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**INTERIM EVALUATION**

**MATERNAL CHILD HEALTH /  
CHILD SURVIVAL**

**PROJET SESA (SOIN D'ENFANT  
SUD ET ADAMAOUA)**

**Project No. : 631-0056**

**by**

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**December 1991**

INTERIM EVALUATION

MATERNAL CHILD HEALTH / CHILD SURVIVAL  
PROJET SESA (SOIN D'ENFANT SUD ET ADAMAOUA)  
PROJECT NUMBER 631-0056

MINISTRY OF HEALTH  
REPUBLIC OF CAMEROON

NOVEMBER 4 - DECEMBER 13, 1991

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ACADEMY FOR EDUCATIONAL DEVELOPMENT

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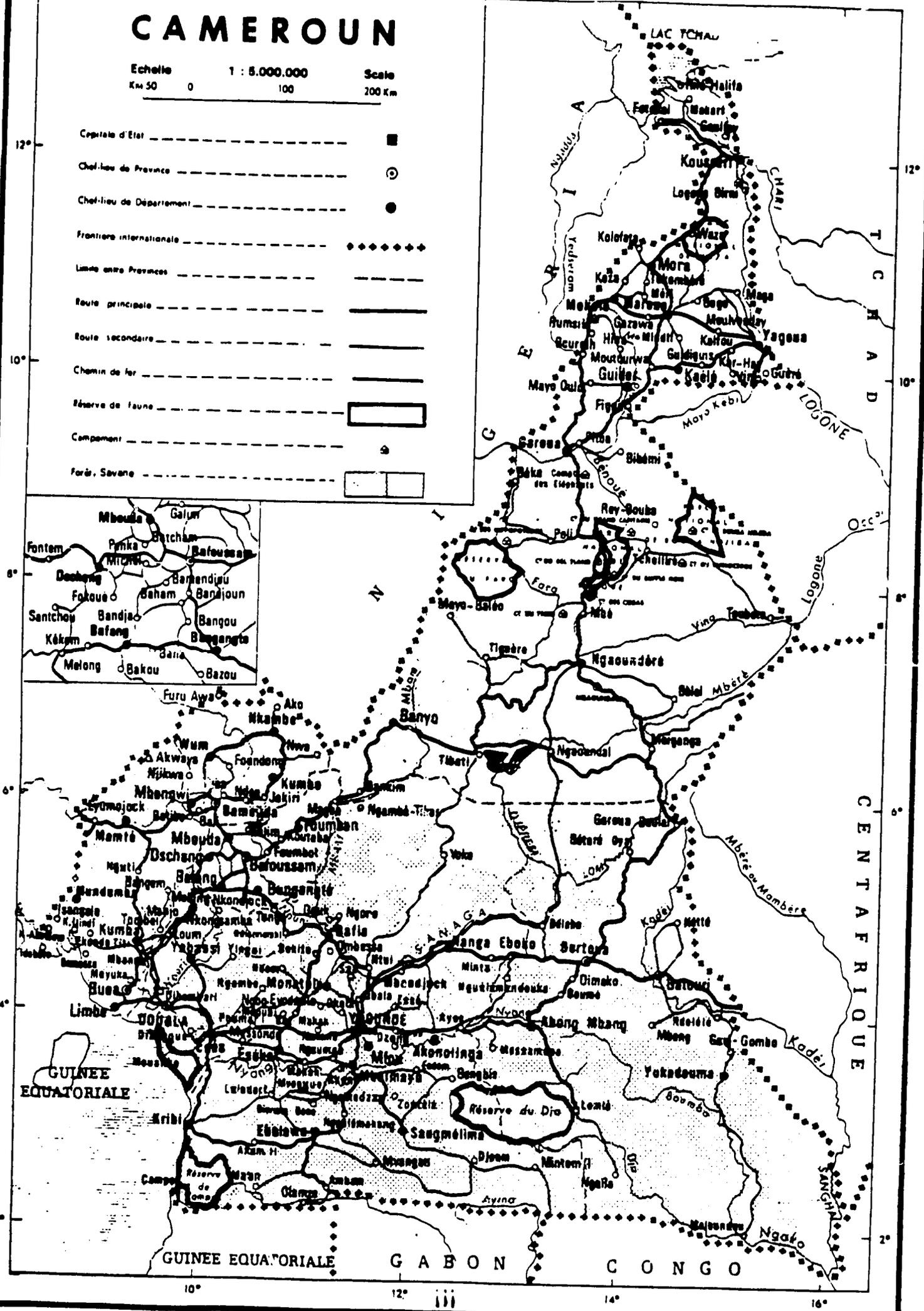
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# CAMEROUN

Echelle 1 : 5.000.000  
 Km 50 0 100 200 Km

- Capitale d'Etat ■
- Chef-lieu de Province ⊙
- Chef-lieu de Département ●
- Frontière internationale ◆◆◆◆◆
- Limite entre Provinces -----
- Route principale —————
- Route secondaire ———
- Chemin de fer ———
- Réserve de faune ▭
- Campement ⊙
- Forêt, Savane ▭



## ABBREVIATIONS

AED	ACADEMY FOR EDUCATIONAL DEVELOPMENT
CDD	CONTROL OF DIARRHEAL DISEASES
CIM	BELGIAN HEALTH PROJECT
COGAR	DISTRICT HEALTH MANAGEMENT COMMITTEE
COGE	HEALTH CENTER MANAGEMENT COMMITTEE
COSA	COMMUNITY HEALTH COMMITTEE
COSAR	DISTRICT HEALTH COMMITTEE
CS	HEALTH CENTER
DEPS	DIRECTORATE FOR STUDIES, PLANNING AND STATISTICS
LMH	DIRECTORATE FOR HOSPITALS
DMPR	DIRECTORATE FOR PREVENTIVE AND RURAL MEDICINE
DPT	DIPHTHERIA, PERTUSSIS, TETANUS
DSFM	DIRECTORATE FOR FAMILY AND MENTAL HEALTH
EPI	EXPANDED PROGRAM ON IMMUNIZATIONS
EPP	PROVINCIAL PHARMACY TEAM
FCFA	FRANCOPHONE AFRICA CURRENCY
GTZ	GERMAN AID
GDP	GROSS DOMESTIC PRODUCT
HBCU	HISTORICALLY BLACK COLLEGES AND UNIVERSITIES
HC	HEALTH CENTER
HIID	HARVARD INSTITUTE FOR INTERNATIONAL DEVELOPMENT
HMIS	HEALTH MANAGEMENT INFORMATION SYSTEM
IEC	INFORMATION, EDUCATION AND COMMUNICATIONS
JSI	JOHN SNOW, INC.
KAP	KNOWLEDGE, ATTITUDES AND PRACTICES
ME	ESSENTIAL DRUGS
MCH	MATERNAL AND CHILD HEALTH
MOH	MINISTRY OF HEALTH
MOPH	MINISTRY OF PUBLIC HEALTH
ONG	NON-GOVERNMENTAL ORGANIZATIONS
ORT	ORAL REHYDRATION THERAPY
PACD	PROJECT ACTIVITIES COMPLETION DATE
PCV	PEACE CORPS VOLUNTEER
PHC	PRIMARY HEALTH CARE
PMI	MATERNAL AND CHILD HEALTH
RMA	MONTHLY ACTIVITY REPORT
ROPHC	REORIENTATION OF PRIMARY HEALTH CARE
SESA	INFANT CARE IN THE SOUTH AND ADAMAOUA PROVINCES
SPMH	PROVINCIAL HOSPITAL SERVICE
SPSFM	PROVINCIAL SERVICE FOR FAMILY AND MENTAL HEALTH
SS	HEALTH SERVICE
SSP	PRIMARY HEALTH CARE
USAID	UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

## EXECUTIVE SUMMARY

In accordance with USAID's Project Paper Supplement on Maternal Child Health/Child Survival Project (MCH/CSP), No. 631-0056 dated March 18, 1991, an interim evaluation of the MCH/CSP in Cameroon known as SESA (Soin d'Enfant dans le Sud et Adamaoua/Infant Care in South and Adamaoua Provinces) was to be done in November 1991. John Snow, Inc., was requested by USAID/Yaounde to do the work.

The Project, conducted by a contractor consortium of the Harvard Institute of International Development (HIID), the Charles R. Drew University of Medicine and Science, and the Academy of Educational Development (AED), began in 1987 assisting the Ministry of Health (MOH) to strengthen Cameroon's existing health system to improve health services for women and children in South and Adamaoua Provinces. The Project's strategy of centrally-managed and MOH financed operating costs was based on the delivery of five key MCH/CS vertical (not integrated) interventions - immunizations, diarrheal disease control, nutrition promotion/growth monitoring, child spacing and malaria treatment. A revolving essential drug fund was to be established to assure regular supplies of drugs. Management, logistics and supervision systems were to be developed to support delivery of interventions.

Within a year after authorization of the Project, the MOH conducted a review of its primary health care (PHC) and child survival (CS) programs and found that the health centers (HC) were not functioning effectively and that the health care delivery system was over-centralized and not meeting the people's needs. Budget cuts due to the economic crisis reduced HC support and drug supplies to the point where HC services diminished drastically toward the end of 1990 under the old system.

In May 1989 the MOH announced its new health care delivery strategy called "Reorientation of Primary Health Care" which emphasizes:

- integrated delivery of preventive, curative and promotion services rather than limiting services to CS interventions; continuity of care;

- decentralization of health care planning to the health district level;

- cost recovery through fees for services and sales of drugs to cover most recurrent health care delivery costs (MOH salaries excluded);

- community co-management and co-financing of health care.

The project embraced the objectives of this new PHC strategy in late 1989. Since that time the Project has taken the following positive steps toward achievement of these objectives: health area limits were identified, training manuals were developed, community

health committees and health management committees were organized and trained, a drug supply and cost recovery system was put into place, MOH personnel were trained and pyramidal supervision was designed (central to province to department to district to health areas) and monthly activity forms were designed and printed to help manage the system.

In January 1991, pharmacies were established in 17 health centers and ten hospitals. Seven drug depots were established to supply them. Community health committees with sub-committees for management were established for the 27 health center areas and districts to enable community co-management of cost recovery and drug supply systems.

The interim evaluation mandate is not to measure health impact of the new system but to assess achievements to date in putting the new system into place and assessing the potential of the system to achieve its objectives by the end of assistance in 1993. After reviewing documents, talking with MOH, SESA, USAID and other donor agency personnel, and visiting over half of the health centers, pharmacies and drug depots involved in the new initiative, the team observed, in addition to the above achievements, the following:

curative services (limited due to inadequate drug supply), promotion of health services and to a lesser extent preventive services are being provided under the new health care system (marked improvement over 1990 year end);

the institutional environment, particularly the management, supervisory, and information systems are not sufficiently developed to allow the cost recovery system to function effectively;

operational problems (selling drugs on credit, waiving consultation fees, stock-outs, incomplete filling out of control forms, etc.) exist due to inadequate follow-up of activities after launching of new system;

monthly activity report forms (health center management forms) are not collected or analyzed regularly or reliably to determine health center utilization, cost recovery irregularities, potential pharmacy/health center viability);

training has been of high caliber and highly appreciated by participants but they are experiencing difficulty in translating what they learn at seminars into operational activities;

health personnel and public accept in general the new health care initiative, but many MOH personnel and community members do not fully understand the new system and all its administrative procedures;

the legal basis for community health committees and their management sub-committees as well as their relationship to health centers and MOH personnel and their appropriateness in the Cameroonian culture context remain unclear and need resolution.

