LIGHTINGS

Strategic Health Information Bulletin in Cameroon: Volume 1, N°2; 30th November, 2009

Editorial

With this second issue, Lightings is providing you with fruits of our efforts to synthesizing scattered data available on healthcare financing in Cameroon. Indeed, if estimates from inquiries by the National Statistics Institute and the World Health Organization depict an image of the monetary dimension in the formal and informal modern sector, one should recognize that the monetary and material expenses for purchasing African traditional healthcare usually remain underestimated. With the advent of global innovative health financing mechanisms, we propose a short overview of what is the SWAP mechanism as well as some strategic options to accelerating the enrolment into community based health insurance schemes also known as health mutual organizations. While enjoying this issue, please feel free to share with us your comments and suggestions for improvement at cdbpsh@yahoo.fr. Enjoy it!

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HIGHLIGHT: HEALTH FINANCING

After its independence in 1960, Cameroon economic growth rate has been sustained till late1970s to mid 1980s, regrettably short-lived due to the concentration of the efforts mainly in urban areas and industrial sector, rural areas and social sectors being less underserved. The economic crisis during the 1980s and 1990s has engendered a drop of the national human development index from 0,504 in 1985 to 0,481in 1995 and 0.523 in 2007 ranking 153rd globally. The health sector has been one of the most hit with severe alteration of health indicators. Despite improvements observed in terms of geographical coverage of health facilities, a lot of inequalities between regions remain.

The Government was urged to disengage during the period of the economic crisis by requirement of the structural adjustment plans. Thus was established de facto a decentralization process of management and financial autonomy for almost all types of health facilities. Indeed, the burden of healthcare financing rely on sick patients, their families and relatives. Households' contribution to health expenses has been constantly increasing since 1996, 73 % out of 173 billion CFAF, 83 % out of 409 billion in 2001 and 90 % out of 600 billion in 2007 (World Health Statistics Report, RSM, ECAM). At the same time, the number of persons temporally or permanently excluded from timely access to the health services and the basic health care has been on the rise.

Despite numerous mechanisms set up by the Government in collaboration with his technical and financial partners to reduce financial pressure on households and to improve financial accessibility to certain basic health services and care, households' contribution to purchase healthcare and health services is still paid from savings by an average of 93%. Although the prices of essential medicines were harmonized and reduced by 65 % in state and churches health facilities, purchasing generic medicines for non communicable diseases such as high blood pressure, diabetes or degenerative osteoarthritis remains rare and paying for medicines and health technologies represents close to 71% of the total health expenditures. By paying up to 94.8% of the private total health expenditures through out-of-pocket at the point of care, Cameroonians whose 39.9 % live below the poverty line are unlikely to always expend wisely and rationally while purchasing healthcare or health services because less than 3% do have a health insurance scheme. The health financing reform paper is combining strategies to reduce financial barriers to healthcare, to promote health risk sharing mechanisms as well as a transition towards a Sector Wide Approach (SWAp) aiming at enhancing coordination, alignment and harmonization amongst health development partners to ensure a greater effectiveness of public spending within the health sector.

FAQ: WHAT IS A SWAP?

The SWAP (Sector Wide Approach) is a mechanism aiming at enhancing the effectiveness of the international aid and cooperation in a given developmental sector. This approach brings together Government's efforts along with the international and national technical and financial partners for health sector development. The SWAP is characterized by the implementation of synergistic mechanisms amongst interested parties instead of stand alone programs usually crafted by international donors with typically little coherence with country policies and strategies.

Leaning on Paris Declaration to enhance the effectiveness of international aid for development that encourages alignment and harmonization of supportive procedures, the SWAP mechanism comprised the adoption and implementation of common operating procedures under the leadership and the coordination of the Government. In a given sector, external donors as well as national donors align their aid to agreed national priorities and strategies while harmonizing their operating procedures.

Typically, the Government and his partners will commonly adopt processes and procedures in order to (1)elaborate a common program, an updated sector strategic plan with a comprehensive budget integrating all sources of financing and presented as a Mid Term Expenditure Framework (MTEF); (2) supervise and evaluate the implementation of the common sector strategy and inform all stakeholders, including civil society; (3) supervise the resource management while making sure that all the financing sources and procedures are simplified and integrated; (4) ensure coordination of the various actors. Government's leadership is assumed to be inclusive in managing of all the available resources (state internal resources, external cooperation). However, SWAP is not synonymous of money, although financing constitute one of the essential ties.

