DEVELOPMENT OF THE NATIONAL HEALTHCARE TECHNOLOGY POLICY FOR CAMEROON

J. Riha*

*German Technical Cooperation GTZ / EPOS Health Consultants / Ministry of Public Health, Cameroon
c/o GTZ / EPOS  BP 7814  Yaoundé, Cameroon  josef.riha@epos.de  fax  +237 – 22 23 23 72

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Abstract

The paper describes the process of developing the first National Healthcare Technology Policy for Cameroon as experienced by a member of the drafting committee. Background and context are explained, the approaches used are elaborated, and lessons learnt are presented to serve as encouragement to other healthcare administrations.

1 Introduction

The Ministry of Public Health (MoH) is by far the largest provider of health services in Cameroon, managing over 1,600 health facilities of various kinds for a population of about 16 million. However, given the limited resources allocated to the sector and due to poor management practices the performance of services to the public has been consistently criticised. The lack of a rational approach to Healthcare Technology (HCT) has been identified as one of several weaknesses in the Ministry and has contributed to a lamentable state of many health facilities, to considerable waste of resources, and to much frustration amongst patients and staff. Various donors have also demanded a fresh and transparent approach to the management of infrastructure and equipment as a precondition for further support to the rehabilitation of existing facilities or for new investments. The Ministry has consequently realised the need to develop a comprehensive HCT policy. Due to its long-term presence in the health sector in Cameroon and due to the specific support given to HCT management, the German Technical Cooperation Agency (GTZ) became actively involved in the process to develop this policy.

2 The Challenges facing HCT Management in Cameroon

A number of issues can be identified which have contributed to the current state of health facilities and which a HCT policy would need to take into consideration:

- Lack of coordination within the Ministry of Health while responsibilities for HCT are spread over numerous departments (planning, budgeting, buildings, medical equipment, inventory, information management);
- Political considerations are frequently overshadowing attempts at rational planning;
- Considerable opportunistic behaviour both within the Ministry and in the private sector: lack of transparency in tendering processes, maintenance at times used as a fig leaf to create fictitious expenditure, lack of respect for contractual agreements due to poor control and supervision, coupled with a high level of impunity;
- Parallel but uncoordinated initiatives by different vertical programs (donor pressure);
- Shortage of technical and management skills and know-how on all levels;
- Unattractive civil service salary structure;
- Cumbersome public finance procedures;
- Budgetary constraints.

3 The Role of the German Development Cooperation

The German Development Cooperation has assisted the Ministry of Health in Cameroon for several years, to support infrastructure development via the German financial cooperation agency (KfW), and through its technical cooperation agency (GTZ) to support public health management and to develop policy guidelines in various areas. The GTZ programme component responsible to support the MoH in the management of physical assets had been contracted out to EPOS Health Consultants.

- GTZ programme support is typically provided at central level in parallel with activities in the field, encouraging integrated and participative approaches in the periphery as a fundamental principle.
- Consequently, field experience can inform the decision-makers, and influence at the centre can support the field activities. This two-pronged approach has proved successful and gives GTZ a reputation in the MoH for offering realistic models and relevant experiences.
- The German Development Cooperation agencies are considered important donors in the health sector in Cameroon and have consequently a certain political weight in discussions with the MoH.
- This allowed for critical voices to be raised, and to demand that a HCT policy be developed as condition for future support, which was echoed by other donors, notably the African Development Bank (ADB), the World Bank (WB), and the French Cooperation (AFD).
During 2004 the MoH commissioned from its own budget a national baseline study on the status of HCT in Cameroon, resulting in a detailed report, with critical analyses and proposals for improvement. However, reaction to and discussions of this report were slow.