The team feels that decentralization of health services to the district level, co-managed and co-financed by the MOH and the community, is an appropriate mechanism for delivering health care services to the people of Cameroon. However, the administrative and financial feasibility and sustainability of this approach is contingent upon both the continued commitment and capacity of the MOH and the continued willingness and ability of the population to pay for health services. Priorities must be set to determine what can be financed through the cost recovery mechanism as funds may be inadequate to finance all of the planned expenditures.

The team also believes that the problems noted in this evaluation can be rectified through improved health management systems. It will be necessary to revise end of project objectives to conform with the reality of what can be achieved.

Greater emphasis on improving systems development at this time will facilitate expansion of the new system and extend integrated health care services to a larger segment of the population in the future. The team, therefore, recommends that the mission provide follow-on assistance to the MOH for continuation and expansion of its new health care initiative. Please see ANNEX J for a complete list of recommendations.

#### SUMMARY OF OTHER MAJOR RECOMMENDATIONS

1. Emphasize on-site training rather than seminars to assure that health workers implement correctly those procedures for which they have been trained.
2. Develop the current Project information system so that data collection, transmission, and analysis are carried out systematically and reliably. This includes adapting data collection instruments to correspond to reporting forms (or vice versa), modifying current reporting forms, improving supervision, and training local and regional health personnel in data collection, analysis, and use.
3. Provide on-the-job training for provincial and arrondissement supervisors; expand content of supervision; improve supervisory protocols; study organizational issues related to supervision and management.
4. Resolve immediately the drug supply problem by proceeding with existing plans to train provincial staff in international procurement procedures. In addition, to mitigate supply delays,

the Project should expand either the role of the provincial depots or the departmental depots in the provincial capitals to stock additional quantities of drugs and make them available to other depots throughout the province in case of stock outages.

5. The Project should compile essential drug lists more appropriate for hospitals at all levels. The MOH should explore the possibility of changing the law which restricts hospital drug sales to in-patients.

6. Improve the cost recovery system by finalizing the hiring of a financial analyst, selecting treasurers on the basis of competence, requiring bank or postal accounts, simplifying the management and accounting procedures while enforcing compliance with mandated procedures, and reviewing the current system of health care pricing and charges.

7. Study legal status of community health committees (rights and obligations in management of funds, obligations to MOH under present statutes, establishment of contractual relationships, etc.), and determine, from experiences of other community organizations, whether such committees operate more successfully as management or as advisory groups.

8. To help assure sustainability of the new health care delivery system, all members of the provincial health team should be more active in improving and expanding the system as well as assisting MOH and USAID to monitor availability of government counterpart funds generated within the provinces.

9. Give higher priority to quality, integration and continuity of health care in the centers by increasing quality clinical supervision and on site training.

10. To launch the second wave of co-financed health centers, the Project should proceed pragmatically and assure that all necessary conditions are met before a HC is brought into the cost recovery system (population sufficient to support health center, no competing health facilities in the immediate area, renovation and security of pharmacies, availability of qualified supervisory personnel, etc.).

11. Project staff, USAID and the Ministry should carefully review stated end of Project objectives and revise them to conform with the reality of what can be achieved.

#### ACKNOWLEDGEMENT

The team would like to thank the people in the Ministry of Health, USAID, the Consortium, UNICEF, GTZ, Religious Missions and all the other health care providers as well as the people in the Administration and the Communities who so patiently fielded our questions in a frank and straightforward manner.

## I. PURPOSES OF EVALUATION

The two main purposes of the interim evaluation of the MCH/CS Project were:

to assess the Project's achievements and potential for achieving its end of project status indicators by the project activities completion date;

to identify, if feasible given the limited experience to date, the need for any future USAID assistance to achieve sustainable health systems in Adamaoua and South Provinces.

(see annex A for detailed scope of work)

## III. METHODOLOGY

The evaluation team under contract with John Snow, Inc., included:

Anne Marie Foltz, MPH, Ph.D., Institutional Analyst/Social Scientist

Arthur Lagace, MPH, PH.D., Health Economist

Harry Godfrey, Health Planner/Team Leader

The team met on October 30, 1991, at John Snow, Inc., headquarters in Boston to review key Project documents and meet and talk with members of the contractor consortium (HIID, Drew University and AED). The team then went on to Cameroon and was joined by a staff member of the MOH:

Benoit Etoa, Chief, Community Health Service and Traditional Medicine

The four team members held in-depth meetings in Yaounde with the MOH, USAID, contractor personnel, UNICEF and German Cooperation. They developed, in collaboration with field staff, a travel schedule and questionnaires in preparation for approximately three weeks of field trips. In the two provinces (Adamaoua and South), where the new health care delivery system is operational, they met and interviewed the provincial health representatives and their teams (chiefs of the different health services). They met with the Governors of the two provinces and the Prefets and Sous-Prefets, or their representatives, in most of the areas where the evaluation was being carried out. They observed and assessed operations in most of the seventeen health centers, twenty-seven pharmacies and seven drug depots operating under the new health care delivery

system. They attended two community health committee meetings and talked with members from most of the twenty-seven community health management committees. They met and discussed with two private health care providers (religious mission hospitals), but did not observe MOH health centers that are not yet included in the new system.

After debriefings with field staff the team returned to Yaounde November 29 for debriefing with MOH staff. The week of December 2 was spent following up on questions that came up during field visits, debriefings with USAID and Project staff and preparation of the first draft of the evaluation report. A draft of the findings, conclusions, recommendations and two page executive summary was submitted to all interested parties on December 9 and reviewed by those parties and the team on December 11. The team completed other parts of the draft by December 13, submitted the document still in draft form to USAID and departed Cameroon on the 14th.

#### IV. BACKGROUND

##### A. HEALTH-POPULATION PROFILE

Since 1950 life expectancy at birth has risen from 35 to 54 years. Infant mortality (under one year of age) has declined from 170 deaths per 1,000 live births to about 90/1,000. Child mortality (under age five years) has declined from 25% to 15%.

The crude birth rate is estimated to be between 42 and 45 births per 1,000 population. At current fertility rates, the average Cameroonian woman can expect to have six living children during her reproductive years. Contraceptive prevalence rates are still estimated to be two percent.

Morbidity and mortality among infants and children in Cameroon are largely preventable and generally caused by illnesses whose early diagnosis and treatment could substantially save lives. The most important among these are malaria, measles, tetanus, diarrhea, pneumonia, meningitis and malnutrition.

Cameroon is divided into 10 provinces two of which are included in the SESA Project:

Area	Population	Sq.km.	Density	Health Districts
Adamaoua Province	410,500	58,631	7/sq.km	11
South Province	465,000	51,645	9/sq.km	15

## B. MCH/CS PROJECT (SESA) - PURPOSES, OBJECTIVES, EVOLUTION

The Project, conducted by a contractor consortium of the Harvard Institute of International Development (HIID), Drew University, and the Academy of Educational Development (AED), began in 1987.

The Project purpose was stated in the 1987 Project Paper as follows:

To strengthen the existing GRC [Government of the Republic of Cameroon] health services system in such a way that it operates more effectively and efficiently in providing needed services to women and children in the South and Adamaoua Provinces. (p.36)

This broad purpose was then broken out into a series of process objectives. The first group of these objectives was directed toward systems development. It included the implementation of a management system, including regular supervision, in-service training, a medical and equipment logistics system, model cost recovery systems, health information system, and operations research. The other process objectives were directed toward implementing a series of what became viewed eventually as vertical interventions: malaria control, immunizations, growth monitoring, oral rehydration therapy, child spacing, and health promotion.

During its first two years, the Project concentrated its activities mainly on the vertical interventions, particularly immunization and the control of diarrheal disease. However, some work was begun on systems development. Project staff assisted provincial officials to undertake a census of health facilities to build their information base for management; to improve data collection, the Project helped initiate the use of the Road to Health record for child health monitoring throughout the Cameroon; Training for supervisors was also begun, with resources for supervision made available at the provincial level.

Meanwhile, in early 1989, the Ministry of Public Health (MOPH) had issued a draft of a new policy directive whose purpose was to reorient primary health care throughout the country by providing integrated primary health care services, by focussing on the health district (arrondissement) as the primary health unit which would be supplemented by referral units at the departmental and provincial levels. The reorientation stressed the implementation of a structure for "community dialogue" with local health committees, co-financing of health services and self-management of health resources. This reorientation with its emphasis on primary care and on the health district was entirely in keeping with the World Health Organization's policy for achieving Health for All by the

year 2000. The draft that emerged was not so much a program, as a policy statement, and although, to date, it has not yet received formal acknowledgement through the rule-making process, it has been the de facto policy of the MOPH since 1989.

The Project immediately began to shift its orientation to support the Ministry's initiatives. Specifically, starting in early 1989, it turned away from supporting training and supervision for vertical interventions and toward activities promoting integrated primary care. The Project developed an impressive array of supervisory protocols which were designed with the assistance of local supervisors, physicians and nurses. The Project also carried out a base line study in the targeted centers to assess the activities of nurses, the quality of care, and utilization patterns that would provide indications of feasibility of cost-recovery schemes. It became increasingly evident to project staff that it would be difficult to assure effective delivery of the health interventions without getting in place, first, the necessary management systems and a cost recovery system.

The project also accelerated its planning for the district system, community participation, and a cost-recovery and drug distribution system. The shift in this approach which would necessitate more time for implementation was ratified by USAID formally by a Project Amendment (signed somewhat belatedly in early 1991) which allocated \$2 million additional to the project and extended the PACD by one year to 1993.

The Project Amendment stated that the project purpose remained the same, to strengthen the existing health system. End of project status objectives continued to focus on systems development in the two provinces, specifically:

- Community co-financed and co-managed health care available in 96 health areas with an operating model cost-recovery system, as well as an operations research program to evaluate the cost-recovery model;

- Management system effectively administering **integrated** [emphasis added] curative and promotion services; regular supervision of health workers; an operational medical supplies and equipment logistics system; an operational cold chain; an operational health management information system; regular in-service training in management and health care delivery and promotion;

The Project Amendment also specified achievements in malaria control, immunization, growth monitoring and nutrition education, oral rehydration therapy, and child spacing and health promotion.

Thus, the reorientation policy and the observation that the previous policy of introducing vertical interventions could not be

successful until systems development had taken place, indicated the necessity for the project to give primary attention to restructuring an operational health services delivery system. In a sense, this was a return to the original project objectives.

