



STRATEGIC HEALTH PURCHASING IN CRISIS-AFFECTED SETTINGS: STRUCTURAL DEFICITS, PROVIDER INCENTIVES, AND IMPLEMENTATION PATHWAYS IN THE CAMEROON HEALTH VOUCHER PROGRAMME

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Abstract

Cameroon's national health voucher programme, supported by the French Development Agency and German Financial Cooperation, was extended to the Northwest Region in October 2024 and now operates across 51 accredited facilities. However, no rigorous qualitative investigation has examined how its strategic purchasing functions operate within this conflict-affected setting. Adopting the World Health Organization strategic health purchasing framework (Mathauer, Dale, Jowett, & Kutzin, 2019) as both theoretical foundation and analytical architecture, this study investigates how benefit package design, provider selection and contracting, payment mechanisms, and monitoring and accountability systems operate in practice. Semi-structured interviews comprising twenty-one questions across seven thematic

domains were conducted with six purposively selected Regional Coordinators between September and November 2025. Data were analysed using a hybrid approach combining reflexive thematic analysis (Braun & Clarke, 2006) with Framework Analysis (Ritchie & Spencer, 1994). The programme has established a foundational strategic purchasing architecture but operates substantially below its design potential. The most consequential findings include systematic payment delays reaching nine months in 2025, the unanimous absence of performance-based contracting, non-functional digital platforms, geographic coverage limited to 51 facilities, and significant provider motivation deficits. The post-service reimbursement model creates systemic risks that cascade across all purchasing functions simultaneously. Eight evidence-based policy interventions are advanced to inform the Government of Cameroon's scaling strategy and to contribute to the international evidence base on health financing reform in fragile, conflict-affected settings.

Keywords: universal health coverage, strategic purchasing, health voucher, maternal health, fragile settings, Cameroon

INTRODUCTION

Maternal mortality is one of the most pressing inequities in global health today. Despite sustained international investment and technical cooperation, sub-Saharan Africa accounts for about 70% of global maternal deaths, with maternal mortality ratios well above the Sustainable Development Goal 3.1 target (World Health Organization, 2010, 2024). Cameroon presents a complex picture within this regional context. The national maternal mortality ratio fell from 467 per 100,000 live births in 2018 to 258 per 100,000 in 2023 (Ministry of Public Health, Cameroon, 2023). This national-level improvement, however, hides large geographic and sectoral differences. Some regions have seen minimal progress, and rural areas remain seriously underserved.

The Northwest Region, where this study is situated, illustrates these structural problems. The region has historically recorded an estimated 467 maternal deaths per 100,000 live births, with persistent barriers to maternal healthcare rooted in economic, geographic, and infrastructural constraints. About 50% of deliveries continue to occur outside formal health facilities. The epidemiological situation is further complicated by the region's ongoing sociopolitical crisis. Since 2016, the Anglophone separatist conflict has disrupted health system functioning, displaced populations, restricted mobility, and eroded community trust in public institutions. Healthcare workers have been targeted, facilities damaged, and access to essential supplies severely compromised. These dynamics are typical of fragile and post-conflict health

systems across the continent (Newbrander, Waldman, & Shepherd-Banigan, 2011; Witter et al., 2016).

To address these connected challenges, the Government of Cameroon, with support from development finance institutions, introduced a health voucher programme in 2015 as a demand-side financing mechanism for maternal healthcare. The intervention reflects evidence that cost remains a significant determinant of health facility utilisation in low-income settings, particularly among pregnant women in economically marginalised communities (Lagarde & Palmer, 2011). Extended to the Northwest Region in October 2024, the programme operates across 51 selected health facilities. It provides a comprehensive benefit package covering the continuum of maternal care, from antenatal consultation through 42 days post-delivery, at a beneficiary cost of 6,000 FCFA. This represents about 10% of the estimated service cost.