Over 85% out of one hundred SWAPs operating worldwide are located in Africa mainly in sectors such as Education, Health and Agriculture. Beyond common planning mechanisms, follow-up and evaluation, financing, disbursement and coordination, the three common financing approaches are: i) common basket, ii) budgetary support and iii) multi donors programs. Report evaluations of SWAPs is are positive in terms of effectiveness in fostering coherence and enhancing harmonization of the international aid in a given sector. A part from the Health SWAP in preparation since 2005, the forestry sector is implementing a SWAP in Cameroon. The Health SWAP is due to speed up the implementation of the Common Plan in 2010.

2. HEALTH EXPENDITURES

The percentage of the national Gross Domestic Product (GDP) allocated to Health Expenditures was estimated by the WHO as high as 4.6% corresponding to the average mean among Middle Lower Incomes Countries according to the World Bank. Private ex- constitute the main source of financing 78.8% of the total in comparison to Congo Brazzaville where the public expenses are as 71.7% during the same period. The mates of total amount spent for health close to 600 billion CFAF. External financ- represented approximately 8.0 % in 2006, ing so widely the average of the MLIC but low the average funding observed in the region of the World Health Organization These estimates stemming from the World Statistics Report 2009 are based on statistics and other economic database the United Nations System generated from gathered during the past 10 years. These mates are still to be improved mainly be- the weaknesses of national health man- agement information systems and absence able national health accounts and difficul- getting the exact and exhaustive declaration of contributions by technical and financial partners.

Tableau N° : Dépenses de santé au Cameroun comparées à celles des pays à revenus intermédiaires et à la moyenne des pays de la zone OMS AFRO*

		Cameroun	Congo	Maroc	Soudan	Chine	Inde	PRI	Pays AFRO*
% du PIB alloué aux dépenses totales de santé	2000	4,6	2,1	4,2	3	4,6	4,3	4,5	5,5
	2006	4,6	2,1	5,3	3,8	4,6	3,6	4,5	5,5
Contribution (%) du Gouvernement aux dépenses de santé (%)	2000	22,5	57,7	29,4	26,3	38,3	21,8	39,2	44,8
	2006	21,2	71,7	26,2	36,8	40,7	25	43,2	47,1
Contributions privées (%) aux dépenses totales de santé	2000	77,5	42,3	70,6	73,7	61,7	78,2	60,8	55,2
	2006	78,8	28,3	73,8	63,2	59,3	75	56,8	52,9
% du budget du Gouvernement alloué à la santé	2000	6,8	4,8	4	7,2	11,1	3,3	7,9	8,2
	2006	6,7	5,4	4,8	5,8	9,9	3,4	8,2	8,7
Contribution (%) de dépenses extérieures	2000	4,1	4,6	0,8	4,8	0,1	0,6	1,1	6,8
	2006	8	3,4	2,5	6,5	0,1	1	0,6	10,7
dépenses de sécurité sociale (%) / dépenses totales du gouvernement	2000	0,1	0	0	9,3	57,2	5,8	38,7	8,2
	2006	0,1	0	0	12	57,3	4,9	40,3	7,6
% de Paiement direct par rapport aux dépenses privées	2000	94	100	76,6	100	95,6	92,1	91,4	55,9
	2006	94,8	100	77,3	100	83,1	91,4	85,7	49,8

*Région Africaine de l'Organisation Mondiale de la Santé (OMS)

3. CAMEROONIAN HOUSEHOLDS' CONSUMPTION

The contribution and the structure of household expenditures stratified by quintile of population (edges of 20% population), shows (table 1) profound disparities in the distribution of incomes.

Contribution of the households to the various types of expenses

The relative part of contribution of the poorest households belonging to the first one quintile (Q1) represents 4.8% of the total expense against 52.5% for the richest households (5° quintile, Q5). This disparity is more garish when we compare the expenses related to essential social services and the expenses to purchase non essential goods between the various quintiles. This situation can be explained by high prevalence of poverty within the Cameroonian population, 39.9% in 2007 (ECAM 3).