However, other project documents are not as clear:

...Project SESA [sic] **main** [emphasis added] objective is to establish a network of health centers co-financed and self-managed by the population itself. The principal source for co-financing being the participation of the population to the purchase of drugs, SESA [sic] objective is to set up an efficient drug supply system within the 2 provinces<sup>1</sup>

This statement suggests some slight ambiguity in project strategy as to whether implementors see their first and main objective to establish cost-recovery centers, that is, to establish one sub-system or whether it is to develop general management systems for the Ministry.

In the light of this history, the Evaluation Team took as its primary task to assess the extent to which systems development had been accomplished, and particularly, the extent to which management systems were sufficiently developed to support a cost recovery/drug supply system.

## **VI. FINDINGS, CONCLUSIONS AND RECOMMENDATIONS**

### **A. BUILDING THE INFRASTRUCTURE FOR HEALTH SERVICES DELIVERY: INSTITUTIONAL DEVELOPMENT**

#### **Introduction**

In 1987-1989, management of health services and of the whole health services system was weak if not nonexistent. The problems were as follows: there was little or no supervision of health workers; no funds nor logistics were available for supervision; an antiquated civil service system discouraged even dedicated health workers from doing their jobs; the community was losing confidence in the health workers; drugs were unavailable or, worse, were being sold illegally by the health workers; reporting of activities was unreliable; health facilities lacked basic equipment.

The decline in the economy and the lack of financial resources within the Ministry only served to aggravate these problems. Funds for renewal of equipment, for investment in new centers, and for

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<sup>1</sup>Claude Bodart, Robert de Wolfe, Marie Alexandre, Dorothy Madison-Seck. Quarterly Activities Report, SESA, January-March 31, 1990. Annex 3, Reorientation of PHC and Project SESA, March 1990, p. 1.

purchase of supplies and drugs dwindled. Although Cameroon is relatively well endowed with health personnel compared to other countries in the region, the personnel were described as demoralized and unwilling or unable to work. One long-time technical advisor told us that contrary to common belief, Cameroon is worse off than most other countries in the region.

These were formidable challenges for the project staff working within its two provinces. In order to implement the project, they had to assist the Ministry with three tasks: to design a viable cost recovery-drug distribution system; to design methods that would assure that health workers would deliver integrated health care services; and most important, to create a management system that would assure that these improvements could and would be sustained.

Thus, this is an extremely ambitious project and must be judged in that light.

### Development and Implementation of the Management System

We will examine the Project's assistance to the Ministry of Health in improving its management structure through five elements: 1) Training for management; 2) information system development; 3) Supervisory system development and implementation; 4) Decentralization within the Ministry of Public Health; and 5) Decentralization to Community Institutions: Management of the Cost-Recovery Fund by the Community;

#### **1. Training for Management**

Training has been a large, an important, and highly successful component of the project. During 1991, the project has already conducted 19 seminars in the South province alone.<sup>2</sup> Most of these recent seminars were devoted to training community health committees, but the bulk of earlier work has been training in supervision and management.

During 1990, the project team focused on the development of a series of 12 training modules which became the basis for training district (arrondissement) health teams. Four of these modules are devoted to developing general management skills: management of

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<sup>2</sup> Our write-up cannot do justice to the training activity since we were unable to obtain from project staff a complete list of all training seminars for which the project had been responsible since 1987. However, the South Province coordinator did provide us a list for all those seminars for which the South province had been responsible since 1987 and this gave a good sense of the scope of training which had been carried out.

human resources; management of vehicular equipment; supervision of activities; evaluation of activities. Modules are also devoted to managing the drug supply and cost recovery system. One module is devoted to supervision. There is also an extensive module on management of the cost-recovery system. These modules are a good combination of theoretical presentations coupled with real-world exercises and role playing. The presentations are clear. Supervisory arrondissement teams were first trained using these manuals in Maroua in 1990; others, including the provincial supervisors, were trained in the fall 1990 before the first wave of depots and health centers and hospital pharmacies opened. During these seminars, supervisory teams developed action plans for their arrondissements.

The project has also developed manuals for health centers and manuals for community health committees. These have also been used extensively in seminars. All the training manuals have been well received, with one donor suggesting that in training and particularly in document development, this project was far ahead of any others in the country.

Participants in the seminars told us they found the manuals very useful. The only criticism we heard was that they thought the time during seminars was not long enough (2-3 weeks) to cover the material presented. Supervisors said they found the modules useful and had retained their copies. There was some concern that some of the technical material in the health center manual for health workers, as well as some of the presentations in the training for the pharmacy clerks, may need to be simplified to address their levels of education.

The project has continued to support training for vertical interventions. During 1990, several seminars on vaccinations and EPI were held jointly with other organizations and in 1991, a seminar was held on diarrheal disease. The latter is a subject which was frequently covered by the project from 1987-89, and given the project's and Ministry's objective to integrate services, it might be worth considering seminars which emphasize integrated rather than vertical approaches.

Despite their enthusiasm for the training, we found that few of the health workers and supervisors referred to their training documents once they returned to their work place and, more disturbingly, much of what they had learned, they did not implement. This suggests that the formal training needs to be supplemented by more reinforcement on the job. It also suggests that a policy of routinely taking personnel out of their work setting for training may not be as effective as training in the work place.

The high number of seminars has also kept many physicians and nurses in a kind of permanent training circuit. One physician, much in demand, complained that he scarcely had time to carry out

his administrative duties because he was running from one seminar to another.

We conclude that the number of seminars may have reached the saturation point and could perhaps be trimmed back in favor of more on-site training. We also find that the project, now that it has turned again its attention toward training in technical skills, is still emphasizing vertical approaches as opposed to the more integrated ones its objectives call for.

## **2. Information System Development**

**Background:** Information systems are integral and essential parts of management systems. How they are organized determines organizational patterns of relationships among bureaus and levels of hierarchy. Their content, both in quality and quantity, affects the types of management and planning decisions that administrators can make. However, unless these administrators are trained to take advantage of the information a system produces, its existence is of little interest.

The Project implementors recognized that the existing information system in Cameroon could not provide the information needed to manage and evaluate project activities. They also recognized that since no major overhaul of the national information system was imminent, they would have to devise some temporary reporting systems which would provide information sufficient for monitoring project activities and, if they proved useful enough, could eventually be adopted for nationwide use.<sup>3</sup> This decision to institute a parallel reporting system cannot be construed as implementation of a health management information system, but as a second best solution to a problem that could have blocked implementation of all aspects of the project.

**Project Activities:** The new report (Rapport Mensuel des Activités, which we will describe as RMA-Projet to distinguish it from the Fiche Mensuel d'Activités which continues to be used sporadically throughout Cameroon, including at project centers), requests information on utilization of curative and preventive services (new cases), vaccinations, new cases of project target diseases, community activities, as well as a series of questions designed to evaluate the drug distribution and financial management systems.

The RMA-projet innovates and provides many improvements for management and planning over the types of information gathered by

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<sup>3</sup> The Ministry is planning the development of a national health management information system. USAID has already committed technical assistance to this activity and Project staff have contributed to the planning. Development and implementation of the actual system will be for some time in the next two years.

the Ministry in its RMA officiel. For example, to assist health center staff assess coverage and plan their activities, the RMA-projet requires they note their target population, their target coverage, and what percentage of their target they have achieved that month and cumulatively that year. It requires listing vaccinations by dose (1, 2, or 3 for DPT and polio) so that staff can assess the completion rate of vaccination series. The data collected on finances and drug distribution are entirely new and essential for supervisors monitoring these activities.

The format of the RMA-projet report itself is attractively laid out. The sequencing of the information is jumpy (e.g. from children to mothers to children) and a few of the tables are confusing to the uninitiated, but the report, as a whole, represents an important improvement in the potential for gathering data.

The project has also designed and made available a register for curative consultations and notebooks and patient record forms for preventive care for mothers and children. The latter are the nationally used cards, "le chemin de la santé," which the Ministry instituted with Project assistance throughout the country in 1989. These forms are not systematically keyed to the RMA-projet forms, making transfer of data less reliable than may be desired. Project facilities use tally sheets to note vaccinations per session and the number of preventive consultations. Some use notebooks to record prenatal and well-child consultations.

Outreach activities (stratégie avancée) do not have special recording forms. For vaccinations, nurses use a tally sheet. Recording of curative care and other promotion of services is not done routinely.

Because in the past, each vertical program has tended to develop its own reporting system, health workers are expected to fill out about 12 different reports monthly. We were told by the national statistics bureau (DEPS) that compliance with this cumbersome system is spotty.

The Project, in its training manual for health center staff (**Manuel du Centre de Santé**), includes a section on how health workers should fill out the new curative care register, the preventive care patient records, and the RMA-Projet. The Manual provides instructions on how to fill out the curative consultation register (p. 12), and the RMA-projet (pp. 153-159). In our review of these instructions, we noted that definitions were in short supply. For the register, terms such as "consultation" (new case? new episode?), "central population," "peripheral population," were not defined. One column suggests that the nurse indicate the "le numero de la décision figurant sur la strategie correspondant à la plainte principale du patient s'il existe," but provide no instructions about where to find the "numero de la décision."

Instructions for the RMA-projet do not explain how the nurse is to come up with a figure for the population covered in the Health District, but does ask him to note whether the figure is the result of an estimation or a registration of all families in the district.

**Findings:** We found that these new reports were not being well used in the field to provide accurate and timely data. We identified several different types of problems by examining nurse's data collection instruments. In Adamaoua province, of the six health centers we visited, two (Nyambaka, Bekagoto) were not using the new curative care register. None of those using this register were entering the number of the consultation fee receipt. If they used the fee receipt number, supervisors would have been able to verify immediately that each new case had paid the 200 CFA consultation fee. By comparing pharmacy clerk receipts with the nurse's register, we found that at one clinic (Bekagoto) during November, only 10 of the 23 new cases inscribed in the register had paid a consultation fee. At another clinic, about 10 percent of new cases had no corresponding receipt to show that a consultation fee had been paid.

At Dir, the provincial supervisor uncovered another problem: the nurse registered as a new case each different malady of the same patient. Thus, the same patient could appear as a new case two to three times on the same day if he presented with several illnesses simultaneously. We estimated that this inadvertently increased the number of cases reported by 20 to 30 percent. The nurse said he had been using this procedure for a year, but until our visit, the supervisor had not discovered the error. At Kye Ossi, the nurse started numbering new cases at the beginning of each month. Thus, the last numbered case at the end of the month was what he reported as the number of new cases for the month. However, in reviewing the register since January, we found he had skipped numbers. Nineteen percent of numbers had been skipped, meaning that the actual number of new cases was 19 percent lower than what he reported. Such errors are not usual and are easy to correct, but they are important for a project which is using the number of new cases as one of its indicators to evaluate the financial viability of health centers.

Estimates of population as they appeared on the RMA-projet were confusing. While the clinics at Nyambaka and Martap reported their target populations at 4500 and 7500 respectively, the Project census cites them as 5600 and 3000 respectively. The supervisor was unable to explain how the clinics had arrived at their figures which suggest some uncertainty about current estimates of coverage.

