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RESEARCH ARTICLE

Health policy making process in Cameroon: a case for the utilization of the Target Policy Profile [version 1; peer review: 2 approved with reservations]

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Abstract

Background: Translating research findings into health policy often encounters numerous challenges in many African countries, including Cameroon. One of these challenges is the lack of standard tools and procedures to connect researchers to policy makers. A tool such as the Target Policy Profile (TPoP) can help to close this gap, since it is designed to optimize dialogue around the evidence needed to effect a change in policy. In this paper, we assessed the policy making process in Cameroon and suggest how the process can be optimized using the TPoP.
Methods: This study reports on qualitative data obtained from in-depth interviews of purposively selected individuals, and quantitative data extracted from strategic plans and reports of 17 vertical health programs in Cameroon.
Results: The majority (10/17) of our respondents were males and had an average of 6.5 years' experience in policy making in Cameroon. A relatively small number of interventions/policies (19) were introduced by the assessed programs between 2015-2020. An even smaller number (9) are planned for introduction in the upcoming years. Four major gaps were identified in the policy making process, including lack of standardized methods and tools, limited use of evidence, limited ownership of the process by the state, and limited evaluation of newly introduced policies/interventions. Our respondents considered the TPoP to be a useful tool, which can help improve policy development, implementation, and evaluation across their different programs.
Conclusion: The TPoP can help address gaps identified in the health policy making process in Cameroon. Continued advocacy to help

stakeholders understand its value proposition as well as training them
on its use cases, may facilitate its adoption and use in Cameroon.

Keywords
Situational analysis, Health policy, Target Policy Profile, Cameroon,
policy makers, policy making,

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Introduction

In public health, policy refers to health laws and regulations that are aimed at fostering system development for the purpose of achieving defined goals in a given context[1,2]. According to the United States (US) Centre for Disease Control and Prevention (CDC), policy development is a key public health function and its importance cannot be overstated, given that health policies frequently influence the allocation of resources[3,4]. Policy development is intricately linked to available scientific evidence, as health policies are generally developed or changed to suit the latest available research evidence on the subject.

Over the past few decades, a considerable amount of scientific research has informed changes in public health policies to suit the rapidly changing global health picture. These changes in policy have been the driving force behind some of the world's greatest public health achievements[5]. Despite such commendable progress, considerable challenges persist that hinder further progress, especially in the aspect of translating research findings into policy and, subsequently, everyday clinical practice. This is particularly true for low-and middle-income countries (LMICs), where studies suggest that it takes about two decades for innovative health research to be recommended for widescale adoption and use[6]. This lengthy delay emanates, in part, from the fact that many LMICs, including Cameroon, lack standardized procedures and tools to connect researchers to policy makers. The lack of such knowledge translation infrastructure underlines the pressing need to establish resilient policy making systems, which will ensure that pertinent information regarding the uptake of new interventions is factored-in in late-stage clinical trials. This inclusion may galvanize rapid uptake and roll out of live-saving interventions, which in turn may help avert several deaths and propel Cameroon towards its sustainable development goals targets.

To improve on the time lag between evidence generation from research, and the development of related health policy in Cameroon, we undertook a comprehensive situational analysis of the policy making process within the Cameroonian Ministry of Public Health (MoH). In this paper, we report the findings of the situational analysis that examined existing gaps in the policy making and leveraged the findings to make a case for the use of the Target Policy Profile (TPoP)[7] to enhance and accelerate rational health policy making/change in Cameroon.

Methods

Ethical approval

Authorization to conduct the survey was obtained from the Minister of Health, who oversees the National Ethics Committee. Participants were only interviewed after they had provided signed informed consent. Respondents were equally informed of their right to quit the interviews at any time, or to skip/not answer any questions they were not comfortable with. Lastly, participant privacy was ensured by anonymizing transcripts and audio recordings and using transcripts solely for the purpose of the study. Recordings were destroyed after transcription was completed.

Study design and duration

We conducted a mixed method study (qualitative and quantitative) over a four-month period. The quantitative part consisted of a survey of all health interventions/policies introduced between 2015 and 2020, as well as those planned for introduction across 17 vertical health programs (Table 1) of the MoH. The qualitative part, on the other hand, involved key informant interviews (KIIs), to gain insight on the policy making process and explore the perspectives of policy makers on the barriers to policy making/change in accordance with available scientific evidence. Proposals on ways to facilitate policy making and change were equally explored during the KIIs.

Study setting

This study was conducted in Cameroon, a country in the central part of Africa. Cameroon has shown, over the years, to be capable of creating and maintaining good partnership with stake holders and engaging discussions around key topics linked to global development goals. The country has aligned its development and health policies with the Sustainable Development Goals (SDGs) (https://sdgs.un.org/goals), making it eligible for grants from numerous Global Health Initiatives (GHI). This has translated into the creation of several vertical health programs, with the role of achieving these objectives within the stated time frame.

Sampling and study population

This study targeted all individuals involved in the health policy making process within the Cameroonian MoH. Managers of the different health programs were purposefully selected as key informants to be interviewed. This choice was based on the fact that as head of the health program, managers possess the most insight on program policies, vision, goals, and strategies, and are best placed to provide accurate, in-depth perspectives on their respective programs in the most reflexive and articulate manner. In case the manager was not available for the interview, the deputy or closest collaborator was selected.

