

## A b s t r a c t

*Meaningful community participation is essential for the design, implementation, outcome, and evaluation of health programs. However, barriers to community participation can result both from actions of the Ministry in charge of Health and from realities beyond its immediate control. This study of a health program in Cameroon identifies several of these barriers. With a view toward ameliorating the design, implementation, outcome and evaluation of health programs, it is proposed that a health and human rights-based analysis of these barriers offers the potential for identifying the range of factors which inhibit this participation.*

---

*Una participación comunitaria significativa es esencial para el diseño, la implementación, el resultado y la evaluación de programas de salud. Sin embargo, las barreras a la participación comunitaria pueden ser resultado de acciones del ministerio a cargo de la salud y de realidades mas alla del control inmediato. Este estudio de un programa de salud en Camerún identifica algunas de estas barreras. Con una visión dirigida hacia la amelioración de el diseño, la implementación, el resultado y la evaluación de programas de salud, se propone que un análisis de estas barreras, basado en la salud y los derechos humanos, ofrece el potencial para identificar un espectro de factores que inhiben dicha participación.*

---

*Une participation significative de la communauté est essentielle pour la création, la mise en pratique, l'évolution et l'évaluation des programmes de santé. Cependant, cette participation peut se heurter à l'obstacle des actions du Ministère responsable de la santé ainsi qu'à des facteurs ne dépendant pas directement de son autorité. Cette étude, portant sur un programme de santé au Cameroun, met en exergue plusieurs de ces obstacles. Afin d'améliorer la création, la mise en œuvre, l'évolution et l'évaluation des programmes de santé, cet article suggère qu'une analyse des obstacles axée sur la santé et les droits de l'homme peut présenter un grand intérêt pour l'identification des divers facteurs qui restreignent la participation des membres de la communauté.*

# HUMAN RIGHTS AND HEALTH IN DEVELOPING COUNTRIES: Barriers to Community Participation in Health in Cameroon

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

**H**ealth has been a major concern for the governments of Cameroon, Gabon, the Central African Republic, the Congo, and Chad; all former French colonies in the Central African sub-region. In addition to recognizing health as a human right in the Constitutions of Cameroon, the Congo, and Gabon, these nations have become state parties to various United Nations and Organization of African Unity (OAU) treaties that include the right to health. In seeking to promote health, national governments in the Central African sub-region have also endorsed the Alma-Ata Declaration and the Bamako Initiative, both of which emphasize the need for community participation in design and implementation of health services.<sup>1,2,3,4,5</sup> Thus, an emphasis on community participation was included in the Central African Republic's 1994-98 National Plan for the Development of the Health Sector, the Congo's National Plan for Health and Social Development, Cameroon government's Declaration on the Re-orientation of Primary Health Care, and Gabonese draft legislation on national health policy.<sup>6,7,8</sup>

Within the African health development framework, communities are viewed as the cornerstone for implementing health and health-related activities. In turn, operational, technical, and strategic support for those activities comes from local (district), intermediate, and central government levels.<sup>9</sup>

---

*Cheka Cosmas is Senior Lecturer at Yaoundé University. Bergis Schmidt-Ehry is Coordinator of GTZ Health Projects in Cameroon. Please address correspondence to Dr. Cheka Cosmas, P.O.Box 11460, Yaoundé, Cameroon, e-mail: ccheka@cam.healthNet.org*

In order to examine the realities of community participation in healthcare, we studied over a two-year period a typical health program in Cameroon: the North West Provincial Special Fund for Health (hereinafter referred to as "the Fund").<sup>10</sup>

### **The Fund**

The Fund is a nongovernmental organization based on a partnership between the community, health sector donors, health workers, and the government within a clearly defined geographical area. The objective of the Fund is to promote individual, family, and community health through the participation of all. The Fund is managed by three bodies: a general assembly (meeting once a year), a management committee (meeting at least four times a year), and an executive office (responsible for day-to-day operations).