Structure of household expenditures according to quintiles

Table 2 illustrates the share of household expenditures for health not higher than 5.3 to 8.3 %. The richest are allocating a larger portion of their resources for health, therefore deepening the inequalities in access to healthcare and services amongst Cameroonians.

Tableau 1: Contribution de quintiles aux différents types de dépenses des ménages

Postes de dépenses	Q1	Q2	Q3	Q4	Q5
1. Biens de consommation de base	5,4	9,5	13,5	21,2	50,35
2. Biens de consommation non essentiels	4,4	7,7	11,8	20,5	55,9
3. Services essentiels					
- Education	1,6	4,4	9,8	21,3	62,9
- Santé	3,4	7,1	12	18,9	58,6
Dépenses totales	4,8	8,8	13,2	20,8	52,5
source de données ECAM II					

Tableau 2: Structure des dépenses annuelle des ménages par Quintille

Postes de dépenses	Q1	Q2	Q3	Q4	Q5	Ensemble
1. Biens de consommation de base	73,6	70,1	66,8	62,0	48,4	56,8
2. Biens de consommation non essentiels	19,3	21,2	22,2	25,5	36,5	30,1
3. Services essentiels						
- Education	1,9	2,8	4,2	5,8	6,8	5,6
- Santé	5,3	6,1	6,8	6,8	8,3	7,4
Source de données: ECAM II						

4. HOUSEHOLDS' CONTRIBUTION TO HEALTH FINANCING

Paying for healthcare and services relies on public and private contributions, particularly those of the households. Households' contribution has been constantly increasing from 73% in 1996 to 83% in 2001 and 90% in 2007. The total annual health expenditures per household vary between 48,000 and 148,000 CFAF. In 2006, the monthly estimate of health expenditures for curative health per capita was on average 1,454 CFAF [1,671CFAF for women; 1,222 CFAF for men; 1,948 CFAF in urban areas versus 971CFAF in rural areas]. During the same period according to MICS 3, 14% of the households have spent 651 FCA for preventive health [994 CFAF in cities and 310 CFAF in rural areas].

44% of the ill persons actually resort to self medication. Medicines and health technologies, often irrationally purchased, constitute 71% of the total health expenditures largely made through the informal sector (parallel stocks of medicines in health facilities, cash payments to healthcare practitioners, purchase of medicines and care in illicit health facilities).

Financial resources to purchase healthcare or medicines are various, relatives out of the household contribute for about 10%, salaries or available cash contribute up to 62%, savings as high as 24% and loans with or without interests up to 8%. Considering the overall amount of expenditures, savings are used to pay 93% of the bill. The structure of the expenses for curative health stands as follows: purchasing of medicines and health technologies: 71%, medical consultations, care and hospitalization: 14% and 3% for transportation.

READING NOTES

HEALTH CARE COVERAGE BY ASSOCIATIONS FROM BIYEMASSI DISTRICT - YAOUNDE

RESEARCH REPORT BY SÉVERIN CÉCILE ABÉGA ET NOËL SOLANGE NGO YEBGA

This paper was prepared as a research report from the project entitled: "Local Organization of Health Policies in Central Africa". It attempts to clarify if "community-based associations could be actors in health financing matters thus bringing to light the precariousness of the populations as well as individual vulnerability". While studying community-based associations in Biyemassi, authors underline the paradoxical behavior of these associations with regard to health risk management. Indeed, if all the associations were concerned by the health of their members, the action taken in case of illness was far to be consistent with the level of concern. Usually benefits to those facing disease were as high as 10,000 to 20,000 CFAF, amount that would rarely afford severe health problems. The lowness of the helps cannot be understood only by poverty of members because more substantial sums are disbursed for funeral ceremonies and the organization of fiests.

