1. Overview

Cameroon is a lower middle-income country with around 23 million inhabitants, half of whom live in urban areas. This bilingual (English–French) country in Central Africa is made of 10 administrative regions divided into 189 health districts. Primary health care (PHC) is provided in line with the health district framework proposed by the World Health Organization (WHO) Regional Office for Africa, entailing a nurse-based, doctor-supported infrastructure of State-owned, denominational and private integrated health centres. It is supported by a diverse and fragmented system of community health workers recruited by priority public health vertical programmes. The 2016 evaluation of this sectoral strategy found that 7% of the 189 health districts were serviced. The PHC system has achieved high routine immunization coverage rates, high coverage of malaria-preventive technologies and high coverage of HIV screening.

PHC performance in Cameroon is below expectations when compared to the current health expenditure, mostly because of growing privatization, the weak regulatory system and lack of accountability. Cameroon has one of the highest levels of health care expenditure occurring in the informal sector (up to 30%, mostly in primary health care). User fees are usually charged at the point of use, except for some services for specific population groups. Up to 66% of health expenditure is out-of-pocket payments. The maternal mortality ratio has increased in Cameroon during the last 20 years, despite the increasing annual per capita health expenditure, which reached US$ 59 in 2015. Growing privatization has led to a low servicing rate for health districts, particularly in rural areas, and there are stark inequalities in the distribution of human resources.

The epidemiological profile of the country is marked by a predominance of communicable diseases, including HIV/AIDS, malaria and tuberculosis, which represent 23.66% of the overall disease burden, along with a remarkable increase in mortality due to noncommunicable diseases, including cardiovascular diseases, cancers, mental illnesses and trauma due to road accidents, accidents at work and occupational diseases. Among children aged under 5 years, lower respiratory tract infections, malaria, diarrhoeal diseases and nutritional deficiencies are the main causes of morbidity and mortality. Maternal mortality remains high at 782 deaths per 100,000 live births. Between 2004 and 2014, neonatal mortality slightly decreased from 29 per 1000 to 28 per 1000 live births; during the same period, the child mortality rate decreased from 144 per 1000 to 103 per 1000 live births, while the infant mortality rate decreased from 74 per 1000 to 60 per 1000 live births.
2. Key indicators

Table 1 presents key indicators in the PHC sector.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Results</th>
<th>Source of information</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population of country</td>
<td>23 344 179</td>
<td>World Bank database (2015)</td>
<td>From the last general population census of 2007 to 2015 the population increased by 22.4%, or 2.5% annually</td>
</tr>
<tr>
<td>Distribution of population (rural/urban)</td>
<td>51.5/48.5</td>
<td>Third general population census (2007)</td>
<td></td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>55.5 years</td>
<td>World Bank database (2014)</td>
<td>Life expectancy has increased gradually from 51.9 years in 2000</td>
</tr>
<tr>
<td>Infant mortality rate</td>
<td>57 per 1000</td>
<td>United Nations Children’s Fund (UNICEF) (2014)</td>
<td>Trends indicate a decrease from 61 per 1000 in 2012 and 60.8 per 1000 in 2013</td>
</tr>
<tr>
<td>Under-5 mortality rate</td>
<td>87.9 per 1000</td>
<td>World Bank database (2015)</td>
<td>Trends indicate a decrease from 150.4 per 1000 in 2000</td>
</tr>
<tr>
<td>Maternal mortality ratio</td>
<td>782 per 100 000</td>
<td>Demographic and Health Survey (2011)</td>
<td></td>
</tr>
<tr>
<td>Immunization coverage</td>
<td>73% (rotavirus) 85% (pneumococcal)</td>
<td>UNICEF database (2015)</td>
<td></td>
</tr>
<tr>
<td>Income inequality (Gini index)</td>
<td>0.389</td>
<td>United Nations Development Programme (2014)</td>
<td></td>
</tr>
<tr>
<td>Total health expenditure as % of gross domestic product (GDP)</td>
<td>4.1%</td>
<td>World Bank database (2014)</td>
<td></td>
</tr>
<tr>
<td>PHC expenditure as % of total health expenditure</td>
<td>27%</td>
<td>National Health Accounts (2012)</td>
<td>The estimate is derived from expenditure on ambulatory care, immunization, and traditional medicine, while excluding expenditures on medicines</td>
</tr>
<tr>
<td>% total public sector expenditure on PHC</td>
<td>Not reported</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per capita public sector expenditure on PHC</td>
<td>Not reported</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-pocket payments as proportion of total expenditure on health</td>
<td>66.3%</td>
<td>World Bank database (2014)</td>
<td></td>
</tr>
</tbody>
</table>
3. Historical background