However, a defining feature of the programme's operational architecture is its post-service reimbursement model. Rather than capitalising facilities upfront, the programme operates retrospectively. Health facilities must deliver all services, dispense pharmaceuticals, conduct clinical procedures, and provide transport support using their own operational resources. Government reimbursement flows only after services have been rendered, documented, and verified. This design creates a serious tension. Facilities that actively participate in the programme accept vouchers, serve marginalised populations, and honour their commitment to maternal health. In so doing, they progressively accumulate unreimbursed resource deficits. Documented evidence from the Northwest Region indicates payment delays reaching nine months in 2025, a threefold deviation from the contractual 90-day cycle. Such delays raise fundamental questions about the alignment of public financial management with service delivery realities (Cashin et al., 2017).

These structural financing tensions sit at the intersection of important questions in health systems research. How do programme design features interact with contextual constraints to shape implementation effectiveness? How do financial incentive structures influence provider motivation and care quality? Despite a growing international literature on health voucher programmes and health financing reform in low- and middle-income countries, rigorous qualitative evidence on the operational dynamics of strategic purchasing within conflict-affected sub-Saharan contexts remains limited (Bellows, Kyobutungi, Mutua, Warren, & Ezeh, 2013; Obare et al., 2013; Etiaba, Onwujekwo, Honda, Ibe, Uzochukwu, & Hanson, 2018). The Cameroon programme presents an instructive case. It is neither a nascent pilot nor a fully mature system. Rather, it is an early-phase implementation in a genuinely fragile setting. It therefore offers valuable lessons for other developing countries pursuing universal health coverage (Kutzin, 2013; Hanson et al., 2022).

Health voucher schemes are a distinctive intervention within the broader architecture of health financing reform. Unlike universal health insurance contributions or direct government budget allocations, vouchers function as demand-side financing mechanisms. Funds follow the patient, and providers are reimbursed based on the service volumes delivered to eligible beneficiaries (Bellows et al., 2013; Brody, Bellows, Campbell, & Potts, 2013). By placing purchasing decisions in the hands of beneficiaries, vouchers create a market-like dynamic intended to incentivise provider responsiveness and quality.

Performance-based financing mechanisms, which condition payment on the achievement of quality indicators or service standards, have shown significant capacity to improve health outcomes in low-resource settings (Soeters, Habineza, & Peerenboom, 2006; Meessen, Soucat, & Sekabaraga, 2011; Fritsche, Soeters, & Meessen, 2014; Morgan et al., 2018). In Rwanda, the introduction of quality-linked payment was associated with notable improvements in maternal and child health indicators within five years of implementation (Soeters et al., 2006). The WHO framework organises purchasing around four interrelated functions: selecting services, selecting providers, designing payment systems, and ensuring accountability (Mathauer et al., 2019). Comparative case studies in Nigeria, China, Indonesia, and the Philippines have illustrated both the promise and the practical challenges of operationalising strategic purchasing in middle- and low-income contexts (Honda, McIntyre, Hanson, & Tangcharoensathien, 2016; Etiaba et al., 2018).

This article addresses the evidence gap through a comprehensive qualitative investigation of how strategic purchasing functions operate in practice within the Cameroon health voucher programme. It draws on in-depth interview data from six Regional Coordinators directly responsible for programme governance. The WHO strategic health purchasing framework provides both the theoretical foundation and the analytical architecture for the study.

METHODS

This study adopts an interpretive qualitative paradigm. The epistemological premise is that the situated professional knowledge of those embedded within programme implementation constitutes a privileged source for understanding operational dynamics (Bryman, 2016). Quantitative service delivery indicators, while valuable, cannot fully capture the structural incentive mechanisms, governance dynamics, and contextual constraints that shape implementation.