Preparations for a Sector-Wide Approach (SWAp) in the health sector since 2005 lead to increasing pressure on the Ministry to review the current health sector strategy and to engage in a strategic planning exercise. In a SWAp all significant funding for the sector supports a single sector policy and expenditure programme, under government leadership, adopting common approaches across the sector, and progressing towards Government procedures to disburse and account for all funds. [1]

The Minister of Health eventually appointed a committee giving it the mandate to develop a draft for a comprehensive National Healthcare Technology Policy. The author had the privilege to be a member of this committee and could support the drafting process through facilities and funding provided by the German Technical Cooperation GTZ. The insights and experiences gained during this process are the subjects of this presentation.

4 The Policy Development Process

4.1 The Drafting Committee

During August 2006 the Minister of Health appointed a committee with the mandate to prepare a draft for a HCT policy document, to be submitted after three months.

The committee of eleven was made up as follows:

- Director of Healthcare Organisation and Healthcare Technology, as chairperson;
- 6 Assistant Directors (HCT, Maintenance, Infrastructure, Budget, Personnel, Planning);
- 2 Field Officers (District Medical Officer, Provincial Engineer);
- 2 Donor Representatives (ADB, GTZ).

After initial discussions with MoH partners three keynote papers were proposed with the aim to clarify the task of drafting a policy document, to guide the process and to help focus the discussions of the committee.

4.2 Three Keynote Papers

Presentation A. Policy as Part of an Improvement Process. This document was prepared using various management texts and policy documents to deliver the essential message: Policy = Drive for Quality. A policy should provide a coherent framework for solutions to current problems, assuming that these have been identified and should therefore be understood as an important aspect to help continuously improve services, which is synonymous with the concept of quality. In addition, government service has to demonstrate responsibility and accountability to the public.

Quality Service Delivery should be:
- effective
- equitable
- patient (=client)-centred
- safe
- timely

Policy appears as one of the important enabling conditions in the EFQM model on how to achieve improvements:

![EFQM Model Image]

For the purpose of the committee work the following definitions were used:

- **Policy** (also framework policy or macro policy): development of overall vision and framework, based on actual situation; it should provide long-term goals and suggest long-term strategies, as well as guidelines for essential aspects.
- **Strategy** (also strategic policy): choice of an approach to realise particular policy guidelines for the medium term, taking into account identified priorities and means available.
- **Protocol** (also operational policy): defined principle or procedure for specific management aspects.

It was proposed that the HCT policy framework should make the following commitment for its vision: To create a Healthcare Technology System that is consistent and ensures optimal distribution of the limited resources, to facilitate equity in access, with the ultimate aim of improving the quality of health services and enhancing positive health outcomes.

Presentation B The Roles of the Ministry.

An analysis of the existing organisational chart of the MoH and long-term operational experiences was presented leading to the following observations:

**Dilemma:** The MoH is Regulator, Controller, Enforcer, Leader, Coordinator, Service Provider and Administrator all at the same time, hence checks and balances are difficult to achieve. In addition, government procedures are generally cumbersome and budget provisions insufficient to fulfil all responsibilities. Therefore the search is on for options to make the most within the current system, but one should also consider if alternatives outside the current system could be realistic solutions.
Conclusions: The Ministry of Health has a wide range of roles to play with different responsibilities often split between, or mixed in, different departments. A HCT Policy would be an important guide for effective management of the government health services, but should also be a regulatory tool for particular aspects in the non-governmental sector, covering private and confessional health institutions as well as HCT suppliers and service providers.

Presentation C: The Policy Formulation Process.
This presentation was primarily based on relevant WHO publications. [4, 5, 6, 7, 8, 9]

4.3 Preparatory Committee Meetings (2 sessions)
The keynote papers were presented to the committee during its first two meetings, which had to be delayed until November 2006 due to administrative reasons.

Initially there appeared unease and uncertainty amongst committee members about the seemingly daunting task and the numerous aspects of the process, particularly because the mandate was to go beyond the maintenance of medical equipment, as some members had understood. Instead the task was to develop a policy for comprehensive HCT management, including the management of installations and buildings. The committee came to realise that maintenance, in order to be effective, was to be seen as part of a complex cycle of technology management, and not simply a question of ad-hoc technical fixes.