The evolution of primary health care (PHC) in Cameroon covers two main periods—before and after the International Conference on Primary Health Care, Alma-Ata, 1978, the main outcome of which was the Alma-Ata Declaration on Primary Health Care (1, 2). Before Alma-Ata, two approaches had been adopted. The first was a medical approach based on colonial-inspired vertical programmes (urban public hospitals and rural denominational hospitals) in which good health was synonymous with absence of disease. The selected care was free of charge, and the community followed the health workers’ instructions. Following that, a “health services” approach was applied, characterized by the four “demonstration zones of public health action” put in place in 1967 under the inspiration of WHO and intended to introduce progressively selective health care and services deemed economically viable. The approach introduced the concept of village health teams and village dispensing pharmacies managed by local health personnel through a cost recovery mechanism underpinned by working capital. Evaluation of the system showed that (a) community-based health activities had positive effects and stimulated demand; and (b) communities were willing to contribute (to some extent) to the financing of health facilities and activities, including village pharmacies. Community involvement was mostly passive.

In the wake of the Alma-Ata conference, which enshrined the notion that health should go beyond the delivery of care and promote community involvement in order to make a significant impact on health status (3), Cameroon adopted a series of health reforms in 1982. However, the Ministry of Public Health found in a 1988 survey that there had been selective implementation of PHC through vertical programmes carried out in parallel to and independent of the health system. Indeed, the system had not been restructured to integrate PHC; the use of community health workers without proper training was inefficient; mechanisms to ensure proper community participation were non-existent; and health workers did not receive continuing professional development for supervision of community health workers.

The subsequent Reorientation of Primary Health Care (Reo-PHC) involved a realignment of the National Health System towards the social goal of Health for All (4). The purpose of Reo-PHC was to ensure universal access to PHC services through a decentralized management process focused on the health district level, with the institution of the integrated health centre as the first level of contact with the health system (5, 6). The aim was to integrate health activities at the level of the health centre, while empowering the communities involved in financing and management (7). This reorientation, supported by technical and financial partners through regional pilot experiments, has not, however, fully achieved the desired objectives. National seminars in 1993 and 1994 resulted in the development of a legislative and regulatory framework that placed the health district as the foundation stone for PHC implementation, including the institution of district health management teams and district dialogue structures in the form of district health committees and district management committees. This restructuring formed the basis of the Health Sector Strategy 2001–2015 and its updated version of 2007.

Figure 1 summarizes the historical background of PHC in Cameroon.

---

1 Zones de démonstration d’action de santé publique.
2 UNICEF study, 1999.
Since 1999
Promotion of health district approach,
Health Sector Strategy 2001–2015
- Implementation of PHC: PHC activities carried out at the health areas level / community health workers to be revamped
- Dialogue structure gradually put in place / functionality questionable / judiciary framework still expected

Community development approach
- Health = human condition
- Community = help attain the condition by participation in decision-making

1993
National Declaration on the Implementation of the Reorientation of Primary Health Care: partnership between government and communities based on co-financing and co-management

1995
Organization of the health system: national, intermediary, peripheral / health district
- Health district: health area management committee, district health management committee, district hospital management committee
- Regional special fund for health / essential drug programme

1982–1988
implementation of Alma-Ata principles, adopted reforms (1982)

1988
PHC implementation found to be vertical without effect, need for reorientation (Ministry of Public Health)

1978
Alma-Ata 1978
Primary health care reforms

Health service approach
- Health = WHO definition / orientations
- Community = help deliver services

Post Cameroon independence (1960–1978)
- 1967: Demonstration of public health actions – zones in 4 areas: gradual introduction of rationalized and economically sustainable health activities / health team spirit / village health committee

Medical approach
- Health = absence of disease
- Community = follow the doctor

Colonial period and before Cameroon independence (1960)
Dr Eugene Jamot strategy / mobile team / vertical programmes, colonial interest oriented: hospital development
4. Governance

The health district is the operational unit for primary health care. Organized in a territory comprising one or more municipalities, the district shall, by decree, be managed by a district management team. A district health committee and a hospital management committee constitute the dialogue structures responsible for translating community participation into practice and promoting the ownership of health services by local actors (6). According to the 1996 Constitution and the laws and regulations on the decentralization of the State of 2004, the municipalities are responsible for public health and sociocultural development. Figure 2 presents information on the different levels of the health system in Cameroon (8).