We had expected that RMA-projet reports would be arriving regularly at the arrondissement and provincial supervisors' offices since they had been launched only ten months earlier and since frequent supervision had been taking place. We found in Adamaoua province

that through the month of June reporting had been regular, although slow. Supervisors said they frequently had to go on-site to collect. Part of the delays are caused by the need to have the COGE officials and treasurer sign off on the financial tables and treasurers can be hard to find. A second equally significant barrier to reporting was the absence of report forms. According to the Project chief of party, they had had printed and allocated what was believed to be a 24 month supply (1260 reports, three per month for 17 health centers), but Adamaoua ran out after six months and in the South, most health centers seemed to have received only two or three copies. What had happened to the other reports is uncertain. And since the printing firm had since gone out of business, Adamaoua Provincial officials were able to resolve the stock-out only last month. As a result, reporting was virtually absent during the 3rd quarter of this year. Facilities are now catching up. In the South, only one of the four centers we visited was filling out the RMA-projet.

In instituting the new reporting forms, the Project had specified only that reports be sent to the Arrondissement level. In the South, only one set of arrondissement supervisors had received RMA-projets from health centers. In another arrondissement, the health center had filled out reports, but not transmitted them; at another, they had filled them out for only three months. As a result, even arrondissement supervisors were unable to use the reports to assess activities (had they wanted to). The provincial supervisors' information as to implementation was limited to what they could glean during supervisory or inspection visits.

In Adamaoua province, at only one of six health centers visited was the head nurse using the data from his reports for planning. At Dir, the nurse had drawn and posted graphs by which he could trace the monthly variations in vaccinations and preventive and curative consultations. We asked arrondissement and provincial supervisors if they had used these reports themselves or had carried out analyses from these data. The answer was negative in all cases. The new reports which have been introduced by the project are generally not used, even by the project staff, themselves.

We conclude that although new forms have been introduced, and although formal training has been provided at seminars, little or no attention has been directed to the implementation of the data collection process, the transfer of data to reports, and its use in the health centers. The Project staff have not reviewed data collection instruments to assess their appropriateness for providing reliable reporting. They have not yet evaluated how well and accurately health workers collect and maintain the data. Supervisors have yet to undertake this task during their visits. Nor are the supervisors themselves yet using the reports for their own management and planning needs.

At present, eleven months into implementation, supervisors at arrondissement, department and provincial levels are not using and are not being trained to use the routine reporting system. Nor are Project staff routinely using reports to monitor progress. When routine reports are unused, it is hard to justify their existence.

As a result, the project is presently not collecting the routine data it needs in order to assess its progress toward achieving its objectives.<sup>4</sup> For example, health center utilization (new cases per month) is an important indicator for the Project to estimate drug consumption and the viability of the cost-recovery system, but, as we found in the field, some health workers are using different definitions of new cases and recording them inconsistently. In addition, the supervisors are not being trained to do the routine monitoring of Ministry activities which they will have to be able to do if these activities are to be sustained after the end of the project.

Project staff and project consultants are meanwhile assisting the Ministry to develop a much needed national comprehensive integrated routine reporting system, which would, among other things reduce the excessive number of reports currently in circulation. This is a large undertaking, far beyond the scope and resources of the present project.

Project staff expect that this national system can be developed and implemented, at least experimentally, within the two Project provinces by July 1992. We believe that this timetable is an overly optimistic. The design and pretesting of such a system, as well as the training for its implementation, require much time.

By changing again the Project reporting system only 18 months after its first implementation, the risk of health worker resistance (which already appears high in the two provinces) increases. To introduce new data collection instruments and a new reporting form for a second time within a short period is also likely to reinforce the image of activities in the two provinces as "project" and not as Ministry activities. Given the project's unhappy experience to date in implementing its first data collection and reporting forms, it might be preferable to concentrate resources on achieving a

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<sup>4</sup> This problem was recently confirmed by a project consultant: "Le projet SESA a un besoin urgent en information sur la gestion." Rainer Sauerborn, Propositions pour un Systeme d'Information pour le Projet SESA, Cambridge, 10-30-91., p. 15. The Project through its operations research studies, particularly the surveys conducted by Jennifer Litwak and Maria Madison, is and will be gathering data which will permit it to measure changes population attitudes and health services utilization in selected geographic areas at selected points in time. However, such studies are not a sustainable source of information for management and planning.

functioning system within the two provinces and to leave the development of a national system to others.

The functioning system within the two provinces could then lay the groundwork for the accurate recording of data, the appropriate and rapid transmission of reports, and the use of the data for planning and management at local and provincial levels, as well as provide the needed data for project evaluation. When the new national information system is ready for implementation, it can be introduced in the two provinces where habits of good record keeping and analysis have already been established.

### **3. Management and Supervisory System: Design and Implementation**

All successful implementation of project activities depends upon the Ministry having in place a vital management system. These includes internal control procedures for discipline and promotion; management tools such as logistics inventory systems; and a functioning supervisory system that provides on the job training in the planning, management, and delivery of health services. This aspect of systems development has, during the project's history, been recognized as the most needed and may still be the weakest link in project design and implementation.

**Background:** The civil service system in Cameroon, which grew considerably during the years since independence has been described as being characterized by "clientelism" and "patron-client networks that permeate the state structures."<sup>5</sup> With the economic setbacks during recent years (including salary cuts for civil servants), health workers have grown more dispirited and demoralized. Among health workers, their productivity has been particularly low--only 27 percent of nurses' time was spent in productive work, as reported in a 1990 Project study.<sup>6</sup> Although the Ministry is well staffed compared to other countries in the region, these personnel are unevenly distributed. The appointment system is highly centralized. Although the provincial delegués technically have the power to transfer nursing and other staff within their own province (and department chiefs have the same powers within their departments), in actuality, personnel are frequently posted or re-posted by the central Ministry, often without informing local officials, which makes for chaotic planning. The assignment of physicians is made only by the Minister, thus considerably limiting a delegué's autonomy to plan the allocation of personnel within his

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<sup>5</sup> Nicholas van de Walle, The Politics of non-reform in Cameroon. African Studies Association, November 2-5, 1989. Atlanta, GA, p. 13.

<sup>6</sup> Project SESA, Report of a Field Study to Establish the Baseline for Future Activities of Project SESA. HIID, January 1990, p. 4.

province.

**Project Activities:** In early 1989, the Project began shifting its activities from vertical interventions to assisting the Ministry to provide management and supervisory support for integrated care. In this context, the project developed a set of protocols for the supervision of health centers providing integrated services. The protocols included a checklist for inventory management and protocols for supervision of immunization, curative treatment, ORT, growth monitoring, malaria prevention, and prenatal care. These protocols were scheduled to be implemented by the end of 1989, but were set aside to permit Project staff to give first priority the development of a cost-recovery system.

The Project has conducted considerable training in supervision at its seminars during 1990 and 1991. In late August 1990, the project held a seminar for supervisors, at which, among other activities, they developed a list of tasks for supervisors. Project staff had planned for the group to develop a supervisory protocol for the cost recovery system, but because of lack of time, this was deferred until a February 1990 three-day workshop when drafts were prepared. At this second workshop, the participants included, among others, the physician chiefs of departments and arrondissements, two departmental nurse-supervisors, and a peace corps volunteer. The arrondissement nurse-supervisors who are the prime users of the supervisory protocols, were not among the participants. The final supervisory protocols were made available to provincial and district supervisors after a second seminar in May 1991. The target of these protocols was the cost recovery/drug distribution system. Supervisory protocols for other health center activities are not yet developed. Nor have there been final decisions on the supervisory protocols for the provincial teams who supervise the district teams.

The Project has also made available vehicles for supervision (one for each department), funds for fuel, as well as mobyettes and motorcycles for arrondissement coordinators to make supervisory rounds and for health center nurses to do outreach activities.

It is always difficult to gauge how successfully the training that supervisors received in seminars has actually translated into improved management practices. Since we did not visit Project sites before the training began, we do not have a basis of comparison. Thus, our only measure is the extent to which management systems are actually in place and functioning.

**Findings:** At the seminars, the arrondissement teams were trained in vehicle management, but we were unable to assess that the proposed system or any similar system were actually in use for managing vehicles or any other logistics management.

We asked about the action plans which had been developed during the

seminars, whether they had been followed, and whether they had been since revised. The plans were used as the basis to plan and to fund training seminars in the provinces and arrondissements. Most supervisors said they were following their plan but with delays in implementation. The only groups which had drafted a subsequent or a revised plan were those which had done so as participants at a recent seminar at Kribi. Many physicians and coordinators were able to show us a copy of their plan; but a good number were unable to locate them. We came away with the impression that developing a plan is not viewed as a management tool developed during a process carried out in the work place, but as something done during a seminar. Perhaps, training for drafting a plan is best undertaken in the setting in which the plan will be used.

Schedules were established for supervisory activity and we found much of it, at least in Adamaoua province. There, the arrondissement teams, particularly those based at the departments' capitals were very active. At Meiganga, for example, the primary care coordinator and the Peace Corps volunteer made frequent supervisory visits, at least twice a month, to the three clinics and the one hospital they supervised. Some clinics complained this was too frequent. Elsewhere, the frequency was no less than once a month.

In the South Province, supervision visits were less frequent. At some centers, supervisors had not been seen for four months. Although in Adamaoua, the provincial team has been supervising at least once every three months, in the South, supervision by the provincial team has not really taken place.

Since June, when the supervisory protocol had become available, most of the coordinators and PCVs had used it at least once. They said they had found it helpful. A few had never used it and claimed they had not seen it.

Physician chiefs are expected to supervise health centers once every quarter. Among the physicians we visited, some, such as at Ambam and Banyo, had done so. The physicians at Kribi and Lolodorf and Sangmelima had not. At other centers, Meiganga and Ngaoundere, the physicians had been absent since May and July respectively (one studying in the United States, one posted elsewhere). Their absences created problems for their respective supervisory teams which were continuing nevertheless to do good work but needed more support. However, even where the physicians were present, it was clear that most supervision was undertaken by the coordinator and the PCV. Their skills and knowledge determine the quality of the supervision. Most of the physicians were not up to date on what was going on in the health centers, had not reviewed RMAs-projet (when they were available), and were generally more preoccupied with clinical affairs at the hospital, though some took a real interest in supervising the hospital pharmacy in their town.

We noted some ambiguity in responsibilities and authority between the physicians and the coordinators (with their PCV counterparts). The coordinator was the one in the field the most; he was often the most knowledgeable, but was said to lack the authority to get the supervisee to listen to him. We were told by some that only the physician had such authority. It appeared to us an odd situation that could use some clarification. If those who are qualified to do the job are doing the job of supervision, then they should have authority to do so, if necessary delegated to them by the physician chief.

With the discovery of potential and actual fraud taking place, the Ministry and the Project decided, in May, to increase the frequency of inspection visits by the Provincial pharmaceutical team from once a year to once every two months. These visits (with their resulting careful reports), particularly in the South, have proved to be a most useful source of information about the cost-recovery system. The Project has always distinguished these inspections from supervision in that no training is supposed to take place. Inspection is not intended to replace supervision. However, in actuality, we found that it did for the provincial team in the South and that the EPP, when it encountered a problem caused by lack of knowledge of procedures or policies, tended to provide instruction and guidance to the wayward pharmacy clerk, treasurer, or health committee member.