### **Conceptual Framework**

What is effective "community participation," and what is required to enable the community to participate in health care? Community participation involves "a process whereby specific groups, living in a defined geographic area and interacting with each other, actively identify their needs and take decisions to meet them."<sup>11</sup>

The concept of a right to participation in decisions that affect people is recognized in several key human rights declarations and treaties. The Universal Declaration of Human Rights (UDHR) states (Article 21) that "everyone has the right to take part in the government of his country..." and "everyone has the right to equal access to public service in his country."<sup>12</sup> In addition, the UDHR (Article 20) and the International Covenant on Civil and Political Rights (ICCPR) (Article 22) establish the right of association, which is critical for community participation in health.<sup>13</sup> Similarly, the African Charter on Human and People's Rights declares the rights to association (Article 10) and to participation in the government (Article 13).<sup>14</sup>

Further, the preamble to the World Health Organization Constitution states: "informed opinion and active cooperation on the part of the public are of utmost importance in the improvement of the health of the people."<sup>15</sup> Finally, United Nations declarations, including those from the World Health Orga-

nization (WHO) and UNICEF, also focus on the subject of community participation. Thus, Article IV of the Alma-Ata Declaration states:

the people have the right and duty to participate individually and collectively in the planning and implementation of their health care.<sup>16</sup>

Within the Central African sub-region, there is a general convergence of understanding regarding the practical meaning of community participation. From a policy perspective, it implies a departure from the "old," centralized approach (inherited from the French colonial system), to an emphasis on user participation and more localized needs-assessment and decision-making. Thus, community participation in health in the countries of the Central African sub-region involves a shift from "service(s) based in a few facilities to one with activities dispersed throughout the country."<sup>17</sup> User participation both in the planning and in the management of health activities is emphasized.

Community participation in health requires a structure within which to group various partners, including financial investors in health care facilities and programs (e.g., the state), health care providers, and beneficiaries of health services (users). Yet, beyond organizational structures and charts, community participation also requires political will. The sharing of responsibility implied by the concept of community participation requires a positive attitude, as well as concrete steps on the part of governmental authorities. If meaningful community health reform initiatives, like those currently proposed by countries of the Central African sub-region, are to succeed, attention must be paid to barriers to these initiatives within each community before, during, and after their implementation. A useful indicator of the strength of this political will for community participation is the nature and extent of resources, both financial and human, and materials made available for community-based work.

### **Barriers to Community Participation in Health**

Barriers to meaningful community participation in health can be divided into two categories: those directly involving the Ministry in charge of Health; and those extending beyond its purview.

**(1) Barriers involving the Ministry in charge of Health**

These include (a) lack of clarity regarding roles and responsibilities in planning, implementing, and evaluating the health care system; (b) lack of commitment to community participation, including reluctance to share power for health-related decision making; (c) lack of public information about community health status and the need for community participation; and (d) poor resource management by state agencies, together with contradictions in state commitment to health. The cumulative impact of these problems has been community frustration and non-participation. As stated by a community representative, "it is difficult to be involved in what one scarcely understands."<sup>18</sup>

**(a) Lack of clarity regarding roles and responsibilities**

In the absence of clear rules and a legal framework, efforts at community participation in health cannot thrive. In the absence of these structures, it is nearly impossible to mobilize communities to participate consistently in community health activities. Even when a legal framework exists, improper allocation of disciplinary and other powers can lead to flagrant rule violations by the representatives of public authority. This, in turn discourages community participation.

Certain incidents that have occurred within Fund administration exemplify and support the foregoing conclusion. In principle, the Fund benefits from a defined organizational and legally recognized structure. The District and Health Area Committees are governed by a constitution and bylaws. However, the final authority to hire and fire the chairperson of the Management Committee resides with the Minister in charge of Health. Attempts have often been made by chairpersons to exploit this situation.

For example, in 1992, the District Medical Officer who was chairperson of the Nkambe Health District dissolved the elected Nkambe District Health Committee and replaced them with new members. The duly elected and unlawfully disbanded District Health Committee members petitioned the Fund, which determined that the District Medical Officer had no authority to dissolve the elected Health Committee. Similarly, in 1993, the chairperson of the Fund's Management Committee invited several

directors of the Central Services of the Ministry in Charge of Health to attend one of its quarterly meetings. The community representatives at the meeting immediately tabled other matters to determine why these "extra directors" were present. Community representatives complained that the extra directors had come to swell the ranks of Fund members representing public authority, so as to intimidate the other members into making decisions undesired by the community. After only two hours of deliberation, a resolution was found: the "extra directors" were allowed to sit in as observers, with no vote or right of speech unless authorized by vote of the registered members of the Management Committee.

Given that these events took place within a body having a constitution and bylaws, attempts to subvert community participation are likely to be even more flagrant in the absence of a legal framework. Institutional arrangements that fail legally to accommodate community participation are highly vulnerable to failure.