Being member of a community-based association is an important reality in the urban environment in Cameroon. Enrollment in these entities is typically voluntary or sometimes mutually agreed as a support process for the better insertion of recently arrived countrymen in town. Although associations are diverse in their founding grounds, mutual aid and support as well as solidarity are the fundamental bases of these various groupings and take the shape of a financial or psychological assistance which goes beyond the solidarities pre-established by the religion and the belonging to an ethnic group. People in need, including health care in case of disease, can borrow money from the association thus receiving quickly liquid assets, while creating certain precariousness. When confronted with ill health, the amount of money received is usually small. Typically, a lump sum is given to persons in need no matter the severity of the disease. Few associations are organized to assess the disease severity and to provide financial support accordingly. In the later, the amount is also related to the foreseen effectiveness of the care seeking behavior. This financial assistance could also be loans from the "savings bank", or from ad hoc fund-raising scheme usually dedicated to supply the lowness of the benefits from the "health fund". Finally the procedures, even simplified, to ascertain the right for a member to be recipient of any financial assistance in case of a disease can take time and the lowness of the grant does not justify complex procedures.

Recommended Readings on Health Financing

1. Statistical directory 2009, National Institute of Statistics INS
2. Households' Consumption Surveys, ECAM II 2004, ECAM III 2007
3. Demographic and Health Surveys in Cameroon EDSC II 2001, EDSC III 2004
4. Determinants on recourse to care and medicines (RSM 2004) Ministry of public health
5. Multiple Indicators Cluster Survey (MICS 3, 2006), INS
6. Health Sector Strategy of Cameroon 2001-2015, Ministry of Public Health
7. World Health Statistics Report (WHS 2009) WHO
8. Policy brief on scaling up the enrolment in community based Health Insurance in Cameroon, CDBPS, 2009
9. Hill PS. The rhetoric of sector-wide approaches for health development. Social Science and Medicine 2002;54:1725-37

SCALING UP THE ENROLMENT IN COMMUNITY BASED HEALTH INSURANCE

In order to provide affordable and accessible health services and health care to people living in Cameroon, the Government has undertaken a health sector reform aiming at strengthening all the 178 health district systems through a SWAP geared towards improving the quality of care and supporting the demand side. Community-based health insurance known in French as Mutuelles de santé (MS) were identified within this framework as one of the strategies to promote voluntary health insurance and to improve the financial accessibility of health services and care for the poorest by reducing out-of-pocket payments at the point-of-care. Recent evaluation has established an increase number of CBHI organizations but less than 3% coverage rate in the general population in comparison to 40%-target by the year 2015 set forth by the strategic paper to promote CBHI in Cameroon. To accelerate the adhesion in MS, contextualized strategies relative to governance and regulatory arrangements, financial arrangements and delivery arrangements are utmost needed. Key messages from a recently issued policy brief entitled "Scaling up Enrolment in Community Based Health Insurance in Cameroon" are outlined hereafter.

Cameroonian households bear about 80% of their invoice for health care through out-of-pocket payments in 94.8 % during episodes of disease. The absence of a pre-payment system for health care is considered to be the most inequitable way of purchasing care because it does prevent a large share of the population particularly in the low-income countries from a timely access to the appropriate health care and favour catastrophic expenses pushing numerous households into poverty. In 2007, the National Statistics Institute has established that 39.9% [12.2% in urban zones and 55 % in rural areas] of people in Cameroon were living lives below the monetary poverty line set at 269.443 CFAF/year and per adult equivalent and the mean household annual health expenditures vary from 48.000 to 148.000 CFAF, 81% being allocated for medicines and health technologies. It was also reported that out-of-pocket payments constitute one of the enablers for coping attitudes and bribery practices in many public health facilities.

Some of the reasons of the weak craze to the MS are the poor understanding of the notion of risk sharing in case of a disease in the general population, the distrust towards financial management of the MS; populations do not still perceive or are not convinced on the utility of the MS in terms of improving the accessibility and quality of the care, as well as the reduction of catastrophic expenses.

According to available literature, MS on exclusive community base would but not succeed if they should constitute the only model of voluntary health insurance. The factorial analysis of the weak cover of the MS in Cameroon shows that the weakness of the institutional and regulatory support as demonstrated by the laissez-faire, the absence of appropriate legal framework, the lack of information and communication, absence of "visibility" on the package of services and care flatware, are so many factors which undermine the penetration of the MS.