Semi-structured interviews (self-designed) were selected as the primary data collection instrument. This approach maintains sufficient structure to enable systematic comparison

across respondents, while preserving sufficient flexibility to elicit rich narrative accounts. Interviews were organised around twenty-one questions distributed across seven thematic sections: benefit package design and population targeting; provider selection and contracting mechanisms; payment mechanisms and timeliness; monitoring, accountability, and feedback systems; implementation challenges; opportunities and policy innovations; and contextual factors and intersecting crises. The study was nested within existing programme governance structures and conducted with institutional approval from the Catholic University of Cameroon. Interviews occurred between September and November 2025. They were digitally recorded with explicit participant consent, transcribed verbatim, and ranged from 45 to 90 minutes in duration.

Six Regional Coordinators were purposively recruited from the Universal Health Coverage (UHC) implementation structure within the Northwest Regional Fund for Health Promotion. Each participant possessed direct, sustained operational knowledge of the health voucher programme. The sample comprised three male and three female participants. Ages ranged from 26 to 52 years ($M = 38.2$, $SD = 9.8$). Professional designations included an Administrator (Senior Management); a Head of Section, UHC Programme Coordination; a Focal Point, UHC Programme Coordination; Marketing and Communication Officer; a Pharmacy Adviser; and a Programme Support Intern. All six potential respondents identified for purposive recruitment accepted participation. This yielded a 100% response rate. Participant confidentiality was protected through pseudonymisation, and respondents are referred to throughout as R1 through R6.

Data were analysed using a hybrid analytical strategy that combines Braun and Clarke's (2006) reflexive six-phase thematic analysis with Ritchie and Spencer's (1994) Framework Analysis method. This combination allowed for simultaneous inductive theme generation and deductive theoretical mapping, in which findings were systematically organised against the four strategic purchasing functions specified in the WHO framework. Analytical rigour was upheld through Lincoln and Guba's (1985) established criteria for trustworthiness, which include credibility, transferability, dependability, and confirmability.

RESULTS

The thematic analysis generated six primary themes, each corresponding to a distinct dimension of strategic purchasing. Table 1 provides an overview of all themes, their constituent codes, respondent frequency, and analytical priority designation. Figure 1 situates these findings within the WHO strategic purchasing framework.

Table 1. Summary of analytical themes, core codes, and analytical priority

Theme	Core codes and analytical focus	Respondents	Priority
1. Benefit Package Design	Top-down national conception; EPI enrolment pathways; CHW identification role; beneficiary contribution structure; two-stage enrolment process	6/6	High
2. Provider Selection & Contracting	Standardised accreditation criteria; delivery volume thresholds (100/month); infrastructure requirements; absence of performance-based contracting; signed agreements without quality conditionality	6/6	Critical
3. Payment Mechanisms	Fee-for-service universally applied; post-service reimbursement model; payment delays up to nine months; central treasury bottleneck; resource-before-delivery paradox; relational trust-based mitigation	6/6	Critical
4. Monitoring & Accountability	Two-layer verification architecture; 'policing the police' concept; community surveys; CHW feedback relay; billing fraud identification; verification reach constrained in remote areas	6/6	High
5. Implementation Challenges	Digital platform failures; poor connectivity; geographic enclavement; transport deficits; provider demotivation; billing fraud; sociopolitical crisis effects on security, mobility, community trust	5–6/6	Critical
6. Opportunities & Innovations	Digital platform redesign; Camtel connectivity expansion; pre-positioned facility funding; performance-based contracting; solidarity financing mechanisms; NCD integration; scale-up pathways	3–5/6	High

Source: Author's analysis of interview transcripts

(n = 6 Regional Coordinators, Northwest Region, January–March 2025).