Co-management of the non-community budget (various solidarities) within the partnership framework is interpreted differently by officials of the Ministry of Public Health and community representatives. The former consider it their private “turf”, while the latter, though aspiring to be “co-managers”, lack understanding of the expectations and attitudes of the former. Reo-PHC is far from being a reality on the ground. Indeed, the actors have not been appropriately redirected towards this new approach, which probably explains the low level of development of health districts (7%) by the end of 2015 and the lack of involvement of communities, despite the establishment of a number of dialogue structures by the Ministry of Public Health, including the 10 regional funds for health promotion.

The strategic paper on the Health Sector Strategy 2001–2015 had among its major objectives the decentralization of the health system, including empowerment of health districts while the central level gave direction in the areas of monitoring, control, regulation and standards. A gradual decrease in the number of vertical programmes was intended, while health districts developed expertise in providing integrated and comprehensive intervention packages to the population. Indeed, the multiplicity of vertical programmes led to systemic inefficiency, duplication of services and resource wastage, even if the results were satisfactory in terms of coverage of the target population.

---

**Figure 2: Different levels of the health system in Cameroon**

- **Administrative structures**
  - Prime Minister’s Office
  - Office of the Minister of Health
  - General inspections
  - General secretariats
  - General directorates
  - Central directorates

- **Competences**
  - Development of concepts, policies and strategies
  - Coordination
  - Regulation

- **Health structures**
  - General, central and teaching hospitals
  - Centre Pasteur
  - National Essential Medicines Supply Centre
  - National laboratory for Medicines Quality Control
  - Public Health Observatory

- **Dialogue structures**
  - National Council of Health, Hygiene and Social Affairs
  - Regional funds for health promotion

- **Technical support to health districts**
  - Regional hospitals
  - Regional pharmaceutical supply centres

- **Implementation of PHC programmes**
  - District hospitals
  - Health clinics
  - Medical centres
  - Integrated health care centres
  - Dispensaries

---

4 Ministerial decrees No. 0016/A/MSP/SG/OMH/SDH/PFSP/BFSP of 5 November 2001 creating health districts; and No. 0035/A.MSP/CAB of 8 October 1999 fixing the modalities for creation, organization and operation of health districts.
5. Financing

If the health fiscal space has expanded over the last decade with the end of the structural adjustment programme, there is still no taxation directly allocated to health. Cost recovery at the point of care constitutes the main purchasing mechanism for PHC services, and prepayment through microinsurance, mutual funds or health insurance remain of marginal importance. Addressing the three funding functions of primary health care (resource collection, pooling of resources, and purchasing of health care and services) is impeded by the lack of specific documentation.

Prior to Alma-Ata, the majority of certain selected PHC services were free, except for medicines and drugs in dispensing pharmacies and remunerated services in hospitals and health centres. After Alma-Ata, PHC services were free or partially subsidized on the basis of standardized but differentiated care between public, private and for-profit health facilities. With the onset of the economic crisis (1985/1986), which resulted in the imposition of structural adjustment, there were frequent shortages of subsidized drugs and consumables. Under the Bamako Initiative (1987), widespread use was made of cost recovery to access PHC services, with the exception of a few public health programmes such as the Expanded Programme of Immunization.

PHC funding now has two main sources: (a) community based, through fee for services at the point of delivery, purchase of medicines, human investment, donations and legacies; (b) non-community based, in the form of national solidarity through the public budget and international solidarity through public aid to health development. Since 1994 a regulatory regime for fiscal federalism has been in force, with health committees and management committees of public health facilities given responsibility for the pricing of PHC services, determination of the level of the costs, and the allocation of local tax resources generated for the operation according to a distribution schedule updated in December 2016. As for denominational and private health care facilities, pricing is more related to market rules and principles, with marginal regulation of prices under the responsibility of the Ministry of Commerce.