Three strategic options are proposed to improve the adhesion of populations in the MS:

1. ***Creating and sustaining an enabling environment to promote and support the MS***

Implementation Barriers: means to enforce laws and regulations related to creation and operation of MSs; distrust vis-à-vis MSs Management; poor quality of care; resistance to change among healthcare providers.

Strategies: Establish laws and regulations related to creation and operation of MSs; Build on existing community-based organizations, associations, micro finance institutions and local municipalities to promote voluntary health insurance through MSs; reforming hospital management to improve quality of care, transparency and accountability; banning out-of-pockets payments at point of care; Management support to an umbrella organization with merging of several MSs to increase purchasing power at the district level.

2. ***Subsidizing premiums by Government, Partners and Local Municipalities to prevent financial barriers for the underprivileged and improve affordability of premiums***

Implementation Barriers: budgetary constraints for subsidies, corruption with price inflation on healthcare costs and drugs; the poorest populations cannot afford even the low premiums; resistance from the private sector with conflicting interests.

Strategies: Partnership between Government and FTP for financial subsidies to users and/or MSs to improve access of the poorest of the poor unable to pay premiums, engaging local municipalities to subsidize premiums for indigents, establishing norms and standards to improve quality of care, enforcement of the national drug procurement policy to contain inflation on drugs and health technologies.

3. Establishing flexible revenue collection mechanisms; organizing trustworthy and attractive risk-pooling and purchasing mechanisms

Implementation Barriers: Insurance Pool fragmentation, lower subscription rates due to voluntary nature of schemes, mistrust.

Strategies: participative definition of the package of care, flexible payment of premiums to adapt to the instability of incomes of those in the informal sector and rural populations revenues linked to cash crops, rationalizing production costs in healthcare organizations and promoting quality of care in health facilities.

A common barrier for all these Policy Options is the lack of knowledge of the general public and healthcare providers relative to the advantages of MSs, side effects of out-of-pockets spending in health facilities, negative effects of corruption and quality of care. Strategy: Information, Education and Communication for behavioural change among the general public and healthcare providers through the mass media.

POPULATION HEALTH STATUS IN CAMEROON (CONT)

A. COMMUNICABLE DISEASES

To complement our description of the major communicable diseases that are Malaria, HIV/AIDS and Tuberculosis in the previous issue of Lightings, we describe here after some of the rare data available on some other infectious diseases. ***Viral hepatitis*** *and* ***other highly contagious infectious diseases of poverty*** *are overwhelming Cameroonians. Despite the absence of a specific surveillance system,* ***hepatitis*** *constitute a heavy burden with estimates of prevalence toping at 10 % and 13 % respectively for hepatitis B and C among patients consulting in gastroenterology services. They make the bed of cirrhosis and primitive cancer of the liver. The co infection HIV / VHC and/or VHB is also a public health preoccupation.*

The surveillance system of ***Potentially Epidemic Diseases****, despite its weak performance (cf. table 1) notes the following trends: C****holera*** *rages as endemic in five of ten administrative regions of the country in particular the Far North (EN), Littoral (LT), North (NO.), West (OU) and South (SU) with an ongoing outbreak since October 2009 in the Far North.* ***Cerebro-spinal Meningitis*** *typically threatens populations from the North and Far North Regions in a cyclic way as it is the case within the "African meningitis belt". Occasionally, outbreaks are observed in the North West and South West regions. Few cases of* ***yellow fever*** *were confirmed thanks to an effective and responsive mechanism. The resurgence of the* ***Poliomyelitis*** *in 2003 with a peak in 2004 of 13 confirmed cases out of 219 cases of acute flask palsies.*

ZOOM: NEGLECTED TROPICAL DISEASES

Neglected Tropical diseases (NTDs) are infectious diseases typically raging in the underprivileged milieu under tropical humid climate. Must of the NTDs are parasitic and transmitted by several vectors, insects, mosquitoes, simulies, phlebotomes, flies of garbage, tsé tsé flies and gastropods.