Strategic Purchasing Architecture and Implementation Gaps

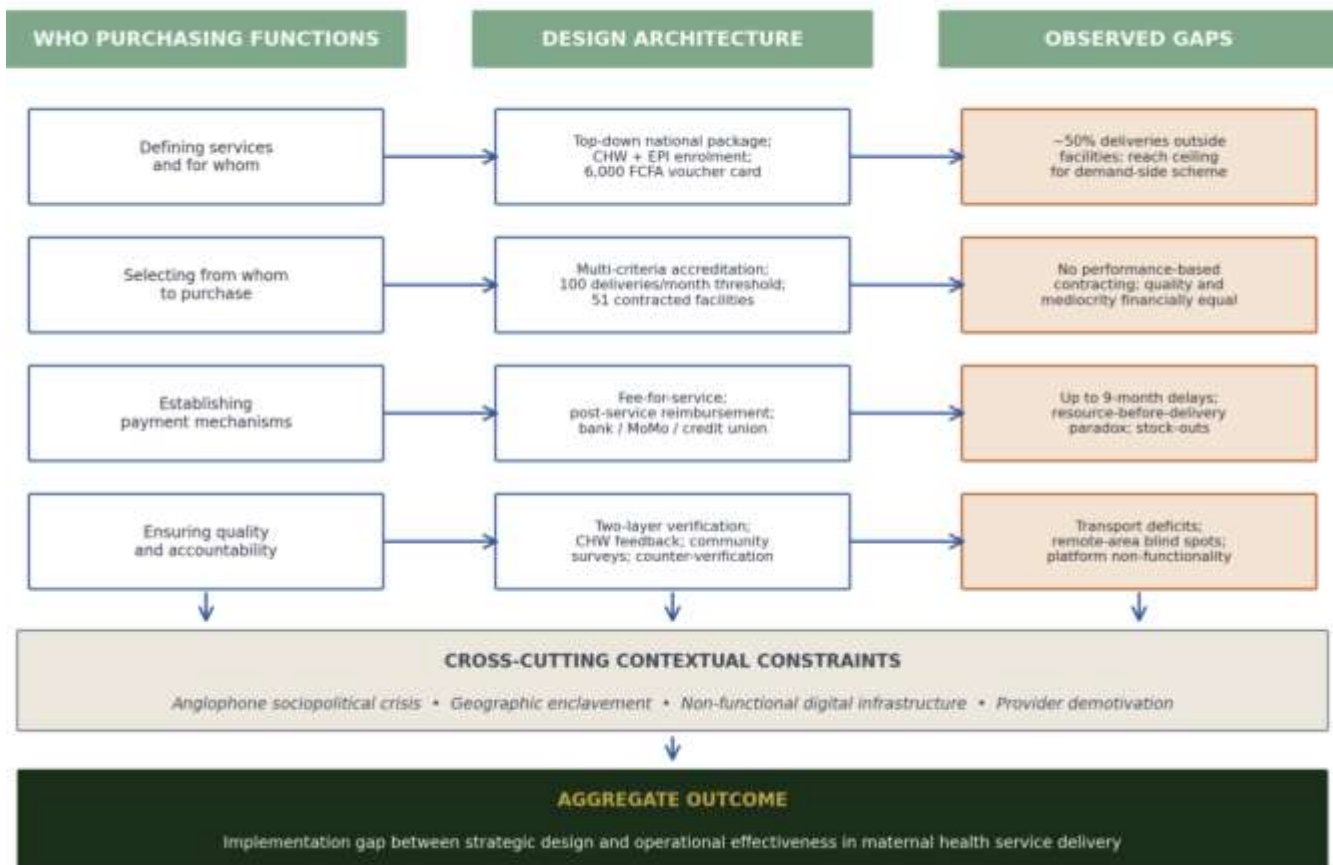


Figure 1. Normative framework of strategic health purchasing in the Cameroon Voucher Programme

Source: Constructed by the author from interview data and the WHO strategic health purchasing framework (Mathauer et al., 2019).

Benefit Package Architecture and Population Access

The health voucher benefit package emerged from a national-level consultative process. The top-down design approach ensures policy standardisation and evidence-informed prioritisation. However, it creates inherent tensions with the contextual heterogeneity of health needs across Cameroon's regions.