The framework of analysis of the National Health Accounts does not allow determination of the relative magnitude of expenditures associated with primary health care. The financial resources for health come from the government, private companies, technical and financial partners, nongovernmental organizations (NGOs), households and benefactors. An analysis of the breakdown of current expenditure shows that households contributed 70.42% in 2012. The share of the Ministry of Public Health’s budget in the overall State budget has stagnated at around 4.87%, far below the commitment under the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, which invited the African States to allocate 15% of their budgets to health (9). Private funding represents 55%, of which 52% is paid by households. External financing of PHC programmes was estimated at 65 billion Central African francs in 2015, mostly geared towards three domains: maternal, child and adolescent health (34%), disease control and health promotion (38%), and health district development and servicing (28%).

Purchasing mechanisms for PHC vary according to government priorities, and may be categorized as follows:

- **Gratuity payments** are the main mechanism used by the State (public funding) to support the control of communicable and noncommunicable diseases for all or part of the population.
- **Subsidies** are in place for the management of certain diseases with social impact, in order to encourage the participation of households. Examples include a voucher scheme for pregnant women; obstetric kits; vitamin A supplements for children aged under 5 years and postpartum women; treatment for acute, severe and moderate malnutrition; cancer chemotherapy; and haemodialysis).
- **Out-of-pocket payments** are the most widespread purchasing mechanism, greatly contributing to the inaccessibility of care for many inhabitants. In 2009, spending on health care in Cameroon was estimated at 680 billion Central African francs, more than 75% of which is borne by households. Around 95% of household expenditure is disbursed at care delivery points during episodes of disease.6

---

5 National Health Accounts, 2011 and 2012.
6 WHO data, 2009 and 2010.
• **Performance-based payment** has been deployed by the government since February 2011 through the World Bank-funded Health Sector Investment Support Project in a few regions in the form of a pilot project to improve the quality of care and the health of the population.

• **Prepayment mechanisms** are poorly developed, contributing to marginal financing of PHC. The open market sector for voluntary health insurance is dominated by about 15 private insurance companies. The coverage rate by risk-sharing schemes varied from 0.1% in 2001 to about 2% in 2015, for example through company health services, commercial insurance schemes, and health mutual funds (158 rural community mutual funds covered 1.5% of the population compared to the 40% target in 2010, versus 43 funds in 2013 covering nearly 43,000 people or 0.2% of the population). Commercial insurance schemes target the high and intermediate income groups, including formal sector workers covered by their employers (10, 11). The poor coverage rate of health insurance schemes partially explains the amount of expenditure in the informal health sector, estimated at 27%.

6. Human resources

According to data from the third general census, the ratio of health personnel to population is 1.07 per 1000 inhabitants (8, 12). The differential analysis confirms that the large deficit of specialists in medicine, maternal health, obstetrics, and child care contrasts with the self-sufficiency in nurses and the inadequate absorption by the public and private sectors. While the prospects for an increase in trained personnel are in some respects favourable – given the national annual increase of trained doctors and pharmacists since 2012, and implementation of a strategic plan for the development of medico-surgical specialties since 2010 – the training in community-centred health care that has long been the hallmark of the Yaoundé School of Medicine has been evanescent for a decade, while three private schools have been training community health workers since 2013 (13).

Inadequate distribution of staff is a bottleneck in the implementation of PHC. The very high concentration of human resources in urban areas contrasts with the shortage in rural areas. Disparities are sharp between administrative regions and between districts. The 2014 personnel census revealed that 147 districts out of 181 had less than 50% of the staff required. The economically wealthier regions – Centre, Littoral and West – concentrated 11,777 out of 19,709 health workers, or 59.75% to serve 42.14% of the country’s total population. This situation has a negative impact on PHC outcomes, for example the coverage of preventive services for mother-to-child transmission of HIV, which is lower in rural areas, and tetanus immunization coverage (80% in urban areas against 68% in rural areas). The four regions with the lowest numbers of health care staff contribute to more than three quarters of the 4500 maternal deaths recorded.