Data collection

Quantitative data were collected by a team of five trained data collectors, (all Master of Public Health graduates who received a one-day training on data collection approaches) under the supervision of investigator RT. Quantitative data were extracted from key documents including reports and strategic plans of each health program for 2015–2020 and from 2021 onwards, using an excel sheet designed specifically for this purpose. The columns of the excel sheet captured information on key aspects needed from these documents while the rows indicated the particular document from which the data was extracted. These key documents were identified following a comprehensive desk review, with additional information obtained during interviews with key informants from the respective health programs. Identified key documents were then requested for and obtained as physical copies from the secretariat of the concerned health program (see Table 1 for the list of health programs surveyed). For each program, information was collected on the number of new interventions implemented

Table 1. List of vertical health programs surveyed.

#	Name of program
1	Information Technology (IT) Unit
2	National Program for prevention and Control of Schistosomiasis and soil-transmitted helminthiasis
3	National Committee for the Fight against Cancer
4	Public Health Emergency Operations Coordination Centre (PHEOCC)
5	National program for blindness control
6	Expanded Program on Immunization
7	National Blood Transfusion Centre (created in 2019 replacing the National Blood transfusion program)
8	Health System Performance Reinforcement Project
9	National AIDS Control Committee
10	The Joint MINSANTE-AFD-KFW Program - Health Voucher system
11	National program for the fight against Leshmaniasis, Leprosy and Buruli Ulcer
12	National Program to combat Onchocerciasis
13	National Malaria Prevention and Control Program
14	National Drug Control Committee
15	Program for the elimination of human African trypanosomiases (sleeping sickness)
16	National Public Health Laboratory
17	National Diabetes Control Unit

between 2015 and 2020, the number of interventions/policies planned for introduction in upcoming years (2021 onwards), the policy making process, the tools used, and whether post introduction evaluations were conducted after introduction of a new policy.

Qualitative data were obtained via KIIs. Individuals identified as key informants were called *a priori* to schedule a suitable date, time, and place at which they could be met for the interview. On arrival at the interview site, the interviewer verified that the interviewee was one of the key informants identified for the interview process. He then went ahead to obtain informed consent from the respondent and proceeded with the interview which lasted an average of one hour. Interviews were done with the aid of a question guide and recorded using a digital audio recording device[8]. Probing questions were used by the interviewer when necessary to get a deeper insight on responses provided by the interviewee. Pertinent points were jotted down as notes during the interview, which continued until no new information was provided by the respondent, at which point the interview was ended. Data collected were revised by the study team at the end of each day to better fit the local context and subsequent interviews.

Data analysis

Data gathered during KIIs were transcribed *verbatim* and checked for accuracy by the study team[9]. Recordings were destroyed once transcription was completed. Data were coded and analyzed using inductive thematic analysis, given that not much literature is available on the perspectives of individuals involved in health policy making in Cameroon, on the health policy making process in the country nor on the TPoP as a tool to enhance health policy making as it is relatively novel. First, the study team went through the transcripts to familiarize themselves with the data set and concepts within it. This was then followed by the development of a coding structure based on major concepts obtained upon reading through the transcripts. Next, the study team had a more detailed read of the transcripts during which they mapped statements and responses provided by participants against the different concepts of the coding structure, using a binary method (1: concept highlighted in the statement, 0: concept absent from statement). Similar concepts were then grouped together into broader groups or themes notably the policy making process, gaps in the policy making process, proposed solutions to identified barriers, feedback on the TPoP as tool to enhance policy making. To reduce any risks related to bias, the coding and thematic analysis

of transcripts was done by several members of the study team and reviewed by the principal investigator.

Results
Characteristics of respondents
A total of 18 interviews were conducted, one (transcript 16) with the technical advisor and representative of the Minister of Public Health, and the other17 with a representative from each health program,the majority (70.6%) of them being males. All survey respondents were involved in the health policy making process at the national level and were still in active service at the Ministry of Public Health (MoH) at the time of the study. Overall, respondents had an average of 6.5 years' experience in the health policy making process in Cameroon.

Policies implemented from 2015 – 2020 and planned policies from 2021 onwards
Table 2 shows the policies/interventions introduced between 2015 and 2020, as well as those planned for introduction from 2021 onwards, across the surveyed programs. A total of 26 key documents were reviewed during the data extraction process. As can be seen, a relatively small number of interventions/policies were introduced over the past five years, and an even smaller number are planned for introduction during the upcoming years. The Malaria control program introduced the highest number of policies/interventions

(06) between 2015 and 2020. This was closely followed by the National HIV/AIDS Control Program and the Expanded Program on Immunization (EPI), which both introduced five policies/interventions during the same period. With regards to planned policies for introduction, the EPI led the way with four policies/interventions planned for introduction from 2021 onwards.

