 3.7% of religious leaders and 5.6% of community leaders have a good mastery of the budget amount. On the other hand, 16.7% of traditional chiefs, 31.5% of religious leaders and 40.7% of community leaders do not know the amount of the budget. (1.9%+3,7%+5,6%+16.7%+31.5%+40.7%=100%)



However, the participation of the population in developing and implementing public policies in general and those related to health in particular requires awareness of what municipalities decide to do each year so that they are on the same wavelength as these decentralized administrative structures.

Nevertheless, all these shortcomings should not overshadow the small but significant progress made by the health decentralization process since 2010, in terms of the implementation - although quite negligible - of several competencies granted to them by the State.

Table 7: Powers which are beginning to be exercised effectively

		LOUM	NJOMBE-PENJA	MAKENENE	ESEKA
		Start in earnest ?			
The creation, equipment, management and maintenance of health centres of communal interest, in line with the health map;	Creation	NO	NO	NO	NO
	Equipement	YES	NO	NO	NO
	Management	YES	NO	YES	YES
	Maintenance	YES	YES	YES	YES
Recruitment and management of nursing and paramedical staff in integrated health centres and district medical centres	Recruitment	YES	YES	NO	NO
	Management	YES	NO	YES	YES
Aid to health and social facilities		YES	YES	YES	YES
Sanitary monitoring of food manufacturing, packaging, storage or distribution factories, as well as of facilities for the treatment of solid and liquid waste produced by individuals or companies.		YES	YES	YES	YES

CHAPTER IV : RECOMMENDATIONS

I. SPECIFIC RECOMMENDATIONS TO THE STATE

- Enforce the laws governing decentralization by making the transfer of responsibilities and resources effective;
- Complete the responsibilities and resources to guarantee total decentralization;
- Provide intellectual support to other participants in the decentralization chain from the communal executives to the population;
- Ensure the legitimacy of communal executives in order to ensure that the masses fully support their public health policies;
- Continuously monitor the management of communal executives;
- Frequently discipline reckless Mayors;
- Ban the power of local officials appointed by the Central Administration, such as mayoral secretaries or prefects, over elected executives;
- Free up more resources for municipalities so that they can create more health facilities;
- Strengthen collaboration between the State and other participants in the decentralization chain;
- Create a national digital platform that combines all the data on decentralisation in order to reduce the lack of transparency of certain communal executives.

II. SPECIFIC RECOMMENDATIONS TO MUNICIPALITIES

- Invest more in claiming the powers and resources offered to them by the decentralization laws;
- To be regularly accountable and to communicate more;
- Promote transparency, a guarantee of a relationship of trust with the population, they must reduce the lack of transparency in their budgets by making them public and accessible to all, both on their digital platforms and in their archives, as the laws stipulate;
- Collaborate more with health facilities;
- Collaborate more with community leaders and associations;
- Create physical and digital exchange platforms with skilled management staff;
- Create communal radio stations ;
- Have Mayors who reside permanently in their municipalities;
- Have elected officials who are more approachable and open;
- Popularize the notion of decentralization in general and health decentralization in particular;
- Popularize or mediatize health policies;
- Rebuild the climate of trust between the communal authorities and the population;
- Avoid political and ethnic discrimination;
- Adapt public health policies to the real needs of the population;
- Promote local democracy.

III. SPECIFIC RECOMMENDATIONS TO ADMINISTRATIONS AND HEALTH FACILITIES

- Strengthen relationships with communities in the health areas;
- Improve the quality of reception and service in the health facilities;
- Remain attentive to patients ;
- Improve the moral and ethical training of health workers;
- Continuously collaborate with the communal authorities;
- Banish the two-headedness at the head of health facilities torn by the power of the devolved hierarchy on the one hand and the decentralized one on the other;
- Take action to encourage the members of the dialogue structures and community agents;
- Ensure the popularity of community representatives within the dialogue structures;
- Fight against the misappropriation of grants intended for the population;
- Fight against discriminatory allocation of funds;
- Fight against the withholding of information on prestigious grants;
- Fight against the payment and commercialization of services that are known to be free;
- Redesigning the image of health facilities and personnel among the population and communities;
- Create websites or blogs;
- Increase the number of outreach campaigns;
- Organize small surveys or focus group surveys on a frequent basis;
- Increase and strengthen collaboration with the communities and their representatives.