**(b) Lack of commitment to community participation**

During a field trip to community participation structures in the Bamenda Provincial Hospital (a technical structure of the Fund) in Cameroon in June 1993, barely used biomedical equipment was found, including some still packed in crates and containers. In addition, the Nkambe health district received equipment designed to operate by electric power, when three-quarters of the area has no electricity. In reaction to situations like these, community representatives have believed it wrong to expect them to participate in financing public health, when their contributions have been spent on unusable or unsuitable equipment. It was obvious to them that communities are often not involved in the design of projects intended for their benefit. Consequently, project design priorities and goals frequently fall short of the beneficiary community's needs, thereby demotivating otherwise key participation. Moreover, a certain number of community health project designs insist on results within an unrealistic short period, failing to consider community and logistical realities. Similarly, communities are often inadequately involved in the follow-up phase of community health projects.

**(c) Lack of information about health and community participation**

Article 19 of the UDHR, and the International Covenant on Civil and Political Rights (ICCPR), establish the right “to seek, receive and impart information.”<sup>19,20</sup> However, in the geographical area served by the Fund, discussion with community representatives revealed an absence of adequate information about what is expected of them with regard to community participation in health. Most community representatives knew neither why nor whether community participation was a spontaneous or continuous exercise, nor did they know who was considered competent to participate and in what way.

**(d) Poor management and contradictions in state commitment to health**

Ministries may make arbitrary decisions without consulting community organizations. For example, we learned from community representatives that participation initiatives in their health district had been destroyed when the central government created new health districts without consulting the various communities. In addition to arbitrary actions, government officials may deviate from legislated decentralization policy. For example, in the Congo, power was “deconcentrated” from the capital to the regional headquarters. However, this did not result in enhanced community participation, because of the paternalistic attitude of relevant health professionals. In turn, this created community resentment directed towards health officials and refusal by the community to participate or cooperate.

Article 21 of the UDHR recognizes the right to equal access to public service.<sup>21</sup> Thus, reserving a public post for certain individuals clearly violates this right, and shows that public health technocrats are disrespectful of, and lack confidence in their community representatives.

For example, in Cameroon, Decree N<sup>o</sup> 93/227/PM of 15 March 1993, created Management Committees with community representation in public health units throughout the country.<sup>22</sup> However, the Decree also reserved the post of Treasurer for civil servants. In a session of the Fund’s Management Committee, community representatives charged that this provision showed little respect for the potential, honesty and integrity of community representatives. They further argued that the public service

regulations insulated civil servants from immediate prosecution for misappropriation. They reasoned that community representatives, governed by common law, would be more quickly prosecuted (thereby protecting the community better) should they misappropriate funds.

## **(2) Barriers to community participation extending beyond the Ministry in charge of Health**

Given the complexity of health systems and their relationship to particular social, economic, political, and cultural contexts, it is not surprising that barriers to community participation may arise in areas not generally considered part of the relevant Ministry's area of responsibility. Examples of such barriers to community participation include issues which can be recognized as violations of human rights such as illiteracy, poverty, religious intolerance, and ineffective judicial systems.<sup>23</sup> Members of the Fund highlighted crime (especially burglary and embezzlement) as a major barrier to effective community participation in health.

### **(a) Burglaries**

Socio-political and economic instability provide the ideal climate for an increase in burglaries. When these are successful, community health assets in collective ownership are subverted. Due to the situation in the North West Province of Cameroon during the study period, community pharmacies suffered burglaries resulting in substantial loss of accumulated community capability. During the first half of 1993, an average of 1.4 burglaries per month were reported, compared to only 0.6 burglaries monthly during 1992. These occurred despite reinforcement of pharmacy windows and doors with metal bars, and recruitment of night watchmen (measures not considered necessary prior to July 1992). The financial loss suffered by the community as a result of burglaries in the first quarter of 1993 alone was nearly equivalent to all burglary-associated losses during 1992. The total loss during 1993 (at then-operating exchange rates of 250 CFA per US dollar) exceeded US\$25,000. Both the absolute amount of loss (per capita income in Cameroon is less than US\$425) and the demoralizing impact on Fund finances threatened essential community support.

Governmental failure to ensure civil order and stability, at the same time as it protects human rights, can interfere with, or even prevent, community participation in health.