Decision making process for the introduction of a new policy/intervention
The decision-making process for changing or introducing a new policy/intervention is shown in Figure 1. The process generally begins with informal discussions between a development partner and the target health program, and these discussions are often initiated by the latter. These informal discussions then lead to more formal talks, where a business case for a change in policy/intervention is presented to the appropriate policy making body such as the Country Coordinating Mechanism for HIV/AIDS, Malaria, and Tuberculosis or the Inter-Agency Coordinating Committee for vaccines. The business case is then discussed in detail, necessary modifications made, and an approval to introduce/update the policy/intervention given. However, for certain health programs such as the EPI, the introduction of a new policy or intervention follows a more stringent process. For this program, a scientific opinion is sought from the National Immunization Technical Advisory Group

Table 2. Interventions introduced per program between 2015 to 2020 and 2021 onwards.

Health Program Assessed	2015 – 2020	2021 onwards
National Malaria Control Program (NMCP)	Long lasting insecticide treated bed nets Intermittent preventive treatment of malaria in pregnant women Free testing and treatment in children below five Seasonal chemoprophylaxis Community directed interventions	Mobile clinics Indoor residual spraying
National AIDS Control Committee (NACC)	Test and treat Free testing and viral load Switch from CD4 testing to viral load Switch to Dolutegravir (DLT) for adults Introduction of DLT for kids	
Expanded Program on Immunization (EPI)	Injectable Polio Vaccine Pneumococcal vaccine COVID-19 vaccine Switch from Trivalent Oral Polio Vaccine (OPV) to Bivalent OPV	Hepatitis B birth dose vaccine Meningococcal vaccine Novel OPV Switch of Rotavirus vaccine
National Onchocerciasis Control Program	Community directed treatment with Ivermectin	
National Program for the Fight Against Soil Transmitted Helminths	Community directed treatment with mebendazole/albendazole	
Health Information Systems	District Health Information System Version 2.0 (DHIS-2) Logistic Information Management System	Electronic registration
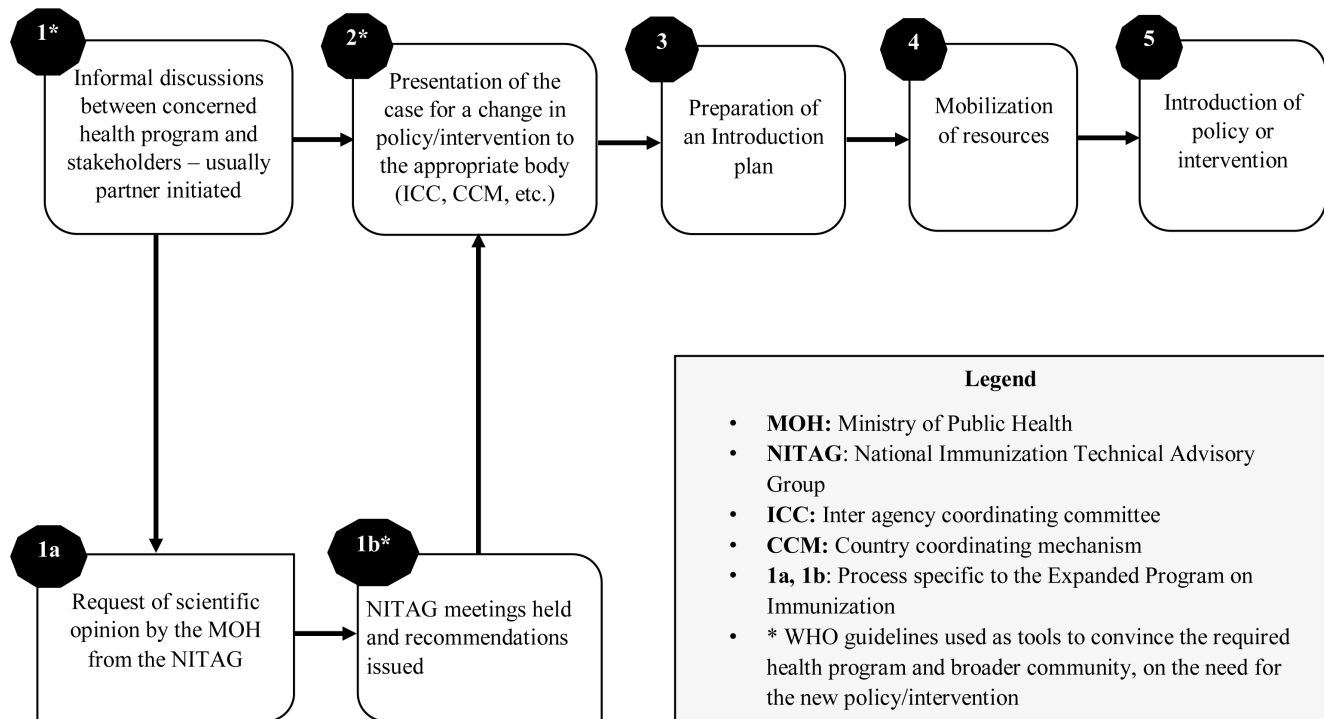
Figure 1. The health policy making process in Cameroon.

(NITAG) before a new vaccine can be introduced. The recommendations issued by the NITAG are then presented to the Inter-agency Coordinating Committee for approval. From here on, a common pathway is followed, where approval of the intervention leads to the preparation of an introduction plan, outlining how the policy/intervention will be implemented. This document aids in resource mobilization, which are in turn used to drive the introduction process.