A further challenge was the term ‘policy’, because the working language of the committee was French, which does not differentiate between the terms ‘policy’ and ‘politics’, there is just one expression - ‘la politique’. Hence ‘policy statement’ would be translated as ‘statement of principle’ which has a somewhat different connotation.

In retrospect the three keynote papers proved to be ice-breakers, provided invaluable guidelines, and allowed two discussions to be initiated and quickly concluded:

1. Establishment of working principles of the committee, like time table, procedures and internal responsibilities:
   - Weekly meetings were agreed as the only way forward to achieve the task in the prescribed time frame;
   - Discussion papers and proposals on agreed topics to be prepared in advance by individuals or small working groups;
   - In addition to regular minutes, records were to be kept of all ideas and contributions made during the proceedings even if not immediately relevant to the current discussions, in order to establish a ‘memory’ of ideas for later inclusion at the appropriate moment. This approach was proposed in order to encourage participation of all members.

2. Agreement on the schedule of the policy formulation process:
   - Presentations of the baseline study and other relevant experiences;
   - Situation analysis: to highlight the major problem areas, undertake a SWOT analysis, propose possible solutions;
   - Definition of the important policy elements which would address the problems identified;
   - Identification of the major strategies and management systems to support the policy elements;
   - Consideration of processes and structures to be adapted or introduced;
   - Revision of the draft policy document in an enlarged circle to help arrive at consistent and realistic proposals;
   - Reworking of the proposal where needed;
   - Presentation of draft to the Minister of Health requesting approval for validation;
   - Validation and publication as the official HCT policy document.

4.4 Committee Work (14 weekly sessions)
- The consultant of the baseline study was invited to present an analysis of the overall situation. [2]
- Other experiences by the Ministry, by various projects and donors, and by the private sector were presented, including the GTZ experience with decentralised maintenance as an integrated approach on district level, coupled with a certain supervision concept.
- Additional policy papers, documentation and WHO recommendations were introduced.
- Presentations and proposals were discussed and scrutinised for relevance.
- Group brainstorming proved useful at certain stages, using mind-mapping software on a laptop with video projector, which allowed ‘live’ documentation of the deliberations and immediate feedback to participants. This approach was also successfully used to present extracts and conclusions from existing reports and analyses as a basis for further discussions. It allowed the committee work to remain focused and to proceed relatively swiftly, but demanded careful preparation of the meetings.
- The initial problem analysis was thus developed and eventually enriched by a SWOT analysis (Strengths – Weaknesses – Opportunities - Threats), which lead to the identification of priority aspects and slowly allowed agreement to emerge about essential policy elements and the general document structure.
- Discussions on the policy implementation approach seemed the most difficult aspect, as all options necessarily lead into uncharted territory. From various approaches proposed and considered a decision was nevertheless reached unanimously.
- Small working groups then developed the individual chapters and elements.
- The committee scrutinised, discussed and assembled the document as initial draft.
4.5 The First Draft

- The First Draft of the policy document was sent out to a selection of 40 healthcare professionals on operational and central levels, with countrywide representation, including private and confessional institutions. A two-day seminar was subsequently conducted to allow reflection over the draft, where background information and concepts were presented before topical discussions were held in various working groups. Committee members were participating in the working groups to clarify issues where needed and to note the sentiments expressed. The conclusions were presented by the working groups and documented in a detailed report by the moderator, summarised as follows:
  - a need to reduce the quantity of information and proposals made in the draft to ensure that essential messages are not diluted;
  - a need to improve consistency between several policy aspects;
  - consensus was reached on the structure and format of the policy document.
- The committee discussed the report of the moderator and other observations and impressions gained and made appropriate modifications to the proposal.
- The Second Draft of the HCT policy document was then presented to the Ministry of Health in March 2007, to be forwarded to the Minister for appreciation and approval, so that a national validation process could be initiated.

The drafting committee had thus concluded its task during an intense period of work covering four months, inclusive of one national seminar.