*Despite the variety of their etiologies, they commonly engender severe incapacities and permanent handicaps such as i) the reduction perms of the human potential, ii) the maintain of several persons in poverty, iii) a heavy economic burden, iv) blindness, deformations or mutilations in certain cases; v) and the death in few weeks or months when they are in an advanced stage. Ranked in an ascending order according to areas at risks and actual prevalence, these NTDs are****: schistosomiasis*** *(> 200 million persons),* ***lymphatic filariasis*** *(> 120 million persons),* ***trachoma*** *which represents the first cause of blindness from infectious origin (> 80 millions victims),* ***onchocerciasis or river blindness (>*** *37 million persons). The* ***Chagas disease*** *is found in America whereas* ***leishmaniasis*** *is present in Africa (> 12 million persons). Other NTDs are the* ***leprosy, Ulcer of Buruli, the African Human Trypanosomiasis (AHT), Guinea worm and geo helminthiasis or as intestinal worms****.*

Approaches to fight NTDs are carried out essentially in the form of vertical programs ensuring mass distribution of drugs whereas specific care are more and more questioned because of the scarcity of resources and available effective interventions. Building on the similarities in terms of clinical presentation and etiological agent, recent global recommendations are geared towards integrated and synergistic strategies for fighting these NTD into three groups in particular (1) Group 1: Leishmaniasis, Pian, the Leprosy and the Ulcer of Buruli; (2) Group 2: lymphatic Filariasis, Onchocerciasis, Schistosomiasis, AHTA and Guinea Worm and; (3) Group 3: Trachoma.

B. NON COMMUNICABLE DISEASES

Cameroonians are increasingly confronted to non communicable diseases (NCD) and chronic diseases. 12,000 new cases of ***Cancer*** *are diagnosed annually on average while prevalence estimates are as high as 25,000 cases according to the WHO in the absence of a national Cancer Registry.* ***Epilepsy*** *rages on the whole territory, with an average frequency of 1,85 % in pediatrics consultations in hospital environment and certain zones reach a prevalence around 5 % particularly facilitated by the* ***neurocysticercosis****.* ***Mental disorders*** *although prevalent are not subject to surveillance.* ***Sickle cell disease*** *touches all age groups, with higher prevalence amongst people aged between 10 and 29 years who represent 89.2 % of the patients. According to DHS (2004), iron deficiency related* ***anemia*** *is highly prevalent (68%) among 6 -59 month- old children with 72% prevalence in rural areas versus 64% in urban settings; this prevalence is even higher (80%) among the age group 6-23 months. In the same line, 51% of pregnant women present anemia with surprising features 59% prevalence in Douala, 48% in Yaoundé and 42% in rural areas.* ***Dental affections*** *for which the dental caries and its complications constitute the first cause of oral health consultations with nearly 85%.* ***Hearing deficiency*** *profile is unknown. According to DHS (2004),* ***obesity and overweight*** *constitute nowadays heavy threats to women's health with regards to high prevalence described in the general population, 41% of women older than 35 years suffer from overweight and obesity versus 28.7% over weighted and 8% obese in the age group 15-49 years. The prevalence of overweight and obesity vary from 44% in Douala and Yaoundé, 33% in other cities to 18% in rural areas. In Douala, 48% of women are overweight and 17% are obese in comparison to 40% and 14% in Yaoundé. The same are respectively 22/4%, 38/12%, 30/6% in the Centre, Littoral and North West regions.* ***Diabetes'*** *prevalence is estimated at 6% of the general population, 85% of the cases are type II. Meanwhile,* ***High blood pressure*** *is encountered in 24% of the population beyond 40 years.* ***Chronic kidney diseases*** *requiring dialysis are constantly rising with more than a thousand of patients.* ***Neurologic complications*** *of high blood pressure such as stroke are among the first motives of prescribing CT scans in Yaoundé and Douala.* ***Arthritis and gastritis or duodenal ulcers*** *are top leading motives of medical consultations at the first line health facilities. Due to this rising prevalence and their relationship with life styles, an integrated approach is needed to ensure prevention and appropriate care as from the first line health facility. Many of the non communicable diseases are not currently subject to any surveillance; AIDS has also become a chronic illness thanks to ART access. Road traffic injuries and traumatism related to urban violence should be added to this picture with their tens of thousands of victims according to the Civil Protection Directorate in the Ministry of Territorial Administration.*

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STRAIGHT NEWS : DELIBERATIVE FORUM ON COMMUNITY-BASED HEALTH INSURANCE NOV 11TH.