It is important to highlight that not all business cases or interventions presented to the appropriate body are approved for introduction.

Gaps in the policy making process across the assessed programs

Four major gaps were identified in the health policy making process. First, the policy making process appeared to be unstandardized, with most of the surveyed programs lacking a standard methodology and tools for policy making. For instance, one participant noted that "…the general impression raises questions about the consistency of the process". Another mentioned that "…to the best of my knowledge, the process seems to be standardized only within the scope of the Health Sector Strategy and for some programs like the EPI".

Second, there seemed to be limited use of available evidence in the policy making process. One respondent mentioned that "Instructions from hierarchy lead to new policies at the expense of evidence, which is less utilised". Another further noted that "most of the local data used for policy making is often unreliable".

Third, there was a considerable lack of post introduction evaluations for newly introduced policies/interventions. For instance, one respondent noted that "the culture to conduct post introduction evaluations is yet to be adopted in our setting".

Finally, we noted a general lack of ownership of the policy making process by the state. The process is generally initiated and led by a development partner, and it most often does not involve all the stakeholders, as noted by one respondent "the process is mainly led by technical and financial partners and is not inclusive enough for all stakeholders".

In addition to these barriers, other factors impeding proper policy making were identified. These included health system barriers such as the lack of adequate and trained human resources for policy making, lack of financial resources to support the policy making process, and weak governance to lead and coordinate the entire process. External barriers were also noted, including frequent changes within the MoH, social upheavals and infrastructural challenges amongst others. A detailed outline of these barriers, as well as proposed solutions is presented in Table 3.

Feedback from respondents on the Target Policy Profile and potential use cases of the tool

Following the assessment of the policy making process, the TPoP was presented to respondents to obtain their feedback on the part the tool could play in enhancing the process. There was great optimism from respondents regarding the tool, with all 17 assessed programs expressing their interest in using it for rational policy making. For instance, one respondent

Table 3. Proposed strategies to address identified barriers to policy making.

Barrier type	Definition	Strategies to address barrier	
External settings	Environmental factors that are outside of the health system (e.g., political changes, social upheavals, geographical in accessibility, economic and infrastructural challenges)	• Address insecurity • Increase domestic funding to meet Abuja requirement	
Process Barriers	Barriers related to policy design, planning activities, executing activities, and monitoring and evaluating the activities	• A more forward-looking policy making (professional policy making) • Assess & adapt implementation of Policy Making process guidelines • Revamp policy dialogue between Ministry of health & private not for profit partners, other stakeholders • Involve more policy implementers in expert groups, assessments, preparing guidelines, or assessing particular actions in other to facilitate policy design and decision-making • Strengthen science-policy interface platform (go beyond policy briefs) • Strengthen evidence -based policy (data collection, prioritization, balance dialogue with donors, comprehensive national health policies, strategies and plans is as much a political process as a technical one) • Increase appropriation of policies • Promote and fund relevant and comprehensive policy assessments • Develop comprehensive strategic documents taking into consideration human-financial- resources as well as material & equipment • Policies & strategic documents should take into consideration insecurity, outbreaks, natural disasters including funding of contingency plans • Sharing of good practices and knowledge • Adopt a culture of assessment of our health policies and strategies implementation	
Health system barriers	Across the health systems building blocks, issues related to human resources, finance, and governance	Human resources	• Built the Capacities of policy makers (including positive mindset) • Provide more opportunities to local expertise • Leadership development across health system • Promote rational management of human resources • Improve working conditions of health personal and efficiently use existing skills
		Finance	• Speed up procedures while reducing overlapping controls in the spending chain • Increase domestic funding to meet Abuja requirement • Raise more resources to match needs • Enhance equitable distribution of resources across the 3 levels of the health system
		Governance	• Develop a policy making process guideline that will help address leadership conflicts, conflict of interest • Roll out training & implementation of policy Making process guidelines

mentioned that "the tool is a very interesting and useful one. Very relevant in the domain of knowledge translation which is a neglected field in our setting".

Another respondent noted that "…our decision makers are waiting for WHO or other organizations to develop the policy they are going to implement. It is a big step to develop the policy and this tool can be of great interest by guiding the process".

One respondent further highlighted that "…one major issue is the implementation of policies after their development. This tool tries to deal with the issue by advising to involve the decision makers at the beginning of the process and during all the process. That may surely improve the ownership and therefore the likelihood of utilization of the policy".

Building upon the feedback and information obtained from respondents, we identified five potential use cases for the TPoP which are summarized in Table 4. As illustrated, the use cases ranged from researchers using the TPoP to identify policy relevant research questions, to using the tool to develop a standardized method to appraise new policies/interventions and developing a policy implementation and evaluation guide. Potential amendments that could be made to the tool to render it more context specific and increase the likelihood of its utilization are highlighted in Table 5.

Discussion

The present situational analysis aimed to achieve four specific objectives, namely: map out the current health policy making process in Cameroon; identify and characterize existing gaps in the process in order to develop informed, appropriate,

Table 4. Potential use cases of the Target Policy Profile for health policy making in Cameroon.