The content of the supervision is almost entirely focused on the cost-recovery drug distribution system. Both supervisors and health center personnel confirmed that since the beginning of the new system the supervisors had not, looked at any other aspects of services delivery. They did not observe patient consultations, check the cold chain, check for cleanliness, health education, or review data collection systems. One nurse said he had asked his supervisor for help in filling out the RMA-projet, but there had never been enough time. Everyone we talked to agreed that it would be good to expand supervision to other areas ("that way I can grow professionally," said one nurse), but for the time being, there were still too many problems with the cost-recovery system to allow time for anything else.

Nor has the supervision, focused as it is on one sub-system and despite its frequency, necessarily uncovered all cases of error, fraud, and abuse. The sub-system is very complex and only a limited number of the coordinators really understand it. The PCVs often have a better grasp than their counterparts. We found, for example, that one influential coordinator's misunderstanding of how to calculate drug consumption had spread well beyond his own arrondissement. On the other hand, some particularly conscientious PCVs have been meticulously correcting the errors made by pharmacy or depot clerks or by treasurers. Although they have thereby kept the books straight, this tendency to protect rather than reveal incompetence has also masked the extent of difficulty Health

Committees are experiencing in managing funds.

The relationship of the health personnel to community Health committees has involved the coordinators, the physicians, and the health center staff in entirely new activities. It has thrust them into an arena of community development where communication and political skills are more important than technical skills. Not everyone comes by these skills naturally, and despite the training provided by project seminars, most health workers need additional support. This may help explain why the health personnel feel so frustrated in their relations with community health committees. Moreover, their anomalous position as supervisors without authority vis-a-vis the health committees, makes their task difficult.

Within the Ministry, among health workers themselves, recommendations by supervisors can be often ignored, with supervisors having little recourse. The lack of sanctions and means of discipline within the civil service make the likelihood of cooperation low. The major technique used by the Ministry to deal with recalcitrant or intractable personnel is reassignment (presumably to other less fortunate localities).

We conclude that, given the problems in the cost-recovery system, close supervision on this sub-system alone will have to be maintained for some time in these centers from the first wave. Until these problems find at least partial resolution, the Ministry and the Project will not have available the resources in supervisory personnel in order to open new cost-recovery centers and, equally important, to improve the quality of integrated health services. Moreover, the Project and Ministry need to find ways to improve the morale and discipline of health workers.

#### **4. Decentralization within the Ministry of Public Health**

The Cameroon government administers through four levels: the central level; the Province headed by the governor; the department headed by the prefect; and the arrondissement headed by the sous-prefect. The 1989 Reorientation of primary care policy of the Ministry selected the arrondissement, as the focal point of health services delivery. This means putting resources at the disposal of the arrondissement and giving it latitude to plan and organize its work. Below the arrondissement are health center areas, clustered around health centers (some of these are still being developed). The arrondissement has two administrative health staff: the physician-chief (who is also simultaneously chief of the arrondissement hospital and carries out clinical work) and the nurse coordinator of primary care. In the arrondissements in which project health centers are operating, a third person, a peace corps volunteer has been placed.

In those arrondissements which include the capital of a department, the chief physician of the Department serves also as chief of that

arrondissement. This Department physician-chief is expected to be a full-time administrator for the Department since the hospital has its own administrator. The Department physician-chief has a staff consisting of a nurse Bureau Chief (chef de bureau de santé) as well as an administrative person who, among other functions, collects and transmits statistics. Under present Ministry systems, health center reports are collected by the Department level where they are synthesized and transmitted to higher levels.

The provincial level is headed by the Delegué who is assisted by the provincial team consisting of representatives from the directorates of the Ministry, most of them physicians. There is also a nurse coordinator of the Directorate of Preventive Medicine who carries out general supervisory functions for the province.

This is the formal organization. In the field, we found that operationally, relations did not always appear as on paper. Although we scarcely had time nor occasion to do a systematic operational organization analysis, we did note some ambiguities which, until they are clarified, could complicate project implementation.

We make two observations: First, under the Reorientation policy, the role of the Department is uncertain. Despite having considerably more resources than the arrondissement (full-time administrator, vehicle, statistical capacity), its role and activities seem restricted. The responsibilities of the Department (which has a broad mandate to organize, program, manage, supervise, and control all health services in the department)<sup>7</sup> and the arrondissement whose mandate is much more restricted, seem to bring them into overlapping and duplicative activities. Having the two layers may create a lot of administration for what is a relatively small geographic area in terms of the facilities and population.

Second, the operational lines of responsibility (if not authority) for supervision appear between two hierarchies, one going through nurses, the other through physicians. Formally, the medecins-chefs of departments and arrondissements are responsible for supervising all health activities within their administrative units. Actually, these administrative physicians appear to do very little supervision. During our field visits, we estimated that 80 percent of supervisory visits and activities are carried out by nurse coordinators with the assistance of PCVs. We noted that the physician-chiefs, were not, as a rule, well informed as to what reports health facilities had sent to them, were not analyzing implementation of project activities, and were not regularly making the expected quarterly supervisory visits. This work was carried

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<sup>7</sup> See République du Cameroun, Decret No.89/011 du 5 Jan 1989 portant reorganisation du Ministère de la Santé, Chapitre II, Article 70.

out by the nurse coordinators at all levels and the PCVs.

We were given several reasons for phenomenon: that the arrondissement physician chief was expected to administer the hospital and fulfill clinical duties; the departmental physician chief, although in theory freed from such obligations, is nevertheless in great demand as clinician; physicians, as a rule, has little or no public health training, and may have little inclination in that direction; both physicians benefit financially from clinical practice through the system known as "quote part" which returns to physicians a part of the consultation fee.

The long-term solution to this problem is to encourage more physicians to train in and enter public health, and/or alternatively, as is now common in Europe and the United States, to use non-physicians for public health administration. Meanwhile, in the short-term, the Ministry still needs to administer and supervise health activities.

A short-term solution may lie in recognizing and using more effectively the informal administrative arrangements which are already in place, that is, to recognize that coordinators will continue to carry out most of the supervisory activities and to give them the administrative support to do so. A study of how physician chiefs and coordinators at the provincial, department and arrondissement levels use their time and what tasks they carry out, can provide a first step in helping the Ministry clarify existing work patterns and how to make them more effective. This study could be carried out with technical assistance for design and analysis, but it would be most effective if nationals were involved in the study so that, in the future, they will be able to carry out similar organizational studies themselves. This study could also examine the relationships between arrondissement and department tasks and responsibilities.

A partial solution may also lie in restructuring the "quote part" system to expand the categories of health personnel and the types of health facilities which benefit from the shares of consultation fees.

A final note on decentralization within the Ministry: the Reorientation strategy calls for decentralization of health planning and management to the arrondissement. It is not clear how far this decentralization is intended to go. Traditionally, government, in Cameroon, has been highly centralized.

Decision-making affecting project activities (drug distribution system, supervision, training), is centralized in Yaoundé. Local officials are asked to find their answers to policy, planning, and management issues in the training modules or in the training manuals. When the answers are not in the documents, the questions are taken to Yaoundé. We were told, at least for the start-up

phase, that it is important to follow the model.

This may be true, but if decentralization is the goal, to ask local officials to follow a centralized model may be sending the wrong message to them. New models, untested as they are, need strong input from those who implement them because these officials may be the most familiar with what problems are being encountered on the ground. When their observations are distrusted or their proposed solutions ignored, the project decreases its capacity to implement effectively and loses, as well, the opportunity to demonstrate, by example, how decentralization can work.

#### **5. Decentralization to Community Institutions: Management of the Cost-Recovery Funds by the Community**

**Background:** The Ministry's reorientation strategy adopted in 1989 puts considerable emphasis on the role of the community.<sup>8</sup> It specifies the development of "dialogue structures," which are embodied in health committees at the levels of the village, the health center, and the arrondissement.

The reorientation strategy specifies that health center and arrondissement committees will elect a management committee: Membership in the health center management committees is to be composed of three persons from the health area, two health center staff, and the *medecin-chef* of the arrondissement. The health center committees are to meet once a year; its management committee, every two months.

Membership in the arrondissement committee's management committee is also specified: including two members elected by the health committee and political and ONG representatives as well as the *medecin-chef* and coordinator of the arrondissement and the hospital director and financial manager. The Reorientation strategy also specifies that the arrondissement health committee is a sub-committee of the Arrondissement Development Committee.

This Reorientation strategy, although the operating policy of the Ministry of Public Health, has not yet been formally ratified by the Council of Ministers.

**Findings:** The framework described above has been modified in the creation of arrondissement and health area committees in the Project provinces. The documents we consulted relating to the establishment, roles, and responsibilities of these committees are as follows:

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<sup>8</sup> Cameroon Ministry of Public Health, *La Reorientation des Soins de Sante primaires au Cameroun* Doc. 1/1/89 rev.

- Module 5: Promouvoir la Participation Communautaire, April 90.
- Manuel du Centre de Santé (pp. 178-183), Sept 90
- Manuel du Comité de Santé de l'Aire de Santé, June 90
- Manuel du Comité de l'arrondissement, August 90.
- Lettre Circulaire no. D30/LC/MSP/SG/DMPR/DAMPR/ SDRR/SSCMT du 7 juin 1990
- Lettre Circulaire No. 678/LC/MSP/DSPSP/SPMPR/SUD: Formation et Constitution du COSAAR/COGEAR du 14 Aug 1990
- Proposition of arrete sent to the Delegates of the two provinces on the legal status of the COSA (regroups the information on the tasks and membership of the committees as given in the June and August manuals for committee members) no date-probably mid-1991.

No legal texts have yet been adopted relative to these new structures. We were told that some texts were circulating, but as of now, one year and one-half since project documents first described these committees (Module 5-April 1990), the legal status of the health committees remains uncertain. None of the above documents mentions any relationship between these health committees and the arrondissement development committees as had been described in the Reorientation strategy document.

The arrondissement committee of Ebolowa has been officially recognized by the Prefect as an Association. But it is the sole one to have a legal status among the 27 functioning committees which are managing the finances of the hospital and health center pharmacies.

Early project documents (April 90) discuss "self-management" of the revolving funds by the health committees. By September 90, "co-management" is the term that is used. However, the management responsibilities are identical for both early and later documents:

[le role du COGE est d'] assurer la gestion et l'administration du CS et l'aire de santé...Execution de la decision de l'utilisation des benefices et d'autres decisions du COSA

-Manuel de Santé, p. 182

La communauté au travers des comités de santé et de gestion va gerer les recettes provenant de la vente des médicaments et du paiement des actes medico-sanitaires....Le commis est...supervisé par le comité de gestion.

-Manuel du Comité de Santé, aire de santé, p. 1

[Attributions du COSAR]: ...gerer toutes les ressources de la communauté.

-Manuel du COSAR, p. 5.