4.6 The Validation Process

Due to a highly centralised decision-making process in the Ministry various delays were subsequently encountered through lost instructions and slow follow-up. A change of Minister followed, which was however seen as an opportunity to re-introduce the HCT policy document as a priority issue. Indeed, instructions to validate the document were given and the drafting committee was once more called upon to participate in a validation seminar during November 2007, uniting 35 healthcare professionals with countrywide representation.

A select working group had been given the authority to finalise the document, and issues raised during this seminar were discussed and when considered relevant were incorporated into the policy. The validated HCT policy document was then sent to the Minister for approval.

The document was consequently presented by the chairman of the drafting committee to the annual conference of all high-level MoH functionaries in January 2008. The document is expected to receive approval for the final format in which it is to be published during April 2008, before translation from the original French version into English followed by the official bi-lingual launching by the Minister of Health.

5. The Structure of the Policy Document

After an introduction and some background information the document presents an abbreviated situation analysis, areas of application and the key objectives.

The policy document has been drafted in alignment with WHO recommendations, it relates to the EFQM management model and should be seen as an important step in the SWAp process as regards to rational HCT management. It also refers to the particular responsibility of public institutions regarding energy management, to reduce waste and unnecessary consumption in the face of Global Warming.

The document then introduces the four phases of the HCT management process, which are linked in a cyclic fashion, requiring appropriate management systems, but taking place in different administrative contexts. This leads to the presentation of the following ten policy elements:

- **Four Key Policy Elements** representing the four phases of the HCT management process:
  2. **Planning & Budgeting**: output: decisions based on needs assessment.
  3. **Acquisition & Commissioning**: output: appropriate material, equipment, etc.
  4. **Operational Phase**: use of HCT, maintenance, etc.

- **Six Transverse Policy Elements**:
  5. Human Resources
  6. Financing and Economic Issues
  7. Public – Private Partnerships
  8. Legislation, Regulations, Safety
  9. Information Management
  10. International Cooperation

- **Implementation, Monitoring & Evaluation**:

The final element covers the mandate of the proposed commission to be charged with guiding the implementation of the HCT policy, and the relevant steps to be taken by it. It is the task if this commission to use the strategic principles of the policy to determine what kind of structures, guidelines, instructions, standards, procedures etc. will eventually need to be developed. These processes need to be understood as dynamic in order to allow for correction and fine-tuning as well as adaptation to organisational and HCT developments, as policy implementation is a process and not an event. The reasoning behind the proposed HCT implementation process is described in more detail in the following chapter.
Each of the ten policy elements consists of one policy statement (= objective), plus some important strategy elements to define the framework of desired action, to give direction and to indicate essential considerations.

The committee debated the inclusion of further policy elements, but it was felt that the priority issues to be addressed in the foreseeable future are adequately covered by these elements. Adding more policy elements would carry the risk of diluting the essence of the document. The proposed HCT policy is consequently a concise document of just 17 pages addressing the above areas of major concern.

6. Proposed Approach to Policy Implementation

The external consultant who had conducted the baseline study had originally proposed two alternative solutions to make HCT management more effective in the Ministry:

1. Creation of an autonomous nationwide structure charged with all aspects of HCT management on behalf of the MoH, including purchase, operation and maintenance, with its own budget and personnel structure. This could be either a para-statal organisation or a private contractor.

2. Restructuring of the Ministry, with an organisation chart more suitable to efficient HCT management on all levels.

These ideas were considered by the committee, but were found wanting for various reasons:

- Both proposals require a lengthy political process to prepare the necessary legal basis as well as presidential approval for the desired changes to take effect.
- Considerable organisational modifications are proposed. In the long run this might indeed need to happen, but the current basic management problems would not be solved by organisational changes alone.
- Creation of an autonomous structure would require the clear definition of countless interfaces with the Ministry and with health facilities, a difficult process requiring also considerable management and legal skills.
- Such an approach is likely to duplicate many organisational features of the MoH and is likely to be plagued by the same management weaknesses, political interference and nepotism, risking even more wastage.
- It is an illusion that HCT management can be successfully outsourced without proven political will and responsible supervision of the external organisation by the client ministry. While these are exactly the current weaknesses of the MoH.
- No private organisation or company in Cameroon currently has the capacity in terms of staff or means to manage a proposed nation-wide service, and there is a lack of qualified and motivated staff both in the public and private sector.
- Budgetary constraints currently would not support such an approach.