The enrolment pathway reflects deliberate architectural choices. Community Health Workers (CHWs) serve as the primary identification agents. They leverage existing Expanded Programme on Immunization touchpoints to identify eligible women. Upon identification, women undergo a two-stage process: pre-enrolment verification, followed by formal enrolment. At formal enrolment, they receive a unique Maternal Patient Identifier number and a voucher card valued at 6,000 FCFA. As one administrator noted, '*Pregnant woman/state of a woman; pre-*

enrolled; enrolled, given an MPI number (unique).' This staged process reflects a deliberate design that balances universal coverage intent with administrative verification requirements.

Perhaps the most analytically significant finding within this theme concerns the programme's actual reach. One regional administrator reported that *'approximately 50 percent of pregnant women in the region continue to deliver outside health facilities.'* If accurate, this observation carries profound implications for programme impact assessment. Health voucher programmes are demand-side interventions designed to reduce the financial cost of facility utilisation (Bellows et al., 2013; Lagarde & Palmer, 2011; Brody et al., 2013). When half the target population does not use health facilities regardless of financial incentives, the voucher scheme can reach a maximum of only 50% of its intended beneficiary population. This finding necessitates complementary supply-side investments such as community-based skilled birth attendance, outreach maternal health services, and mobile health units.

Provider Selection, Accreditation, and the Absence of Performance Conditionality

Provider selection is governed by a standardised multi-criteria accreditation framework. It encompasses delivery volume thresholds, human resource adequacy, infrastructure requirements, and operational continuity. Notably, all six participants demonstrated consistent articulation of these criteria.

The delivery volume threshold of 100 deliveries per month (or 150 annually) warrants analytical scrutiny. This threshold operationalises the principle of selectivity, ensuring that participating facilities possess sufficient service volume to generate economies of scale. However, it may inadvertently exclude lower-volume facilities operating in remote areas. These peripheral facilities are precisely those most needed to serve geographically enclaved communities.

The most analytically consequential finding within this theme is the unanimous confirmation by all six participants that formal, operationalised performance-based contracts are not currently in place. Signed contractual agreements exist. Standardised accreditation criteria are uniformly applied. Yet these agreements do not incorporate quality-linked payment mechanisms or performance conditionality. This represents a critical structural deficit within the strategic purchasing architecture. In the international health financing literature, performance-based financing constitutes a foundational mechanism for linking provider payment to service quality and accountability outcomes (Mathauer et al., 2019; Bertone & Meessen, 2013). Rwanda's national experience showed that quality-linked payment was associated with significant improvements in maternal and child health indicators within five years (Soeters et al.,

2006). Cameroon's programme currently operates through fee-for-service reimbursement without quality conditionality.

Payment Mechanisms and the Resource-Before-Delivery Paradox

The health voucher programme employs a fee-for-service payment mechanism. This was confirmed without exception by all six participants. Under this arrangement, health facilities declare services rendered and receive reimbursement based on documented service volumes. Reimbursements are processed through multiple financial channels, including bank transfers, mobile money, and credit union accounts.

A defining and systematically problematic feature of the programme's financial architecture, however, is its post-service reimbursement model. Unlike prepayment approaches that capitalise facilities upfront, the Cameroon voucher operates on retrospective reimbursement. As one Pharmacy Adviser observed, *'If the health facility have funds upfront, I think the performance will be far more better because the main issue is lack of resources at hand before rendering services.'* This observation reflects a wider international pattern of misalignment between budget cycles and service delivery cycles (Cashin et al., 2017).

The consequence of this architecture, when combined with payment delays, is a phenomenon herein termed the *resource-before-delivery paradox*. Every voucher a health facility honours represents an immediate draw on its operational resources, with no guarantee of when replenishment will occur. Facilities facing payment delays of nine months must finance the drugs, equipment, supplies, and clinical staff time for beneficiaries for nine months before receiving reimbursement. This creates a perverse structural disincentive. Figure 2 presents this cycle schematically.