The demotivation and frustration of community health workers are related to abuses of authority and low, irregular and discriminatory wages. The 5% increase in the wages in the public sector in 2014 did not catch up with the loss of purchasing power of health personnel after the wage cuts of 1992 and 1993 and the devaluation of the Central African franc in 1994. Health professionals at the operational level denounce the harsh living conditions in rural, landlocked areas, the lack of socio-educational infrastructures, insecurity, sociocultural problems, arbitrary assignments and noncompliance with the regulations governing the management of careers (14, 15).
7. Planning and implementation

After Alma-Ata, the implementation of reforms started without proper planning or integration of pre-existing interventions. The 1988 assessment confirmed the relative effectiveness of vertical programmes independent of the health system and not related to the ideals of PHC. However, no structural reform had been initiated to integrate PHC services; community health workers had been identified in the communities and recruited without appropriate training and supervision on the ground; and participation of the community in the identification of health priorities was virtually non-existent. These observations led to a new policy direction, as enshrined in the 1993 National Declaration on the Implementation of the Reorientation of Primary Health Care. However, there was no integrated strategy for policy implementation. Several planning mechanisms have been imposed by technical and financial partners as a consequence of the national planning policy being abandoned in the context of the structural adjustment programme (4).

The first national approach to health sector planning occurred in 2000, though health districts had been set up in 1994 and the Framework Law on Health had been adopted in 1996. The first Health Sector Strategy 2001–2015, updated in 2007, was followed by the failed introduction of a Sector-wide Approach (SWAp) in 2006/2007. Multiannual development plans at the level of the health districts, consolidated at the regional level, were developed in a participatory manner using the same approach at the national level. However, the experiment has not been repeated. On the other hand, annual workplans for vertical programmes are regularly developed and implemented with some efficiency. Communities have been little involved in planning whereas they are regularly called upon for the implementation of interventions at the operational level (for example, social mobilization for immunization, vaccinovigilance).

The main planning tools in the health sector are the Medium-Term Expenditure Framework (sectoral and ministerial MTEF) and the programme budgeting. Community participation remains marginal, and there is a lack of technical staff and management structures to ensure the involvement of the community as a partner, in accordance with the canons of PHC and on the basis of co-financing and co-management as stipulated in the National Declaration on the Implementation of the Reorientation of Primary Health Care.

8. Regulatory process

The Cameroonian system has shortcomings in several areas, including (a) the obligation of civil servants to be accountable for the deployment of resources and the achievement of objectives; and (b) the capacity to undertake a number of activities, including monitoring the quality of services; providing the needed infrastructure, medical equipment and products in conformity with standards; development of guidelines, norms and standards; and protection of the interests of users. The weak enforcement of laws and regulations pertaining to licensing health professionals and PHC services jeopardizes the quality of services (16). Several informal health care centres and dispensaries as well as street vendors of medicines are diverting up to 27% of household health expenditures. The National Drug Commission operates in a very approximate manner and the professional orders are still centralized within their legislative frameworks adopted in the early 1980s.
9. Monitoring and information systems

The midterm evaluation of the first Health Sector Strategy 2001–2010, carried out in 2006/2007, led to its being updated in line with the achievement of the Millennium Development Goals in 2015. The 2001–2015 Health Sector Strategy reinforced the role and viability of the health district by strengthening the health district system, including through integration of reforms in line with the Alma-Ata Declaration, leading to greater institutional, technical and economic autonomy for health districts.

Overall, monitoring and information systems are performing poorly in Cameroon. An evidence-based policy brief (17) noted the following in 2010: (a) only one of the health districts went farther than the start-up phase in the process leading to autonomy; (b) routine population-related data were poorly reported, including in the areas of epidemiology, the budget, mapping of health facility services, infrastructure and equipment, and human resources. The updated health sector strategic paper considered health information as a priority intervention area, with the aim of having 90% of health facilities managed using proper documentation. Specifically, this involves (a) properly organized data collection; (b) analysis of the data; and (c) using the data for continued improvement of the quality of services and care. An analysis by the Health Metrics Network gave the following scores on a scale from 0% to 100%: data management 28%, civil registration system (including registration of births and deaths) 18%, access to census information 38%, access to information on health mapping 39%, and access to information on human resources 59%.

Very often, information is not considered as a resource, and being transferred to a data collection unit is perceived by the staff as a form of punishment. The lack of analysis and exploitation of data at the local level, the low levels of feedback, and inadequate sharing of data between public and private actors within the health pyramid reinforce the perception that the data collected are useless. These weaknesses undermine the monitoring and evaluation of the use of resources, the supervision of the servicing process of health districts, and equity-oriented planning.