After long discussions and much consideration, the committee finally agreed to propose a different solution in order to capitalise without much delay on a certain dynamism currently displayed by the MoH: specifically by attempting to reform the HCT management processes from within the existing structures and to make health care institutions more responsible and accountable for their own equipment and infrastructure. Private HCT service providers should be involved wherever their capacity would be considered a cost-effective alternative. Even the consultant of the baseline study was eventually in agreement with this approach.

The proposal calls for the creation of a permanent commission directly reporting to the Minister, with all departments represented amongst whom the responsibilities for HCT are currently dispersed. This body should have the authority to establish priorities according to the HCT policy document, to develop an appropriate plan of action and to oversee its implementation. Expected advantages are:

- The process can be initiated by simple ministerial decree;
- Progress and impact can be monitored through the commission;
- It is a low-risk approach, without creation of new structures based on hypothetical concepts and assumptions;
- The approach allows the MoH to demonstrate the required political will and attitude as well as quality consciousness;
- It allows easier involvement of the local community on peripheral level to demand better quality of service through existing dialogue structures;
- If concrete experience shows that certain organisational changes should indeed be effected in the long run then these can be initiated while the policy implementation process is continuing.

7. Lessons Learnt

7.1 Drafting Committee

The importance of choosing the right committee members can not be over-emphasised, as there is need for a dynamic core group to drive such a process, otherwise the exercise would be stillborn from the outset. In the present case this turned out to be a group of four committed individuals, while two members were inactive for all practical purposes. It is essential to identify enthusiastic individuals who can express themselves in a critical but constructive manner, and who see the need for a consistent policy based on their own professional experiences. The choice of committee members is a delicate balancing act, it has to be inclusive and representative while it must not appear to be a donor driven exercise. Nevertheless some influence must be taken to arrive at a committee that it likely to deliver.

The three initial keynote papers had been proposed rather intuitively in order to focus the first discussions. The approach proved very useful for the intended purpose and our recommendation would be that such introductions should be very carefully crafted to the national context.
A strict schedule of weekly meetings was recognised as the only way to remain focused and to achieve the task in the prescribed timeframe. More frequent meetings would not have been possible given the busy schedules of committee members, but demands had to be made on some members to participate in smaller groups and to prepare presentations for subsequent meetings.

The drafting committee had decided that the external consultant of the baseline study should only be invited as resource person at certain stages, so as not to monopolise the proceedings. A continuous dialogue was however maintained throughout the drafting process and the consultant also participated in both seminars and the validation of the policy document. The approach proved fruitful as the consultant could present a range of analyses and alternative views and still identify with the process at all stages.

The need to prepare documents and proposals and to synthesise reports ahead of meetings became apparent early on, otherwise too much time was lost in the search for essential information and in the discussion of minor details. Sub-groups of two or three committee members undertook these tasks.

Mindmapping with a laptop and video projector proved to be a veritable accelerator at particular phases of the process, as it focused the discussions and provided documentation and feedback at the same time. A freeware product was used by the committee [3] which allowed interested members to use the software at their own discretion.

The proposal to establish a ‘memory’ of all ideas expressed during discussions for later inclusion at the appropriate moment proved popular as a concept but was difficult to follow consistently. However, whenever the mindmapping software was applied it conveniently and easily provided this kind of function as a bonus.

Small incentives like snacks and beverages, the payment of transport allowance for weekly meetings, and of allowances for presentations and guidance of working groups during the seminars contributed to a smooth process at all stages.