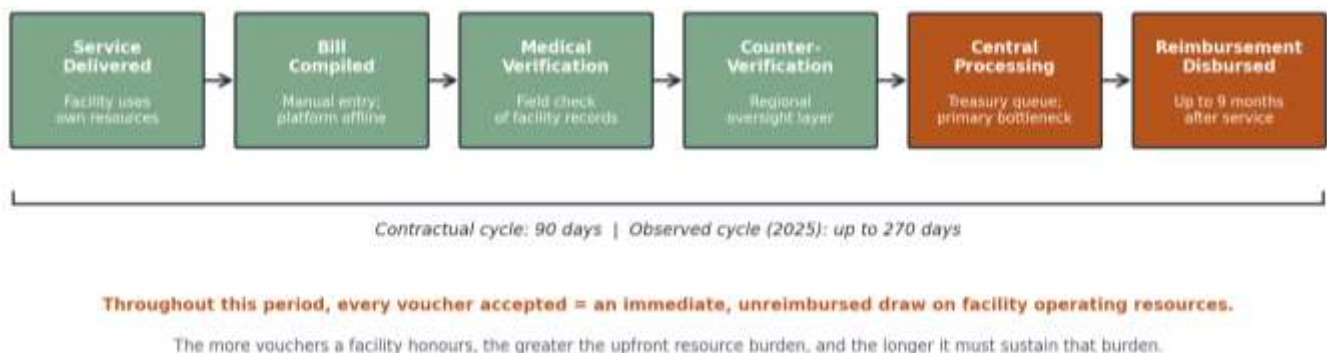


Figure 2. The post-service reimbursement cycle and the resource-before-delivery paradox

Source: Synthesis of interview accounts from

Regional Coordinators (R1–R6) and contractual cycle specifications.

The manifestations of this paradox are concrete and consequential. Pharmacy stock-outs occur when facilities exhaust drug supplies but cannot replenish them. Equipment deteriorates when maintenance costs cannot be met. Skilled staff attendance becomes inconsistent. One regional administrator articulated this dynamic with evident frustration: *'Healthcare providers are non-willing/reluctant to provide the service because of lack of material resources; high burden on pharmacies.'* In the absence of structural delay-mitigation mechanisms, regional coordinators have adapted by employing relational trust management. Table 2 contrasts contractual payment specifications against observed implementation reality.

Table 2. Payment system parameters: contractual specifications
versus observed implementation reality (2025)

Payment parameter	Contractual standard	Observed reality (2025)	Assessment
Payment cycle frequency	Quarterly (90 days)	Up to 9 months	Severe deviation
Central to regional transfer	Not stipulated	Variable; 2–6 weeks (primary bottleneck)	Structural failure
Regional to facility transfer	Not stipulated	Approximately 4 weeks	Acceptable
Billing accuracy	Accurate, auditable	Documented inaccuracies and fraud	Counter-verification required

Source: Author's compilation from interview transcripts and contractual specifications.

Monitoring, Accountability, and the Two-Layer Verification Architecture

The programme's monitoring system is structured around a hierarchical verification and counter-verification architecture. Health facilities declare services rendered through formal bill submissions. Independent Medical Verifiers conduct field verification of declared services. The Regional Coordination team undertakes counter-verification as a second-order check. This two-layer system embodies what one marketing officer aptly characterised as *'policing the police.'* It reflects sophisticated awareness of the need for hierarchical independent oversight in a programme context susceptible to billing manipulation.

Community-level feedback is gathered through community surveys and CHW-mediated reporting networks. The use of mobile phones and text messages by CHWs reflects adaptive appropriation of available technology in low-resource contexts. However, this feedback system's

dependence on telecommunications reliability introduces a vulnerability in areas with poor connectivity. The absence of designated transportation for Medical Verifiers creates systematic accountability blind spots in the most remote communities.