Use Case	Person(s)/body
1. Identify policy relevant research questions, to carry out targeted research works, that will generate evidence required by policy makers to change existing policy or make new policy.	Researchers
2. Make a case for policy change by pointing out limitations of evidence backing current policy and highlighting the added value of new evidence/policy.	Researchers
3. Develop a standard appraisal methodology for assessing new interventions/policies based on cost effectiveness, feasibility, and risk benefits, and define a minimum threshold that appraised policies should meet to be considered for introduction.	Policy makers, National expert bodies, Health programs
4. Develop a pipeline of appraised interventions/policies for introduction and financing based on their level of priority or urgency.	Policy makers, National expert bodies, Health programs
5. Develop a policy implementation and evaluation guide	Policy makers, Health programs

Table 5. Proposed context specific amendments to the Target Policy Profile.

1. Translation of the tool to the French language for wider acceptability and use.
2. Incorporate questions seeking information on the expected funding source of the policy/intervention, to enhance the resource mobilization process should the intervention/policy be approved.
3. Include assessment of potential threats to the envisaged intervention/policy and explore mitigation strategies. This is particularly important in conflict afflicted regions of the country, where special considerations may be required for effective implementation of the policy/intervention.
4. Incorporate a comprehensive assessment of the mapping of partners who could be potentially involved in the coordination and implementation of the new intervention/policy. This will help improve on the coordination and implementation of the intervention/policy, as well as enhance inclusiveness in the policy making process.
5. Include questions assessing the ability of the government to bear the financial responsibility of the policy/intervention, once funding from external sources/partners is no longer available.
6. Shorten the tool by exploring ways to merge and summarize certain question prompts.

context specific solutions; leverage on results obtained to make a case for the use of the TPoP as a standardized tool to enhance and accelerate rational health policy making/change in Cameroon; and obtain feedback from key stakeholders on the TPoP and use this information to propose use cases and context specific amendments.

With regards to policy/intervention introduction, we found that a relatively small number of interventions/policies were introduced between 2015 and 2020 across the assessed programs, with a smaller number planned for introduction during the upcoming years. This could be attributable to a couple of reasons. First, information regarding policies/interventions introduced and those planned for introduction were not readily available in the strategic plans and reports for a considerable number of the assessed programs. Also, study respondents had little information on policies/interventions planned for introduction within their respective health programs. The second reason is the considerable time it takes for health interventions/policies to transition from research and development to effective implementation[6]. A study conducted by Brooks *et al*. assessing the interval between approval and introduction of four vaccines and a malaria intervention revealed that five years following approval, no low-income country had introduced the vaccines, while only 7% had introduced the malaria intervention[10]. A decade after approval, only 4% had introduced the vaccine against 37% for the malaria intervention[10]. Such a considerable time gap between intervention/policy approval and introduction would imply that only a few interventions can be introduced over short time frames like that assessed in our study (5 years). Improving dialogue between researchers and policy makers could help reduce this time gap, which in turn will accelerate the translation of research findings into policy and clinical practice. This could help curb morbidity and mortality figures in most developing countries, including Cameroon.