Though the development of multi-year health development plans at the health district level and their consolidation at regional level in a structured and organized manner were put in place in 2008, monitoring and evaluation are confined to each implementation structure, including programmes, without merging into an integrated monitoring and evaluation plan, as provided for in the Health Sector Strategy 2001–2015. PHC activities were taken into account in the pilot phase of the World Bank-supported Cameroon Health Sector Investment Support Project through performance-based funding in some health districts, and in the monitoring and evaluation mechanisms for the National Health Development Plan 2012–2015. The monitoring and evaluation system for performance-based funding has focused on a few performance indicators of the management process: outcome indicators and impact indicators regarding relevance, effectiveness, efficiency, equity, accountability and transparency; flows and use of financial, human, material and logistic resources; and user satisfaction in terms of preventive and curative care under the Minimum Package of Activities and the Complementary Package of Activities. However, these activities were monitored and evaluated in less than a quarter of the health districts in four regions.

A monitoring and evaluation framework was established to align with the 2012–2015 National Health Development Plan. Apart from activities within programmes and some health districts, no planned monitoring and evaluation activities were carried out. Despite these shortcomings, some significant results have been recorded by the National Institute of Statistics (18) as follows:

- Infant and juvenile mortality decreased from 144 per 1000 to 103 per 1000 between the periods 1999–2004 and 2010–2014 (though not reaching the target of 76 per 1000).
- Overall HIV prevalence decreased from 5.5% to 4.3% between 2004 and 2014, though with marked disparities between regions and certain social groups.
- Distribution campaigns for long-lasting insecticide-treated nets achieved a 54.8% coverage rate amongst children aged under 5 years in 2014 against 0.9% in 2000.
- Free-of-charge care against malaria amongst children aged under 5 years has been effective since 2013.
- Full vaccination coverage for children aged 12–23 months increased from 48% to 75%, while immunization coverage against measles rose from 64% to 89% between 2004 and 2014.
10. Strategic outlook and considerations

The Cameroonian health system has adopted its Health Sector Strategy for 2017–2026. The strategy is aligned with the Growth and employment strategic document 2010–2020 (19), with the development of the health district as a strategic priority objective and with universal health coverage as the ultimate goal. The proposed structure of the community-level health services aims to strengthen the integration of health programmes and accelerate the development of the health district model. There is continuing debate on how to implement decentralization of public health through the effective transfer of powers from the central State to the municipalities. The option chosen was the adoption of performance-based funding as part of the State budget allocation framework for the purchase of care and services. The architecture of universal health coverage has recently been adopted, though the weak regulation of the health sector and the liberalization of training for health care professionals continue to conspire to relegate primary health care and the concepts of community health to the background, to the benefit of curative care in a profit-oriented environment.

References

5. The implementation of the reorientation of PHC services in Cameroon. Cameroon: Ministry of Public Health; 1997.
17. Ndongo JS, Ongolo Zogo P. Policy brief on strengthening the health information system to accelerate the servicing of health districts. Centre for Development of Best Practices in Health, Central Hospital, Yaoundé, Cameroon; 2010.
This case study was developed by the Alliance for Health Policy and Systems Research, an international partnership hosted by the World Health Organization, as part of the Primary Health Care Systems (PRIMASYS) initiative. PRIMASYS is funded by the Bill & Melinda Gates Foundation, and aims to advance the science of primary health care in low- and middle-income countries in order to support efforts to strengthen primary health care systems and improve the implementation, effectiveness and efficiency of primary health care interventions worldwide. The PRIMASYS case studies cover key aspects of primary health care systems, including policy development and implementation, financing, integration of primary health care into comprehensive health systems, scope, quality and coverage of care, governance and organization, and monitoring and evaluation of system performance. The Alliance has developed full and abridged versions of the 20 PRIMASYS case studies. The abridged version provides an overview of the primary health care system, tailored to a primary audience of policy-makers and global health stakeholders interested in understanding the key entry points to strengthen primary health care systems. The comprehensive case study provides an in-depth assessment of the system for an audience of researchers and stakeholders who wish to gain deeper insight into the determinants and performance of primary health care systems in selected low- and middle-income countries.