Implementation Challenges and the Sociopolitical Crisis Dimension

Beyond the structural deficits within the strategic purchasing architecture itself, the study identified a constellation of implementation challenges. Digital infrastructure failures constitute the most pervasive operational challenge, cited by five of six participants. The enrolment platform, billing submission platform, and health facility statistics management software are variously non-functional or persistently unreliable. One administrator noted: *'Platform for enrollment not working; software to manage health facility statistics not working; poor internet connections.'* This digital infrastructure gap is a foundational constraint on strategic purchasing effectiveness. All four purchasing functions depend fundamentally on accurate, timely, and accessible data (Mathauer et al., 2019).

Provider motivation emerged as a cross-cutting challenge with direct implications for care quality. One marketing officer captured this dynamic with striking precision: *'Health voucher providers are left unrecognised; the program is free and providers go unmotivated. When providers are not motivated, quality can be a challenge.'* This observation resonates with broader findings on health worker incentives in fragile and post-conflict settings (Witter et al., 2016). Billing fraud and data falsification represent a documented programme integrity risk. Participants directly referenced *'faking values that are not real in the field'* and *'billing inappropriate values.'*

The sociopolitical crisis in the Northwest Region adds a crucial contextual dimension. The Anglophone separatist conflict has generated security challenges, restricted provider mobility, disrupted supply chains, and created pervasive community distrust of public institutions. One participant noted: *'Network is poor; geographical topography is a bad factor; denial from pregnant women who don't want or their spouses thinking it's political.'* The ongoing conflict thus adds a critical additional constraint layer that amplifies all other implementation challenges (Newbrander et al., 2011).

Policy Opportunities and Pathways Forward

Despite the constellation of implementation challenges, participants demonstrated sophisticated awareness of potential solutions. With regard to digital reform, one coordinator specifically advocated for *'leveraging Cameroonian software engineers to come out with platforms that are efficient, easy to use by anybody.'* The most analytically sophisticated

recommendations concerned innovative domestic financing mechanisms. Participants proposed pre-positioning of funds at the central level, a solidarity fund model financed through civil servant health levies, tax reform targeting health-damaging products, and the expansion of technical partnerships. Pre-positioned facility funding, endorsed by five of six respondents, addresses the resource-before-delivery paradox directly. *'The ministry should make money available in advance so that bills are paid immediately they are tabled,'* one Head of Section urged (Cashin et al., 2017).

DISCUSSION

This investigation reveals a health voucher programme that has successfully established a foundational strategic purchasing architecture. Yet the programme operates substantially below its design potential. The implementation gap between technical design and operational effectiveness is wide.

The most analytically consequential finding concerns the post-service reimbursement model and its systemic consequences. Unlike prepayment architectures that distribute financial risk prospectively, the Cameroon voucher systematically transfers government UHC commitment as a financing burden onto the health facilities. Payment delay is therefore not a peripheral operational inconvenience. It is a mechanism through which structural financing deficits cascade across all four strategic purchasing functions simultaneously. The 9 month payment delay documented in 2025 has four cascading effects: it undermines benefit package delivery, weakens provider contracting relationships, creates conditions conducive to billing fraud, and diverts monitoring capacity toward delay communication. These dynamics illustrate broader public financial management challenges documented across African health systems (Cashin et al., 2017).

The absent performance-based contracting represents the second critical structural deficit. The international evidence base unambiguously shows that quality-linked payment mechanisms improve healthcare quality, enhance provider motivation, and strengthen accountability (Soeters et al., 2006; Bertone & Meessen, 2013; Fritsche et al., 2014; Morgan et al., 2018). Rwanda's nationally scaled results-based financing model provides a particularly instructive precedent (Soeters et al., 2006). Comparable evidence from Nigeria suggests that the design of the purchaser-provider relationship is critical to whether strategic purchasing translates into improved population health (Etiaba et al., 2018). Cameroon's programme currently forgoes this proven lever for quality improvement.