Regarding barriers to policy making and introduction of interventions, we identified four main factors that impede the health policy making process in Cameroon. These factors included the lack of standardized process and tools, limited use of available evidence, lack of ownership of the process by the state, and the lack of post-introduction evaluations. Addressing these barriers could be pivotal in enhancing health policy development and implementation. However, for these barriers to be properly addressed, their root causes will need to be identified and targeted strategies developed in collaboration with all relevant stakeholders[11,12]. The lack of post-introduction evaluation observed highlights the pressing need for regular policy/intervention assessment. This could help identify underlying policy issues and lead to an in-depth policy review and the subsequent cascade of events that could terminate in policy change[13]. The presence of these process barriers could be explained by the lack of standardized guidelines and tool to guide the policy making process. The use of a standardized tool can ensure that research conception and design align to public health needs, and that results obtained from such works are relevant for policy making. This could make the process more standardized, evidence based, and quicker, such that
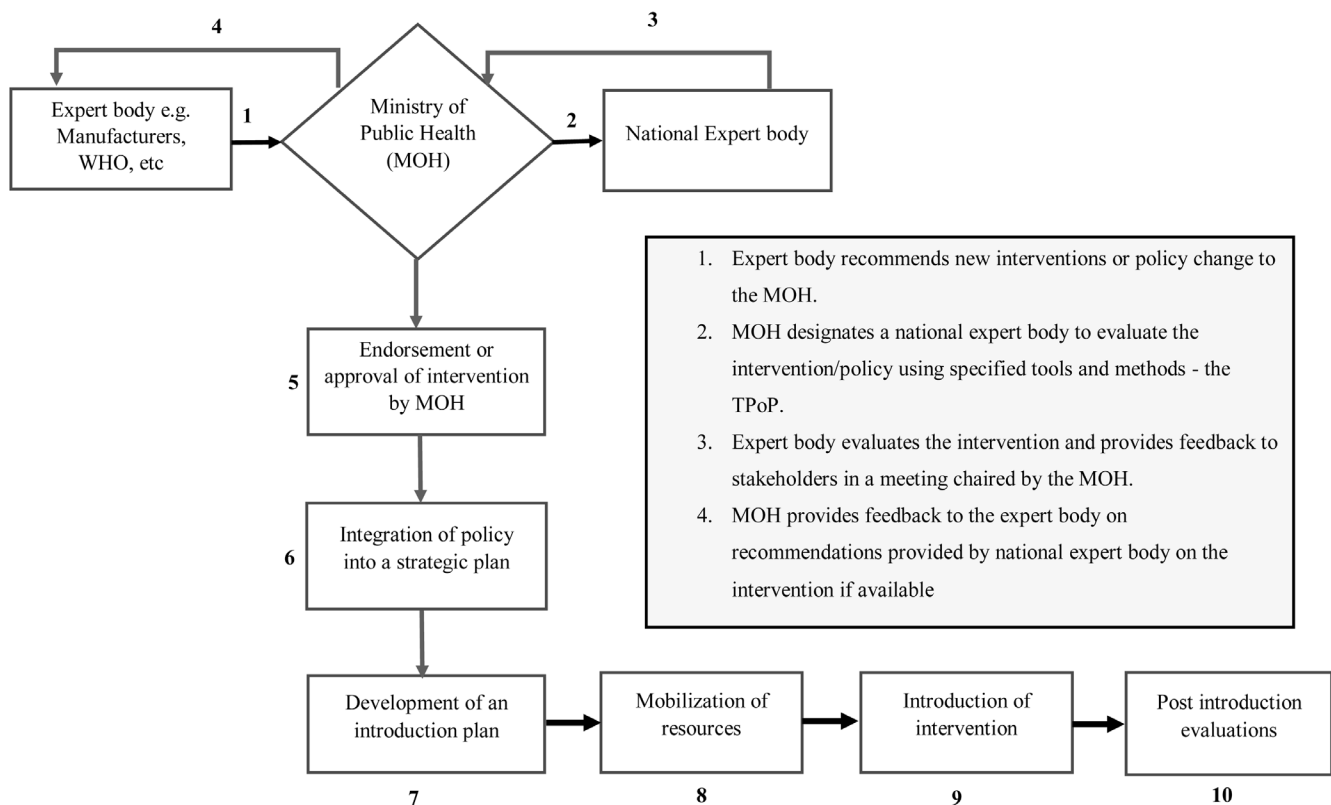
life-saving policies/interventions get to the point of care as soon as possible. The TPoP is one of such tools that could help close this gap, as it can enable focused discussions with all relevant stakeholders[14,15].

The potential role of the Target Policy Profile in enhancing policy making in Cameroon

On presentation of the TPoP to respondents, most of them felt the tool would help address the observed shortcomings in the health policy making process via several ways. First, it would provide a standard appraisal methodology that could be used to develop criteria for the appraisal of new policies/interventions, such that only policies/interventions meeting specific criteria are approved for introduction. This appraisal may focus on several parameters such that only cost-effective and context specific policies/interventions are approved for introduction. This may help improve on the methodology for policy making. Furthermore, the TPoP would provide a medium for researchers to identify policy relevant research, directly discuss the results of such research with policy makers, while guiding the course of these discussions as well. This would result in more evidence-driven policies/interventions. In addition, the TPoP will equally help to improve effective policy implementation, as it encourages engaging decision-makers at the beginning and throughout the research process. This engagement can enhance policy ownership and the likelihood of policy utilization. Our respondents indicated that the TPoP can enhance both policy formulation and implementation within their respective health programs and were optimistic about integrating the tool into the policy making process of their programs. However, effective use of the tool will require that policy makers be trained on its content and use cases.

The way forward

We leveraged findings from this study and our professional experience to propose a new model for enhancing policy making and implementation in Cameroon. We believe that this model (Figure 2) may render the policy making process in Cameroon more rational, standardized, and evidence driven. The model will also enhance dialogue between policy makers and researchers. In the model, entities interested in triggering a policy change (for instance the World Health Organization (WHO), manufacturers, and technical and development partners) will address correspondence to the MoH. The MoH will then seek a scientific or informed opinion from a national expert body designated *a priori* for such a purpose. This body will then review and assess the proposed intervention, using a standardized appraisal methodology and tool, such as the TPoP. Using the TPoP will equally ensure that policies/interventions for which positive feedback is given by the national expert body to the MoH, align with the current health sector strategy, thereby increasing the probability and speed of uptake of the policy/intervention, as well as its ownership by the state. Upon review of the feedback from the national expert body, the MoH will be better-informed to endorse, reject or demand modifications to the policy/intervention. Feedback is then provided by the MOH on its decision regarding the policy/intervention, alongside corresponding justification, to the entity (WHO, manufacturers, and technical development

1.	Expert body recommends new interventions or policy change to the MOH.		
2.	MOH designates a national expert body to evaluate the intervention/policy using specified tools and methods - the TPoP.		
3.	Expert body evaluates the intervention and provides feedback to stakeholders in a meeting chaired by the MOH.		
4.	MOH provides feedback to the expert body on recommendations provided by national expert body on the intervention if available		

Figure 2. Proposed model to enhance health policy making in Cameroon.

partners) which triggered the case for a new policy or policy change. If the request was for the implementation of a policy/intervention, the MoH will endorse the request and have it incorporated into a strategic document (strategic plan), which will then be used to mobilize the necessary resources for the effective implementation of the policy/intervention. Lastly but not the least, the model also foresees the conduct of post-introduction evaluations, to assess the level of implementation of the policy/intervention.