The documents do not specify the role of health workers in "co-management" except to designate a few as members of the committee and to specify that the health center's chief has to sign off on treasurer's reports and expense reports. There is, however, no mention of supervisory responsibilities of the health workers, nor their source of authority to make the pharmacy clerks and health committees conform to operating principles and priorities. The roles of health workers and health committees in "co-management." are not clear. The texts suggest that the committees are, in fact, autonomous and can manage their funds any way they see fit. This may not be what was intended, but this is how it is being interpreted by some health committees.

As a result, we found that the management of the health funds is not going well (see II-Drug distribution/cost recovery section). The expected community interest in managing the cost-recovery fund has not been in evidence since January. Treasurers do not show up for their weekly meetings, much less the monthly ones; errant pharmacy clerks are not disciplined; COGE members fail to show up for meetings or to review the financial books. Some committees are neglecting their responsibilities, leaving all the work up to the health workers. Others are spending the funds intended to purchase drugs and health supplies for frivolous ends.

Attempts to change the behavior of the community committees can be frustrating, particularly since, formally, health workers have not authority over committee members. The Adamaoua pharmacist said when he attempted to provide guidance during inspection visits, health committee members would say to him, "Now, I understand," but when he came back one month later, he found they had not understood anything. Some, or even most, of the ineffectiveness of this inspection/supervision may be ascribable to the fact that the authority of the health personnel to supervise the health committee and its pharmacy clerk is not clear to either party.

Finally, the representativeness of some of these community committees can also be called into question. None of the COSA and COSAR committee presidents we met could list, or give us a list of the names of committee members. In our interviews, we learned that for most committees, a small select elite of only four to six persons (that is the executive board) usually make all decisions. Some of these members are not even community citizens. They are civil servants, such as the sous-prefects and deputy-mayors, who serve as presidents or executive officers in several arrondissement health committees. In few of the health center committees are there active representatives from villages other than the one in which the health center is located; the arrondissement committees also do not appear to include the prescribed representatives from the health center committees, although the latter have an interest in the management of the depot.

We conclude that the Ministry needs to take immediate steps to clarify the legal status of these health committees, to decide what the contractual relationship of "co-management" means. Given the Ministry's difficulty in involving the population in community management of health resources, the Ministry needs to assess how appropriate such models are to the Cameroonian environment. A study of Cameroonian experiences with community organizations (whether in the health field or elsewhere) might be helpful.

#### SUMMARY CONCLUSIONS WITH RECOMMENDATIONS

This is a project in institution building. Recent history has obliged the project to focus on cost recovery sub-systems to build a financial basis for health services. Difficulties in implementing this cost-recovery system suggest that the institutional environment is not yet sufficiently developed to allow this sub-system to function effectively.

We therefore recommend that the project focus on larger systems development in the short term. When that essential component has reached an acceptable level, we recommend the project turn to extending its scope both in terms of increasing the number of health facilities participating in the cost-recovery system and in terms of expanding the capacity of health centers to deliver integrated quality health care.

Our recommendations fall into two groups. The first recommendations serve to reinforce the activities already undertaken whose implementation and execution are still fragile. They should be followed immediately. The second group of recommendations concerns the extension of activities.

The major problems in organizational development are not easily resolved by technical fixes, such as installing computers, but by changes in the way Ministry personnel organize and carry out their activities. They require changes in incentives and behavior.

The project has encountered two major institutional constraints in attempting to implement the cost recovery system. The first is the existing management structure within the Ministry of Public Health, including the supervisory and information systems. The second is the new institutions, the community health committees, which have been created independently of the Ministry, but which are charged with managing the funds earned by the health center pharmacy.

We present first our summary conclusions and then our recommendations for action.

#### **A. Recommendations to assure that activities already undertaken are successfully implemented.**

**Conclusions:** The Project has developed an excellent series of training materials and seminars. Our field visits suggest that Ministry supervisors and health workers are experiencing some difficulty in translating what they learn from the seminars and documents into operational activities.

**Recommendation** We recommend the project develop and support methods for Ministry personnel to provide on-the-job training to reinforce the materials available from the seminars and documents. We recommend this training for all levels of health workers: from provincial teams to assist them with planning and management tasks; to health center nurses to assist them with their whole range of activities.

As a corollary to the above and to ensure that skills are imparted as an integral part of project activities, we recommend that project staff reinforce their role as technical advisors and trainers when working with their counterparts and when carrying out analyses of project activities.

**Conclusions:** The newly introduced data collection forms and reporting forms for the information system in the two provinces are not functioning at a level to provide the project and the Ministry with basic management tools, much less, the means to assess progress toward objectives and the viability of cost-recovery systems. Administrators and supervisors are not using the information which is available for planning and management. Ministry and Project personnel resources are needed to make this information system (with minor modifications) functional in the two provinces. If the project were to introduce a new information system in July 1992, as it currently plans, it would dilute its energies and discourage health workers. Local health centers presently have to pay for the purchase of monthly reporting forms which are required by, and of interest mainly to, higher administrative levels which should bear the cost.

**Recommendation** We recommend that project and Ministry staff focus their activities on modifying modestly the information system and making it operational for data collection, transmission, and analysis. Specifically, we propose the following:

Data collection: Tailor the data collection instruments to the report form by improving format and use of curative care register (allow place for old cases so total center activity can be calculated); assure that there are appropriate data collection instruments for vaccinations, preventive consultations, and all outreach activities, as well as for logistics management (motos, vehicles, fuel)

Train health workers using the provincial and arrondissement supervisors to use data collection instruments and to fill out correctly reporting forms. Training of maximum 1-2 days followed by on-the-job training and supervision during the next month.

Supervise data collection twice a month for next three months; once a month for the following three months. After that, review of the information system should be a part of regular supervisory visits.

Make minor modifications in existing RMA-projet: We recommend that calculation of coverage be simplified; that a standard population denominator be used, preferably by carrying out the long-planned family censuses; Addition of a few indicators of logistics management (moto km. fuel) and all outreach activities; Remove a few indicators not likely to trigger action (e.g. frequency of supervision--data available more accurately from supervisors); stock-outs are best recorded through supervisors' reports since emergency stock-outs tend to be reported immediately by other means.

Clarify and enforce transmission requirements: We recommend that centers not be delivered new shipments of drugs unless their reports are up-to-date and transmitted to the appropriate levels.

We recommend that health centers fill out three reports of which one stays at the center and one is destined for the provincial level. The destination of the third report depends on how the Ministry resolves the relationship of the departmental and arrondissement supervisors. Currently, the departments collect reports. This would be a useful level of analysis for Department-wide planning. If the Department's functions are to be phased out, then the arrondissement is the appropriate level.

Training for data analysis: We recommend on-the-job training for provincial teams, particularly DEPS representative; for the supervisory teams; and for the health centers to turn the data into useful tools. e.g. at health center level, training to graph coverage, medication utilization, analyze outreach activities.

On the job training in management decision making and problem-solving for the Provincial team: We recommend that the project provide more technical assistance to these teams to help them develop management skills to devise revised plans, order drugs, assess and carry out

supervision; assess resource needs and allocations. These tasks should be undertaken by the provincial coordinator.

In addition, we recommend that the development of a national information system not distract project and Ministry staff from laying the bases of a functioning information system in the two provinces. Resources other than this project should be sought to support the development of this much needed national information system. We support USAID's decision to provide long-term assistance to the development of this national system. When it is completed, it should be installed in the two provinces.

We recommend that provincial funds be used to purchase RMA-project reports and that they be provided free of charge to health centers.

**Conclusions:** The Management and Supervisory systems in the two provinces are fragile and have not been sufficiently effective in implementing the logistics management, information, and cost recovery/drug distribution sub-systems. Health personnel remain poorly motivated because rewards do not follow from achievements and poor performance does not occasion disciplinary action. Physician chiefs are responsible for supervision, but nurse coordinators and PCVs carry out most of the supervisory tasks.

**Recommendation** We recommend that supervisory and management systems receive immediate attention from Project and Ministry personnel. Specifically, we recommend that provincial and arrondissement supervisors receive on-the-job training to improve their capacity to supervise and train health workers; schedules for supervision need to be mandated and followed; content of supervision needs to be expanded; quality of supervision (attentiveness, knowledge) needs to be improved. These tasks should be undertaken with support from supervisors at the central level.

We recommend that USAID continue to support the initiative of the World Bank in assisting the Government of Cameroon to reform the civil service.

We recommend the Project assist the Ministry of Public Health to review the system of incentives within the Ministry. A study of incentives should explore alternative ways of restructuring the "quote part" that could offer financial incentives also to health workers and not only to clinical physicians.

We recommend that the Project assist the Ministry to study three organizational issues. These studies should be of the actual organizational patterns as they exist, identifying how and by whom activities are carried out, decisions are made. They should not be theoretical models: 1- the tasks and responsibilities of departmental and arrondissement teams to assess in what ways there is overlap and redundancy between them and to assist in making decisions as to the appropriate administrative level on which to focus supervisory and information gathering activity. 2. The tasks, responsibilities, and authority of physician chiefs and nurse coordinators in supervisory activities to assess how the latter can be more effectively supported in their work. 3. The tasks and responsibilities of the provincial teams, within the team and their supervisory relationship with departmental, arrondissement, and health center personnel..

**Conclusions:** Although it is too early to expect that project outputs will be sustainable, the project has begun to establish the elements that give it the potential for sustainability. Those elements not yet in place are the integration of the project at the operational level which would give nationals a sense of ownership and the Ministry's financial contribution to project activities. [See also other issues of sustainability and viability in the section on the cost recovery system.]

**Recommendation** We recommend that in the provinces, at the operational level, Project activities and resources be more closely tied in with the Provincial team's activities, with the Project provincial staff serving under the Délégué as advisor to the entire Provincial team. We also recommend strongly that provincial teams be allowed greater flexibility in adapting the cost recovery model to the exigencies of the terrain without having to refer inevitably to the project's central direction. This recommendation, if followed, would also be in the interests of the Ministry's stated policy of decentralization.

We recommend that USAID and the Ministry monitor closely the actual availability of the counterpart funds that the Ministry makes available for project activities at the provincial level. This should be done through quarterly reviews of the expenditures in the provinces, departments, and arrondissements.

**Conclusions:** The functioning of Community Health Committees and

their management of the revolving funds of health center pharmacies have been a source of disappointment. Some of the problems encountered can be attributed to unfamiliarity with community organizations; some can be attributed to the anomalous legal status of these organizations; some can be contributed to their ambiguous relationship to Health Ministry structures; and some can be attributed to lack of interest on the part of the community.

**Recommendation** We recommend that the Project assist the Ministry immediately to begin studies on the legal status of the community health committees to assess what are their rights and obligations in managing funds; whether they have any obligations to the Ministry of Public Health under present statutes; what if any are their relationships with provincial development committees; what contractual relationships can such community organizations enter into. Such a study should end with an analysis of the options for the future status of these community committees. Should they be advisory, rather than management committees, giving the community the opportunity to have input into how funds are spent without having to deal with daily financial management?

Concurrently, we recommend that the Project assist the Ministry to study the experience of community organizations in Cameroon. Have there been other successful organizations which have managed community funds? Under what circumstances? Is the cultural environment suitable for this model of community participation?