IV. SPECIFIC RECOMMENDATIONS FOR COMMUNITY AND ASSOCIATION LEADERS

- Be at the service of the government, municipal and health authorities;
- Make themselves available whenever they are called upon;
- Be active in training for civic engagement in public policy;
- To remain in contact with the population;
- Introduce strategies and activities at their level to encourage the population to support public policies;
- To defend the interests of the communities;
- Be less opportunistic and clientelist.

IV. SPECIFIC RECOMMENDATIONS TO THE POPULATION

- Avoid prejudice against modern medicine;
- Participate actively in health-related reflections and activities;
- Volunteer for community health ;
- Respect communal and health authorities as well as community leaders;
- Be more interested in health information;

- Be familiar with the internet and its communication services;
- Be open to offers and health workers.

V. GENERAL RECOMMENDATIONS FOR COMMUNITY AND ASSOCIATION LEADERS (Civil Society)

- Introduce community and associative leaders to decentralization;
- Ensure that they are key links in the implementation of decentralization;
- Provide them with incentives to boost their motivation;
- Allocate to them, at the level of the municipalities, substantial means of action such as material resources and financial support;
- Ensure their legitimacy ;
- Permanently subcontract certain community tasks to them;
- Strengthen their means of communication;
- Introduce them to new information and communication technologies;
- Turn them into strategic partners of the municipalities in the elaboration and implementation of public policies;
- Help them to create websites and blogs for their units, communities or organizations;
- Urge them to renounce tribalism;
- Urge them to reduce corruption, which leads to bargaining over health facilities;
- Create participation committees and health monitoring cells within the chiefdoms;
- Urge community leaders to be less authoritarian;
- Increase the number of community health workers;
- Determine a communal budget line capable of motivating the volunteers of the dialogue structures and the community health agents;
- Reward volunteers.

VI. GENERAL RECOMMENDATIONS IN FAVEAUR OF THE POPULATION

- Increase the number of health dialogue frameworks;
- Continuously submit the population to small surveys in order to gather their opinions before any development of health policies;
- Fight prejudice against the communal and health authorities;
- Fight prejudice against modern medicine;
- Increase awareness in order to train and encourage the population to be more involved;
- Raise awareness among the population about the rights they have in the context of decentralization;
- Encourage them to claim their rights in terms of public health policies;
- Teach them to report bad health practices;

- Continuously select the best among them in order to be involved in specific local reflections;
- To be more attentive to their demands;
- Help them to make appropriate electoral choices in order to have municipal executives who will meet their expectations and who will be accountable to them and not only to their respective political parties;
- Instill in them the principles of respect of public authority.

APPENDICES

Field collection tool: Questionnaire for the local population

Questionnaire for the local population

Targets: Local Population

Instructions: Respondents are required to answer directly and only to the questions. However, he/she could, if he/she wishes, justify his/her answer with a comment.

Name: ……

Profession: ……

Age: ……

QUESTIONS

PART I: Level of transfer of health responsibilities and resources to the local level since 2010

1- Have you ever heard of decentralization? … Yes …No

If yes, what does it mean? ……

If yes, do you think it is implemented in your community? ….. Yes …. No

If yes, are you aware that decentralization involves the transfer of responsibilities and resources to the municipalities? ….. Yes …No

If yes, are you aware that decentralization involves the transfer of health responsibilities and resources to the municipalities? …. Yes …. No

2- Have you ever been invited by the town hall for a communal activity? …Yes …. No

If yes, on which occasion(s) and how often? ……

3- Do you have any idea of communal actions concerning the improvement of the health situation in your locality? ……

4- Do you think that the health authorities are efficient? …. Yes …. No.

PART 2: Level of integration and engagement of local population in public health policies.

1- Is there a health committee in your locality? …. Yes …. No

If yes, how many members are there? ……

Do you think that this committee is adequately represented by the people of your locality? … Yes … No

2- Are you interested in health activities? … Yes …. No

If yes, which one(s)? ……

3- Have you ever participated in a health campaign(s)? .... Yes .... No

If yes, which one(s)? .....