Limitations
Several challenges impeded the data collection process, limiting the exhaustiveness of the information gathered, synthesized, and presented herein. First, despite numerous efforts (paying a courtesy visit to program permanent secretaries, friendly reminders using phones calls, emails, messages) four programs did not contribute to the expected level because of conflicting priorities, as personnel of these programs were on the field for other activities. Furthermore, some government officials were reluctant to disclose information which they considered as confidential, even though we obtained a support letter from the Minister of Public Health, encouraging respondents to provide as much information as necessary.

Conclusions
The health policy making process in Cameroon faces numerous challenges including lack of standard methodology and tools for decision making. A simple tool such as the TPoP can help

resolve some of these challenges by; providing a standard method for appraising policies/interventions, improve dialogue between researchers and policy makers, encourage involvement of policy makers throughout the research process; provide a guide to assess policy/intervention implementation among others. Continued advocacy will be needed to help stakeholders understand the value proposition of the TPoP and training sessions will be required to get them acquainted with the tool and its various use cases. This will facilitate the endorsement of the tool by policy makers for adoption and utilization in Cameroon and hopefully other Sub-Saharan African countries.

Abbreviations
US: United States.

CDC: Centre for Disease Control and Prevention.

LMICs: Low- and middle-income countries.

TPoP: Target Policy Profile.

BMGF: Bill and Melinda Gates Foundation.

SA: Situational Analysis.

KIIs: key informant interviews.

MoH: Ministry of Public Health.

Data availability

Underlying data

Figshare: Data from: Health policy making process in Cameroon: a case for the utilization of the Target Policy Profile. https://doi.org/10.6084/m9.figshare.19664286.v1[9].

This project contains the following underlying data:

- TPoP_KII_Transcripts.rar. (Anonymised transcripts of interviews conducted in the course of the study)

Extended data

Figshare: Interview guide: Health policy making process in Cameroon: a case for the utilization of the Target Policy Profile. https://doi.org/10.6084/m9.figshare.19762099[8].

This project contains the following extended data:

- TPOP_KII_Interview Guide.docx (Question guide and consent form used for interviews).

Author's contributions

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❓ **Justin Parkhurst**

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Health policy making process in Cameroon: a case for the utilization of the Target Policy Profile

This paper discusses health policymaking processes in Cameroon and makes suggestions for ways to improve them in relation to evidence use based on the application of a tool and interviews done.

While it may be that there has been little published describing the process in this country, a challenge I found in reading the paper is that it has very minimal engagement with past work on public policymaking (or health policymaking) in the academic literature (significant amounts in Africa, possibly in Cameroon or West Africa), as well as on the literature around evidence use. In addition, the tool proposed, while straightforward and logical, is just one possible tool of many, and is not discussed in depth in terms of what it aims to do, how it was developed, if it has been used or tested elsewhere etc.

The paper starts with a couple of statements that do not reflect the whole of the field. It defines policy as "health laws and regulations" – yet these are only some forms of policy – the public policy field has noted a large number of other things can constitute policy (Buse, Mays, and Walt 2012; Hogwood and Gunn 1984). It may be that this paper specifically is concerned with laws and regulations, yet if so this should be more clear. Furthermore, much of what is discussed actually reflects ministry programmes (or programmatic decisions, goals, or targets) – which are not laws (that is to say from the legislature) or regulations per se. So more clarity on what constitutes policies, under which authorities, with which features, etc. would be helpful.

The text also says "health policies are generally developed or changed to suit the latest available research evidence on the subject." This is an ideal of some forms of policymaking, but the vast literature on evidence for policy (even in health) has shown that this is often not how policies are developed. If the authors are specifically referring to technical decisions made by bureaucratic bodies under a clear scope and goal set – this can be explained, but classic and modern works on

using evidence have shown that this technocratic approach does not capture a lot of actual policymaking See: (Weiss 1979; Lewis 2003; Nutley, Walter, and Davies 2007).

Thus overall I feel to make an academic contribution to the field, the paper likely should have a stronger background that considers the bredth and depth of past work on knowledge translation in health and tools for improving research uptake, and consider its methods and empirical findings in this light.

There are a range of works which are focussed on knowledge mobilisation in health in particular that could be useful for the authors or individuals hoping to improve evidence use in some way. Work of the McMaster health forum https://www.mcmasterforum.org/ for instance is world leading and globally focussed on brokering evidence to health policy. The forum and related websites like https://www.healthevidence.org/ provide a wealth of strategies and tools for linking research to policy in the health sector. The African Evidence Network is another source for Africa specific work on evidence use: https://africaevidencenetwork.org . The WHO's Evidence Informed Policy Network (EVIPNET) https://www.who.int/initiatives/evidence-informed-policy-network has also focussed a lot on evidence use in health. Many of these resources will have an abundance of insights into factors shaping evidence use for health policymaking which could contextualise this paper and approach.