The 50% non-facility delivery rate presents a fundamental programme adequacy challenge. Health vouchers are demand-side interventions designed to reduce the financial cost of facility utilisation (Bellows et al., 2013; Brody et al., 2013). When half the target population

does not utilise facilities regardless of financial incentives, the voucher scheme can reach a maximum of only 50% of its intended beneficiary population. This finding necessitates a reconceptualisation of the programme's theory of change. Demand-side financing requires complementary supply-side interventions (Hanson et al., 2022).

In fragile and conflict-affected settings, the implementation gap is widened by additional context-specific constraint layers (Newbrander et al., 2011; Witter et al., 2016). The Anglophone sociopolitical crisis generates security barriers to mobility, disrupts supply chains, erodes community trust in public institutions, and creates political contestation around the meanings and intentions of government health interventions. These context-specific challenges require context-tailored, rather than generic, policy responses. Table 3 presents eight evidence-based policy recommendations, sequenced by analytical priority and intended implementation phase.

Table 3. Phased policy recommendations for the Cameroon health voucher programme

Phase	Recommendation	Function addressed	Horizon
1	Establish pre-positioned UHC facility funding mechanisms at the central government level, capitalised at the beginning of each fiscal year. In the short term, establish a revolving facility fund at regional level.	Payment mechanisms	0–24 months
1	Introduce performance-based contracting addenda, beginning with Phase 1 core indicators (delivery volume, patient satisfaction, data accuracy) and expanding to clinical quality measures, with bonus payment structures.	Provider contracting	12–36 months
1	Commission purpose-built digital infrastructure encompassing beneficiary enrolment, provider billing submission, and real-time monitoring modules, with integrated Camtel connectivity at all accredited facilities.	Cross-cutting	0–18 months

Phase	Recommendation	Function addressed	Horizon
2	Implement geographically equitable facility expansion with targeted accreditation support for lower-capacity remote facilities, geographic equity analysis, and mobile health units.	Benefit package access	12–36 months
2	Provide dedicated transportation resources for medical verifiers to ensure systematic accountability coverage in remote areas currently experiencing verification blind spots.	Monitoring and accountability	0–12 months
2	Develop structured provider motivation frameworks combining annual recognition programmes, in-service training, and programme participation allowances.	Provider engagement	12–24 months
3	Evolve the benefit package to include non-communicable disease management, beginning with gestational diabetes and hypertension screening, informed by a rapid burden assessment.	Benefit package design	24–48 months
3	Establish domestic solidarity financing mechanisms through legislative action, creating dedicated revenue streams via civil servant health levies, excise taxes on health-damaging products, and corporate contributions.	Sustainable financing	24–60 months

Source: Author's synthesis of empirical findings and the international evidence base on health financing reform.

CONCLUSIONS

This investigation has presented comprehensive qualitative evidence on the operational dynamics of the Cameroon health voucher programme. It reveals both institutional achievements and critical structural deficits. The findings carry significant implications for programme scaling, policy reform, and the international evidence base on health financing in fragile contexts (Hanson et al., 2022).

The eight evidence-based recommendations advanced are not aspirational. They are operationally actionable within existing governance structures. Pre-positioned funding, performance-based contracting, and digital infrastructure investment have demonstrated precedent in comparable low-resource settings (Soeters et al., 2006; Mathauer et al., 2019; Honda et al., 2016; Etiaba et al., 2018). Their implementation constitutes a systemic prerequisite for the health voucher programme to achieve its transformative potential.

Several limitations of this study merit acknowledgement. First, the sample comprises six Regional Coordinators rather than the full spectrum of stakeholders. Second, the study is situated within a single region (Northwest) and therefore cannot be generalised statistically to other Cameroon regions. Third, the study is cross-sectional. Fourth, the study relies entirely on interview data without triangulation through facility-based observation. Notwithstanding these limitations, the study contributes original qualitative evidence to the health financing literature with direct implications for programme redesign, scale-up strategy, and health systems strengthening in Cameroon and comparable settings.

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DISCLAIMER

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