As part of our knowledge translation efforts, that's to facilitate knowledge exchange and promote evidence informed policy making, we have organized last 11th November 2009 at Centre Jean XXIII de Mvolyé -Yaounde, a deliberative forum informed by a policy brief on "Scaling up Enrolment into Community Based Health Insurance". Forty participants from North-west, Littoral and Centre regions, as well as from public administrations, civil society, health mutual organization promoters, research institutes and cooperation agencies, exchanged around a synthesis of research results on community-based health insurance (CBHI) in developing countries prepared by the CDBPH. While the CBHI have been recognized since 2001 by the government as priority strategy to promoting voluntary health insurance and to reducing out-of-pocket payments for health care and health services, the national coverage rate remains below 2%. According to WHO estimations (World health statistics report 2009), 95.8% of the 600 billion spent in 2007 by Cameroonians to finance health were in form of out-of pocket during illness periods.

So the aim of the forum was to allow the key actors of CBHI in Cameroon to discuss not only on the reasons of the relative reluctance of population for this voluntary disease insurance model, but also about the conditions and successful experiences in developing countries; the aim being them taking advantage of the research synthesis to inform and enlighten their choice of appropriated strategies to achieve the 40% national coverage rate by the year 2015 set forth by the strategic paper to promote CBHI.

The work took place in an atmosphere of serenity and through working groups focusing on the research synthesis and policy options to speed up the adhesion of Cameroonians in health mutual organization schemes. The participants agreed on the followings:

1. *CBHI are and must be considered not only like a priority, but also as a necessity to free people from anxiety of disease and high risk of catastrophic health expenditures pushing or driving a large number of Cameroonians into poverty in case of illness.*
2. *The laisser-faire attitude for communities to initiate Health Mutual Organizations should shift towards greater involvement of elites and municipalities to support and promote these initiatives in collaboration with the local health authorities to offer health insurance to larger groups of the population.*
3. *The lack of national legal and regulatory frameworks set forth the promotion and operation of CBHI constitute one of the hindrances to adhesion as well as a source of distrust vis -à-vis CBHI.*
4. *In fact, the absence of common understanding of the basic concepts of health risk and health risk sharing, the lack of norms and standards for premiums collection, benefits designing and purchasing mechanisms as well as the poor quality of care are barriers to enrolment in CBHI. In addition, the monetary poverty rate as high as 40% of the population (55% in rural areas) constitute another inhibitor for adhesion to a Health Mutual Organization or health insurance scheme.*
5. *The population in general and opinion leaders and political elites in particular are not well informed on the advantages and benefits of CBHI as a means to combat poverty and, those informed don't believe CBHI could ensure universal coverage of health risks.*
6. *Out-of-pocket payments and the handling of cash in health facilities are strong enablers of corruption practices.*
7. *There is a need to establish moderator ticket for purchasing healthcare as well as to engage healthcare providers at the district level to support CBHI. The governance of CBHI needs to be improved through locally appropriate social control mechanisms and sanction against corruption and embezzlement by CBHI managers.*
8. *The payment of membership fees and premiums must be flexible to fit the local economical production mostly in rural areas or in urban areas for the informal sector actors who represent more than 80% of the urban population.*
9. *Taking into consideration current levels of monthly households' health expenditures and incomes, a great majority of households in Cameroon are unable to afford adhesion fees and premiums fees thus making it reasonable to establish mechanisms to subsidize premiums for selected groups of underprivileged.*
10. *Medias have a critical role to play by informing, educating and communicating on the advantages of community based health insurance.*

*This second issue of **LIGHTINGS** was written and reviewed by the CDBPS-H research team: Dr. Pierre Ongolo-Zogo, Dr. David Yondo, Dr. René Owona-Essomba, Dr. François Colin Nkoa, Dr. Jean Serge Ndongo, Dr. Robert Marie Mba, Mrs Renée Cécile Bonono-Momnougui, Mr. Henri Atangana Ondoa, Ms. Patricia Della and Mr. Frederic Messi.*