Availability of allowances to pay external resource persons was also considered essential to ensure timely presentations.

The access to efficient office services and facilities (communication, duplication, secretarial services, video projector) was a prerequisite for progress in the drafting process.

The two seminars to sensitise and involve a larger group process.

The role of GTZ / EPOS as catalyst was certainly an important influence, but a balance was always sought to remain a facilitator and contributor and to avoid being seen as dominating the exercise.

7.2 Risks of an Ambitious Policy

During the drafting process the tendency emerged to get into too much detail while it was realised that the document must not become a list of specific instructions, which would limit its application. If the policy document is too technical and complex, the validation process is likely to last longer or might not even succeed, because of misunderstandings and resistance to change. This was noted during the seminar discussing the first draft, which was considered too restrictive. The HCT policy should be a strategic guide, but if too general then it risks being toothless and ineffective. One therefore needs to find a compromise between the number of policy elements and their degree of generalisation to allow some flexibility. Even during the implementation phase an overloaded policy is likely to loose traction.

7.3 Duration of the Policy Development Process

Considering that the baseline study was conducted during 2004, that the mandate to develop the HCT policy was issued in August 2006 and that the document has not yet been officially launched at the time of writing in March 2008 shows the difficulty to implement changes in a government bureaucracy. As a facilitator one must not be discouraged, it is part of the process of change management while at the same time it is important to remain focused and to keep up a certain momentum. Maintaining contact with the enthusiastic members of the committee throughout all delays proved essential to identify opportunities to advance the process and to vindicate the efforts of all involved.

7.4 Next Steps

Once the policy has been validated and adopted the tendency is to sit back, relax and bask in the glory and satisfaction of achievement. While in fact this is only the beginning of the hard work, to start implementing policy recommendations: to appoint the supervising commission, to decide on priorities, to develop strategies in detail, to lobby for support, the modify procedures, to develop reference documents and manuals, to train people, to develop structures, to obtain necessary hardware, and to monitor and adapt the process.

8. Cost Estimate of Validated HCT Policy

A rough estimate is given of specific expenditures to develop the first HCT policy document for Cameroon, starting from the baseline study to reach the validation stage, but excluding the cost of staff contributions involved in the exercise.

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount (£)</th>
<th>Percentage</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Study, 6 months</td>
<td>72,000</td>
<td>66%</td>
<td>MoH</td>
</tr>
<tr>
<td>2 Provincial Seminars</td>
<td>7,000</td>
<td>7%</td>
<td>ADB</td>
</tr>
<tr>
<td>2 Participants Internat.Conference</td>
<td>6,000</td>
<td>6%</td>
<td>GTZ</td>
</tr>
<tr>
<td>Committee Work, 4 months</td>
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<td>6%</td>
<td>GTZ</td>
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<tr>
<td>2 National Seminars</td>
<td>17,000</td>
<td>15%</td>
<td>GTZ</td>
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</table>

approx. Total 214,000 USD = 108,000 GBP = 137,000 EU
9. Conclusion

Assisting the HCT policy development process in Cameroon has been a rewarding exercise, even if that policy remains first of all just a document. But it is an essential reference for future actions and if there is a certain political will to improve service delivery to the population, a consistent HCT policy will make an important difference. We accept that despite its shortcomings we have to work with government bureaucracy as the medium for organisational change to improve its own performance and to allow alternative approaches to emerge in order to serve the population better.

Many countries are still finding it difficult to agree on a Healthcare Technology Policy or even on the need for one. Sharing the experience of the HCT policy development process in Cameroon and the lessons learnt from it will hopefully encourage other colleagues to overcome difficulties and reluctance in their administrations. Transparent and consistent management is no doubt a key aspect for successful reform, to provide acceptable quality of health services in an increasingly complex technical environment, and for attracting donor support in the future.

To paraphrase Abraham Lincoln: a Healthcare Technology Policy should be 'of the people, by the people, for the people’. Such a policy must have a vision, but it must be realistic to be effective.

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