This study applies a Gates foundation-created tool. Presumably this is why this journal was targeted. While there may indeed be some use of that tool, it would be much more rigorous to situate the tool within a larger consideration of the field of knowledge around knowledge translation, and reflect on other tools perhaps, to justify why this tool was used or what it was trying to achieve. So the paper could do more to consider: Why is this the right tool? What is it trying to achieve? What does it do for us or what else is important that it does not do? How has it been used in the past?

There are also considerable academic works discussing evidence use more broadly as mentioned. Some are reviews or overviews: See (Langer, Tripney, and Gough 2016) (H.T.O. Davies, Nutley, and Smith 2000; Nutley, Walter, and Davies 2007) , as well as many other works on knowledge mobilisation/translation specifically, including some African examples – e.g. (Grimshaw et al. 2012; Straus, Tetroe, and Graham 2011; Kitson 2011; Mitton et al. 2007; Ruth Stewart, Langer, and Erasmus 2019; R Stewart, Erasmus, and team 2017) (H.T. Davies, Powell, and Nutley 2015; Rushmer et al. 2019; Kasonde and Campbell 2012). This is a paper about a system of planning and evidence use, and there are also some works reflecting on what it might mean for evidence advisory systems to function to 'improve' the use of evidence (e.g. (Parkhurst 2017).

Methodologically it is not quite clear what the research questions are – we are told it is a situational analysis and looking for gaps, but more detailed questions could be developed. The methods described are more explanations of what was done, rather than justification of how particular methods provide evidence for specific research questions. Without more clarity on questions and methods, the results of the paper can be unclear at times in terms of what they are hoping to achieve. Most clearly useful is when the paper maps out things like the process in Figure 1 – although it would be useful to know if this really is not yet known or understood. Table 3 also provides a useful summary of emerging thoughts on what might improve the system. The challenge is to know how reliable or robust these findings are based on the small number of interviews and the lack of significant previous literature reviewed or summarised.

The conclusions propose a new structure for policymaking in Cameroon. While the proposal may indeed look to rationalise the process, it appears a bold move to make such structural suggestions based on a small study and use of a single tool when there is a risk that much more is available – either from existing work, other possible tools, or broader empirical work. It may be that other insights, learning and tools would point in the same direction, but without consideration of the broader field of work it appears somewhat premature to make such specific recommendations like these at this point.

Ultimately I can see utility in this study and its findings if indeed there is little known on the process in Cameroon, and if this tool provides useful insights beyond what is already known or could be with other methods – however, there is limited review of evidence and literature to help that decision. I would think situating the work more in existing work – primarily in Cameroon or the region, and secondarily in broader work on evidence use and health policy making – could improve it. References are below – please note mostly these are for the broader evidence use or policy making process – the authors might want to do searches for Cameroon or Regional Health Policymaking and evidence use literature as well to ensure they are aware of it and situate their findings within it.

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Is the work clearly and accurately presented and does it cite the current literature?

No

Is the study design appropriate and is the work technically sound?

Partly

Are sufficient details of methods and analysis provided to allow replication by others?

Partly

If applicable, is the statistical analysis and its interpretation appropriate?

Not applicable

Are all the source data underlying the results available to ensure full reproducibility?

Partly

Are the conclusions drawn adequately supported by the results?

Partly

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Health Policy and politics, evidence and policy

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Reviewer Report 27 July 2022

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Luchou Engelbert Bain iD

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I read this manuscript with astute interest. Indeed, it is an issue of immense public health relevance, most especially for the health policy space in Cameroon. However, some issues might have to be carefully clarified and addressed before the manuscript is indexed in its final form.

1. There are core grammatical mistakes in the entire text that have to be addressed.

2. Manuscript title: add :"The" before "health policy".

3. Provide an operational definition for "policy making experience" when it comes selecting participants for your interviews.

4. The background is not strong enough regarding the rationale for assessment/and/or use of the TPoP.

5. It is unclear from your methodology if all respondents were versed with TPoP? Your methodology sections completely ignore TPoP. It becomes unclear how the situational analysis relates to the TPoP, most especially regarding the conclusions the authors arrive at.

6. Introduction: policy development is important everywhere, and *not* only according to the CDC.

7. Ethics: provide the references of the ethics approval obtained for this study.

8. It is unclear methodologically why authors limited respondents only to 18. This should stand out in your methods section.

9. How were the interviewees selected?

10. Provide a brief content of the interview guides, and possibly, do include the interview guide as a supplementary file in your next submission.

11. Overall, the epistemological link between your situational analysis and the recommendation of the TPoP as an appropriate framework for Cameroon needs to stand out in this paper. To me, in its current form, this is not the case.

Is the work clearly and accurately presented and does it cite the current literature?
Partly

Is the study design appropriate and is the work technically sound?
Partly

Are sufficient details of methods and analysis provided to allow replication by others?
No

If applicable, is the statistical analysis and its interpretation appropriate?

Partly

Are all the source data underlying the results available to ensure full reproducibility?
Partly

Are the conclusions drawn adequately supported by the results?
Partly

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Health Policy Research, Community Engagement in research, Health Policy Experiments, empirical research methods in bioethics.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.