**B. Activities to undertake after the above activities and, particularly, the institutional development activities are well launched, including the information, logistics, and supervisory systems.** (We estimate that the earliest such activities could begin would be in six months)

**Conclusions:** The Project has had to defer putting into practice any measures to improve the **quality of care**, the integration of health services and the continuity of care.

**Recommendation** We recommend that the Project and the Ministry move to a higher priority this aspect of care and incorporate it into its supervisory policies. As a start, the supervisory protocols for integrated health care developed by the Project in 1989, should be reviewed to see what can be usefully applied. We recommend that the Project, when it trains, do so with integrated and not vertical programs. We also recommend that diarrheal disease

control training, which has been amply ventilated in the two provinces, be of low priority except in supervisory visit training when it is necessary.

**Conclusions:** If the Project follows our recommendations that it focuses on institution building in the centers where it is already operating, it will then have to defer the launching of pharmacies in **second wave of health centers.**

**Recommendation** We recommend that rather than launching a second wave all at once, the Project and Ministry proceed pragmatically and assure first that all conditions are met before a health center is brought into the cost-recovery system. These conditions should include first an analysis of the center's potential viability based on its population and the number of new cases it had during the preceding year as well as potential competition from private centers. This analysis should be carried out by provincial team members with assistance from the Project staff.

We recommend that the conditions precedent for a second wave center also include:

- renovation and security of pharmacy;
- well trained supervisory team;
- active and well trained health and management committees and pharmacy clerk;
- bank or postal accounts.

**Conclusions:** The above recommendations, if followed, will inevitably lead to a decrease in the number of health centers which can enter the system before the end of the project and will affect the probability of attaining **end of project objectives..**

**Recommendation** We recommend that Project staff, USAID, and the Ministry carefully review stated end of project objectives and revise them to conform with the reality of what can be attained.

**Conclusions:** This ambitious project is a significant contributor to building the Ministry of Health infrastructure and to instituting viable cost-recovery systems. Institution building is a slow process. At the end of this project's PACD, all health units in the two provinces will not yet be included in the cost recovery system; the institutions developed will still be young: information systems and supervisory systems will have had only two years of experience. Moreover, the project objective of providing integrated services and continuity of care, will only begin to be addressed during the last year of the project.

**Recommendation** We recommend that USAID begin shortly to plan for a

follow-on project that will extend cost recovery systems throughout the two provinces and provide assistance to the Government of Cameroon to strengthen its health institutions.

## B. THE DRUG DISTRIBUTION AND COST RECOVERY SYSTEM

### Introduction

The drug supply and cost recovery system is considered the backbone of the MOPH "Reorientation of Primary Health Care" initiative being implemented on a pilot basis in ten hospitals and seventeen health centers in Adamaoua and South Provinces with USAID support provided through the SESA project. It is assumed that as drugs are made available through the new drug distribution system, utilization of health services in the hospitals and health centers will increase. Revenues from consultation fees and drug sales collected by the cost recovery system would then permit participating facilities to replace drugs sold, increase their inventory and/or to cover certain operating costs not financed by the MOPH.

### Procedures

Procedures describing the operation of the drug distribution and cost recovery system are summarized in ANNEX G.

## FINDINGS

As part of the midterm evaluation of the SESA project, the evaluation team compared the actual operation of the drug distribution and cost recovery system with the procedures described in ANNEX II-1. This assessment was of necessity less comprehensive than a financial audit. It did, however, examine the system in sufficient detail to draw some conclusions regarding its adequacy, the extent to which operating procedures are being followed, and to formulate general recommendations on how the system can be improved. Overall findings are generally consistent with those of MOPH Provincial Pharmacy Team inspections and with observations recorded in the USAID "End-Use" report dated 26 July, 1991.

### 1. The drug supply system.

In stark contrast to non-project facilities, all project pharmacies have an operational drug supply system and a stock of drugs on hand. However, several problems were found in the operation of the system. All of these have an adverse impact on project performance. Some, e.g., problems in drug procurement, could seriously disrupt health services delivery and undermine public confidence in the new system if not resolved in the near future.

Site visit findings are summarized below:

a. Storage. In most of the pharmacies and depots visited during the evaluation, drug storage facilities were adequate. The pharmacies were reasonably clean and orderly, with provisions to ensure security. Drugs were arranged in alphabetic order by date of expiration. However, at the Ebolowa departmental depot and the Ebolowa provincial hospital pharmacy, rodent infestations are resulting in a loss of drugs, and the Kye-Ossi health center pharmacy needs to be renovated to assure adequate security.

Drew University has recently released funds for the renovation of drug storage areas in facilities selected for the second wave. Renovation is necessary to minimize the risk of loss or theft.

b. The essential drugs list. The availability of drugs on the essential drugs (ME) list may of itself improve prescriptive practices by indirectly discouraging the use of other drugs. The ME list used by the project was adapted from that developed by WHO after a great deal of analysis and discussion by MOPH and project staff. The project has adopted standardized treatment protocols and guidelines for the treatment of diarrheal disease and malaria, and plans to develop a comprehensive set of guidelines addressing the most common health problems in the future. It also plans to sensitize and train health providers in the use of such guidelines since prescriptive practices were previously identified as a serious deficiency in the delivery of primary health care.

The baseline study conducted by the SESA project in August, 1989, revealed the following: Of the twenty-two most frequently prescribed drugs, five were inappropriate to the most common diagnoses (Diazepam, Charcoal, vitamins, and intestinal Sulfonamide). Of the remaining seventeen, three (Barbiturates, Anti-Tetanus Serum and Chloramphenicol) appeared to be overused based on medical judgment. The study concludes: "There is strong indication that bad prescriptive practices are rife, including the use of inappropriate medications for certain illnesses, and the over-prescribing of others. Our study indicates that as much as 40% of all prescriptions may be inappropriate."

In her memorandum of 24 July, 1991, Litvack also expressed concern over prescriptive practices, especially the tendency to prescribe less of a medication than needed for a full course of treatment in response to patient objections over prices, and she advocated advancing the timetable for provider training to improve prescriptive practices.

The current list of drugs selected for health centers is inadequate for the ten hospitals included in the first wave, but it was decided that even a partial supply of drugs would be better than none. However, there remains an urgent need to expand this list, especially for the provincial hospitals, which function as referral

facilities. In both Ngaoundere and Ebolowa the project pharmacies must refer several patients per day to private pharmacies for medicines prescribed but not on the list of essential drugs. This situation can disrupt continuity of care and undermine public confidence.

The decision of the Ebolowa hospital to restrict pharmacy use to inpatients also appears to be inconsistent with project goals i.e., improving accessibility to primary care. While there may be a legal basis for this policy, the restriction was not enforced in other hospitals visited. The Ebolowa decision may be related to the fact that the COGE president is a private pharmacist in town. There is a need to review the appropriateness of the law restricting sales to inpatients.

A review of inventories in the pharmacies visited also revealed that some drugs are not used or are used only infrequently. While it is recognized that some infrequently used products are nevertheless essential, the project should assure that providers are familiar with the products on the ME list.

c. Initial drug stock. Because of problems in procurement, the project is providing the initial stock of drugs to first wave facilities in three lots. Although these facilities have been operational since January, 1991, they have yet to receive their third shipment. Moreover, the project decided to include the ten hospitals in the first wave after the initial drug order had already been submitted. As a consequence, initial stock quantities provided to each pharmacy were below originally estimated requirements.

Depots were provided with initial drug stocks but it was impossible to provide them with front-end funding. They must therefore sell drugs to generate funds with which to purchase additional supplies. They are thus unable to build up inventories in anticipation of increased demand by the pharmacies attempting to increase their own inventories.

Because of either delays in shipment or dumping by suppliers, some drugs were close to expiration when received, e.g., Metronidazole: expiration date-7/91. Pharmacies continue to use these expired drugs although medical standards and project policy mandate that such drugs be destroyed.

Implementation of the second wave has been delayed for several months because of difficulties in obtaining its initial stock of drugs. This has resulted in understandable frustration in the communities involved. The delay may be a blessing in disguise however, since there is strong evidence that it may be advisable to postpone initiation of second wave operations until some of the issues raised during the evaluation have been resolved.

d. Inventory control. In most facilities visited, inventory control cards were up to date, with drug clerks posting daily drug consumption and the new balance at the end of each day. A random check of stock on hand revealed close correspondence with quantities shown on inventory control cards. In some pharmacies, e.g., Ngaoundere and Meiganga Hospitals, cards were not current, making periodic reconciliation impossible. Provincial Pharmacy Team (EPP) inspection reports reveal drug losses in a number of facilities. In pharmacies which have sold drugs on credit, e.g., Alomze, Bipindi and Lolodorf, credit sales are not recorded in the utilization and cash journal and on the inventory control cards until payment is received because the system is not designed to handle such transactions. As a consequence, there are significant discrepancies between the inventory control cards and stock on hand. In the case of Lolodorf, the inspection team estimated this discrepancy at over 330,000 FCFA. It is impossible to tell whether these discrepancies are attributable to credit sales, losses or theft.

In most pharmacies initial stock levels were too low to permit the adoption of a bi-monthly requisitioning schedule based on the maximum and minimum quantity of each product as initially planned. In the majority of these facilities requisitions are submitted to the departmental depots 1-2 times per month. Delays in submitting requisitions have resulted in periodic stock outages. For example, the director of the hospital in Kribi complained of outages due to difficulties in obtaining appropriate signatures even though supplies were available at the departmental depot across the yard. Inadequate buffer stocks also contribute to outages at both the pharmacy and depot levels.

Some facilities did not always comply with prescribed procedures for receiving and logging in drug and supply shipments. The receipt of partial shipments not consistent with items and quantities requisitioned complicates this process and increases the risk of irregularities.

e. Emergency drugs. Several hospitals and health centers have established emergency drug supplies (stock d'urgence) for use during off duty hours and on weekends. As described in the HEALTH CENTER MANUAL, drugs sold are periodically replenished and receipts from drug sales are turned over to the drug clerk for inclusion with other receipts. However, a number of facilities have not yet set up a system to ensure drug availability in the absence of the drug clerk.

f. Resupply. Although original plans permitted the provincial depots to select drug suppliers on the basis of price, quality and performance, the project has relied primarily on a domestic source, Ad Lucem, which functioned well at first, but which has become extremely unreliable in recent months. Partially filled orders and delays in shipment have resulted in stock outages throughout the

system. As a consequence, there is growing dissatisfaction on the part of both health providers and the public. Failure to correct this problem could result in serious adverse impact on the effectiveness of the project. The MOPH is aware of this situation and is taking steps to procure drugs from alternative sources.