**(b) Embezzlement**

An unstable socio-political and economic environment heightens the need for a reliable judicial system, in order for community participation in health to succeed. As with burglaries, embezzlement undermines community confidence as well as depletes available resources for health. In reviewing the quarterly reports to the Management Committee on management of the Fund, we found serious evidence of embezzlement by health technocrats and members of the community. Together with the slow system of justice and alleged collusion between police and the judiciary, embezzlers of public and community funds contributed to discouraging community participation. The following two cases illustrate these problems:

- In 1991, a community pharmacy attendant allegedly misappropriated US\$2500. The community reported the matter to the police. The accused person then paid US\$1000 to the investigating policeman. The community pharmacy lodged a complaint to recover the money and to have the police officer disciplined. Two and one-half years later, the case has yet to be heard in court, the police officer has not been disciplined, and the money has not been returned.
- In a second case, a thief allegedly misappropriated approximately US\$3000 from the community pharmacy. Criminal and civil charges were raised against the accused, yet over two years later, the case's first hearing has not been held.

A legal system that does little to speedily dispense justice and protect common resources, especially in a low-income country like Cameroon, seriously undermines community confidence and thus community participation in health.

## Conclusion

It is universally agreed that community participation in the design, implementation, outcome, and evaluation of health systems is essential. Nevertheless, many barriers exist which prevent translation of this goal into reality. Many institutional and other arrangements reflect a conflict between the theoretical desire to implement community participation, and the organization and financing of health systems designed for operation by centralized government. Community participation in health challenges these existing health systems. To ensure progress, institutional arrangements, as well as the social and legal environment must be reviewed.

In seeking to advance this process, it is essential to go beyond consideration of policies and practices of the Ministry in charge of Health alone. A human rights-based analysis of barriers to community participation offers the potential for identifying a wide range of underlying factors inhibiting this participation. This review of experience in Cameroon is proposed as an initial effort in this direction, suggesting concrete and practical steps that must be taken, with the simultaneous goals of increasing community participation in health, promoting and protecting human rights, and working towards the goal of health for all.

## References

1. Current Constitution of the Republic of Cameroon, adopted by the National Assembly on May 20, 1972 and promulgated into law on June 2, 1972, preamble.
2. Current Constitution voted into law on December 20, 1991 and adopted by referendum on March 15, 1992, art. 34.
3. Current Constitution of the Republic of Gabon, preamble.
4. The Alma-Ata Declaration, adopted at the International Conference on Primary Health Care, September 12, 1978, World Health Organization (WHO), Geneva, Health for All Series No. 1.
5. Commitment made by African Ministers of Health assembled under the auspices of the WHO and endorsed by the 24th Summit Meeting of OAU, Bamako, Mali, 1988.
6. Published by the government of the Republic of Central Africa on November 30 1993.
7. *Loi No 014 du 29 avril 1992 portant Plan National du Développement Socio-sanitaire (PNDS) de la République du Congo.*
8. République du Cameroun: *Ministère de la Santé Publique, Déclaration Nationale de la mise en oeuvre de la Reorientation des Soins de Santé Primaires*, 25 mars 1992.
9. G.L. Monekosso and E. Lambo, *Efficient Management of District Health Systems*, (Brazzaville: WHO Regional Office for Africa, 1993).
10. The NorthWest Provincial Special Fund for Health conferred legal

- personality on the strength of Law No. 90/053 of December 19, 1990 (relating to freedom of association) under N. E29/1599/S.1/400 on June 6th 1991.
11. A. Bermejo and A. Bekui, "Community Participation in Disease Control," *Soc. Sci. Med* 36 (1993): 1145-1150.
  12. Universal Declaration of Human Rights, G.A. Res. 271A(III), UN Doc. A/810, preamble (1948) (hereafter UDHR).
  13. International Covenant on Economic, Social and Cultural Rights, annex to G.A. Res. 2200, 21 GAOR, Supp. 16 UN Doc. A/6316 at 49(1966) (hereafter ICCPR).
  14. African Charter on Human and People's Rights (preamble), OAU Doc. CAB/LEG/67/3/Rev.5 (1981).
  15. World Health Organization, Constitution in Basic Documents, 36th ed. (Geneva, 1986).
  16. The Alma-Ata Declaration, see note 4.
  17. G.H. Bloom, N.M. Lenneye, E.T. Maganu, & M. Tselayakgosi: "Health programme planning for consolidation and quality," *World Health Forum* 12: 90-95, 199.
  18. See *Report of Community Health Training Workshop for elected health district representatives of the NW and SW provinces of Cameroon*, (Bamenda, September 12-16, 1994) in unpublished *Documents* of the German Cameroonian Project for the Reorientation of Primary Health Care.
  19. UDHR, art. 19, see note 12.
  20. ICCPR, see note 13.
  21. UDHR, art. 21, see note 12.
  22. Amended and completed by Decree No. 94/328/PM of June 28, 1994.
  23. See for example UDHR, art. 7,10,18,25,26, see note 12.