4- Do you feel you are a key participant in the health process in your locality? ...Yes .... No
5- Have you ever been invited to a health survey in your community? ... Yes .... No
6- Have you ever been invited by the town hall to attend a meeting? ... Yes .... No

If yes, which one(s) (meeting)? .....

7- Have you ever been invited by the town hall to participate in a health debate? ...Yes .... No

If yes, which one(s)? .....

8- Have you ever been invited by a hospital to participate in a discussion? .... Yes .... No

If yes, which one(s) (discussion)? .....

9- Have you ever been involved in a health action? .... Yes .... No
10- Do you have a better relationship with health personnel today? ... Yes .... No

If yes, how ? .....

11- Do you feel that the health structures are closer to you (the inhabitants)? ... Yes .... No
12- Are you interested in taking part in health initiatives? .... Yes .... No

If yes, how ? .....

13- Are you willing to take part in health initiatives? .... Yes .... No

If yes, how? .....

14- Do you have the impression that your opinion is taken into account in the decision-making process regarding health in your community? ... Yes .... No
15- Do you always take part in screening or vaccination campaigns organized in your locality? ... Yes .... No.

PART 3: The normative framework for the integration and engagement of local population in public health policies at local level

1- Are you aware that the law provides a framework for civic engagement in the development and implementation of health policies? .... Yes .... No
2- Are you aware that you have a key role in improving health conditions in your community?

PART 4: Institutional mechanisms set up at local level to inform citizens about health offers, campaigns

1- Do you listen to news? Yes .... No

If yes, how often? Rarely... Often... Regularly .... Occasionally.....?

If yes, through which channel: Word of mouth.... Television....Radio.....Internet..... Press..... Telephone messages..... Outreach or awareness-raising campaigns ....

If yes, which types of information do you listen more: Sport... Politics... Health... Culture... Environment... Others....

2- Are you often informed of activities initiated or organized by the town hall? .... Yes .... No

- If yes, how often, Rarely...Often... Regularly .... Occasionally..... ?
- If yes, through which channel: Word of mouth.... Television....Radio.....Internet..... Press... Telephone messages..... Local information or awareness campaigns ...billboards...?
- If yes, which activity(ies)? .....

3- Are you often informed about health-related activities here in your municipality? .... Yes .... No

- If yes, how often: Rarely.....Often... Regularly .... Occasionally.....?
- If yes, through which channel: Word of mouth.... Television....Radio.....Internet..... Press..... Telephone messages..... Local information or awareness campaigns ...billboards...?

4- Are you often informed about health campaigns in your locality? ...Yes .... No

If yes, how often, Rarely..... Often ...Regularly.... Occasionally...?

If yes, through which channel: Word of mouth.... Television....Radio.....Internet..... Press..... Telephone messages..... Local information or awareness campaigns ...billboards ...?

If yes, on what did the campaign focus? .....

5- Do you have a mobile phone? ... Yes .... No
6- Do you have an Android phone? ... Yes .... No
7- Are you often connected to the internet? Yes .... No
8- Do you have internet access? ... Yes .... No

If yes, how often do you log on? Rarely..... Often ... Regularly .... Occasionally...?

If yes, how do you rate the speed of the Internet connection: Excellent ..... Good..... Poor .....? .....

If yes, how do you rate the stability of the internet connection: Excellent ..... Good..... Poor ..... Pitiful? .....

If yes, which operator are you connecting through? Mtn..... Orange... Nextel .... Others...

9- What means do hospitals use to inform you about health offers? .....

Do you find them efficient? Yes .... No

10- According to you, what are the necessary improvements in the dissemination of information at local level? .....

PART 5: Budgets allocated to health at the national level (State budget) and at the local level in the 4 communes, sites surveyed over the past 10 years.

1- Are you aware that your municipality has its own budget? ... Yes .... No ....

If yes, did you know the amounts already? .....

If yes, are you aware of the amounts allocated to health? .....

2- Do you think that the resources mobilized at local level help to strengthen the participation of the population in the management of the health system at local level? ... Yes .... No

If yes, why ? .....

3- According to you, what are the noticeable changes regarding the healthier integration of the population? .....

Thank you for being available

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