## 2. The Cost Recovery System

Specific findings concerning the operation of the financial management and internal control system for each of the project sites visited by the evaluation team are presented in outline form in ANNEX II-2. The following paragraphs summarize these findings.

a. Bank/Postal Accounts. Some facilities have established bank or postal accounts, but several have not yet done so. Treasurers frequently have large sums of project generated funds in their personal possession. At least one treasurer has deposited project funds into his personnel account. According to the COSA president, the status of these funds is uncertain. Drug clerks do not always turn funds over to the treasurer as prescribed by procedure. Both treasurers and drug clerks have borrowed from project funds. Lack of bank accounts has necessitated large cash transactions, especially at the departmental level. Reconciliation of cash on hand with financial records occurs on a sporadic basis. All of these factors increase the risk of loss and/or theft. There have been several such incidents since the inception of cost recovery activities.

b. Fee Schedules. Accessibility of primary health services is enhanced if drugs can be sold at the least cost consistent with system viability. However, as shown in cost analyses conducted by project staff, reliance on Ad Lucem as a primary drug source rather than purchasing from the least expensive supplier has necessitated setting drug prices at levels higher than other providers, e.g., GTZ. Patients and practitioners frequently complain that certain drugs are less expensive at private pharmacies and hospitals. This perception, even when unfounded, can be detrimental to the effectiveness of the project. The issue of prices should be addressed in IEC activities.

Recent price increases for certain products have been quite large, e.g.,

Folic Acid 5mg:	5-30 FCFA (600%)
Chlorpheniramine 4mg:	5-20 FCFA (400%)
Ergometrine .5mg	85-230 FCFA (270%)
Levamisole 150mg	68-460 FCFA (675%)
Metronidazole 250mg	19-80 FCFA (420%)

While there have also been some impressive reductions in the price of other products, it is the increases which leave their impression on the public.

Price increases have made it impossible for pharmacies to replace some products with the proceeds from their sale. For example, one depot sold 5000 Metronidazole tablets from its initial stock at 12 FCFA, thereby generating 60,000 FCFA. To replace this stock at the current price of 57 FCFA would cost 285,000 FCFA. Conversely, the prices of other products have been reduced. However justified, price fluctuations complicate the cost recovery process, and when coupled with periodic outages, further erode public confidence in the new system. Similarly, while there may be merit to the policy of differential mark-ups and cross-subsidies, there is some confusion in the field regarding the rationale underlying project pricing.

As recently pointed out by Jennie Litvack, patients may be willing to pay for drugs, but there is widespread opposition to the 200 FCFA consultation fee. Some facilities, e.g., Bekagoto, Kye-Ossi, and Elog-Batindi, have not collected this fee on a regular basis in recent months.

c. Indigent Care. Kye-Ossi indicated that it had adopted a policy whereby 2% of its receipts were set aside to fund the provision of health care to individuals who truly could not afford to pay. Few project facilities have adequately addressed this issue. Yet, the preliminary analysis of the household survey conducted by the project indicates that "not enough money to buy prescription" is the most frequently cited reason (29.4% of all responses) for not using health centers.

d. Internal Controls. As shown in ANNEX II-2, there was inadequate compliance with many internal control procedures in the majority of the project facilities visited during the evaluation. Project correspondence reveals similar deficiencies in other project facilities. These findings are summarized below:

i. Receipt books. Receipt books were not controlled by the treasurer, thereby facilitating "parallel" sales. Some receipt books show evidence of tampering. EPP staff have stated that they are aware of drug sales for which no receipt are issued.

ii. Credit Sales. Because the accounting system cannot accommodate credit sales, such transactions make reconciliation of records impossible, thereby increasing the risk of loss or theft.

iii. Cross-referencing. None of the facilities visited used the prescribed numbering system for cross-referencing new cases in the patient register, consultation slip and sales receipt. As a consequence, the paper trail facilitating reconciliation of the documents does not exist.

iv. Co-mingling of Accounts. Co-mingling of accounts as seen at Tibati and Banyo is inconsistent with generally accepted accounting principles. This practice makes reconciliation of accounts very

difficult, thereby increasing the risk of loss or theft.

v. Daily Reconciliation. Most drug clerks close their records at the end of each day. However, the daily reconciliation of charges, receipts and cash on hand by the drug clerk and the head of the health unit is not routinely done as prescribed in many project facilities. In some cases daily collections are added to those of previous days, making reconciliation more difficult.

vi. Weekly Meeting. Drug clerks usually meet with the treasurer once per week to turn over weekly collections. However, procedures for the weekly meeting of the drug clerk, head of the health unit, and the treasurer for the reconciliation of financial records and cash on hand, and of inventory control cards with stock on hand are seldom followed. In facilities with credit sales such verification is impossible.

vii. Monthly Meeting. While monthly meetings were held in many of the facilities visited, none complied with the procedures prescribed for such meetings, i.e., the control activities performed by the drug clerk, the treasurer and the head of the health unit were not reviewed by a broader committee as described in the HEALTH CENTER MANUAL. A major shortcoming is the failure of COSA and COGE members to attend such meetings. A related problem is the unfamiliarity of committee members with the procedures to be followed.

viii. Monthly Reports. While several centers devote a great deal of time to the preparation of monthly financial reports, seldom are these reports completed in an accurate and timely manner. There is a great deal of inconsistency in the way certain costs such as drug consumption and depreciation are recorded. Discussions with COSA and COGE members as well as supervisors confirmed that there is much confusion concerning the preparation of these documents. Supervisors indicated that these documents are rarely used to assess financial performance. This issue is discussed in greater detail in the section describing the operation of the health management information system (HMIS).

## CONCLUSIONS

### 1. The Drug Distribution System.

The availability of drugs in project pharmacies in contrast to their non-project counterparts dramatically illustrates that the project has succeeded in establishing a functional drug distribution system. Moreover, the decision to incorporate hospitals into the project is consistent with lessons learned in other cost recovery programs in the Third World.

At this time, however, the system is not yet operating as planned

due in part to problems in securing adequate initial drug supplies. Original plans called for a 3 month stock for the pharmacies and a 6 month inventory for the departmental depots. The problem of inadequate drug supplies has been exacerbated by recent difficulties in drug procurement through the local supplier, Ad Lucem. In contrast, UNICEF provides a 12 month initial stock to its pharmacies in anticipation of unforeseen demand and potential problems in obtaining additional supplies.

There are additional issues which must be addressed if the system is to achieve its desired outcomes. It must be remembered that assuring the availability of drugs is a means of improving health services delivery and is not an end in itself.

Within this context, it has already been pointed out that prescriptive practices have long been considered a major weakness in health services delivery. This problem was again identified in the project's own baseline survey. It is further recognized that changing prescriptive practices is a long and arduous process. Dr. Bodart's personal experience in Zaire clearly underscores this fact. One must conclude that greater attention must be paid to this issue and to the formulation and adoption of standardized treatment protocols or guidelines for health centers and hospitals. There is also a need to sensitize and train health care providers in order to improve their prescriptive practices.

It is evident that the project has suffered from its inability to obtain an adequate range and quantity of initial drugs in a timely manner. Eleven months after the initiation of drug distribution and cost recovery activities, project pharmacies have yet to receive their complete initial stock allocation.

It has also proven difficult for pharmacies to expand their inventories in part because of bottlenecks at the departmental depot level. The depots were provided with an initial stock of drugs which they must sell in order to generate revenues with which to replenish their inventory. They have therefore been hard-pressed to expand supplies in anticipation of increased demand from health center and hospital pharmacies. As a consequence, these pharmacies have had to submit requisitions 1-2 times per month rather than every two months as initially planned. As a partial solution to this problem, some pharmacies have been "prepaying" for drugs by providing the depots with front-end funds for drug purchases. Under these conditions, however, the departmental depot functions somewhat like the provincial depot as a pass-through, rather than being able to maintain an adequate buffer stock to minimize system outages.

By far the most serious problem threatening the effectiveness of the drug distribution system is the unreliability of its primary drug source, Ad Lucem. The recent inability of Ad Lucem to provide the range and quantities of supplies requisitioned has created

stock outages throughout the system and has undermined both public and provider confidence. Failure to resolve this problem in a timely manner could jeopardize the viability of the system. The project and the MOPH recognize this problem and have initiated steps to stabilize drug procurement.

## 2. The Cost Recovery System.

All pharmacies and departmental depots established under the project have revolving funds financed through consultation fees and the sale of drugs. Revenues are used to replenish and augment the drug inventory, and will also be used to cover certain operating costs not financed by the MOPH.

A great deal of thought has gone into the pricing structure. Every attempt has been made to set prices below those in the private sector. Yet, there is considerable criticism of drug prices at project pharmacies and widespread if unfounded belief that drugs could be purchased more cheaply elsewhere. This perception was recently reinforced by the sharp rise in the price of certain products sold by the project. As would be expected, there was no mention of price reductions for other products. However, at a time when the project is attempting to gain credibility, price fluctuations accompanied by periodic stock outages are raising public concern over the reliability of the new system.

Discussions with community representatives and MOPH providers revealed that while people are willing to pay for drugs, there is opposition to separate consultation fees. A household survey conducted by the project reached the same conclusion. In his trip report dated 1 March, 1989, Dr. Gilles DesRochers expressed similar concerns over separate fees for drugs and curative consultations.

Although the Litvack study indicates that inability to pay is the major reason for which people do not use health centers, there was a general lack of local policy addressing the needs of the truly indigent in the facilities visited. Only one health center had chosen to earmark a portion of its revenues for indigent care. In sharp contrast, some COSAs had voted themselves price concessions and the right to purchase on credit. COSA members at several other centers expressed interest in granting themselves similar privileges. While this sentiment is understandable, it is clearly inconsistent with the spirit of volunteering and community service which should underlie community participation.

The role of any accounting system is twofold. First, the system must accurately document financial transactions and financial status. Second, the system must incorporate internal control mechanisms which minimize the risk of error, loss or theft. These include minimizing cash transactions, daily deposit of receipts into a bank account, separation of tasks, frequent and consistent reconciliation of accounts, as well as periodic independent verification.

The cost recovery system established by the project includes most of these measures. However, the review of the operation of this system revealed that even when highly motivated, most committees were unable to substantially comply with these internal control mechanisms. This raises serious questions regarding training, supervision and, more fundamentally, about the appropriateness of the system for the environment in which it must function. Interviews with individuals using the system indicated that the concept of internal control is not well understood and that the system is considered too complex. Indeed, the system seemed to function best in sites at which key staff and Peace Corps Volunteers had intervened and were themselves partially fulfilling the COGE role.

Given the complexity and critical nature of the cost recovery system, that there is a need for full-time financial expertise on the project staff, especially during its early operational phases. There is also a need to utilize or develop financial management skills within the MOPH, since such expertise is necessary to maintain the operation of this financial management system in the long run.

#### RECOMMENDATIONS

Defining a problem is the first step in formulating its solution. Indeed the solutions to the drug distribution and financial management problems identified during the evaluation are implied in their analysis in the preceding paragraphs. This section presents recommendations for implementing these solutions in more explicit form.

##### 1. The Drug Distribution System

**RECOMMENDATION:** The project must take immediate steps to resolve the drug resupply problem. The MOPH should proceed with plans to train provincial staff in international procurement procedures as soon as possible. The project must closely monitor the initial implementation of these new procedures to ensure that procurement is proceeding as planned. The system should maintain the capability to procure drugs and supplies from the least expensive and most reliable source, whether the supplier is domestic or foreign.

**RECOMMENDATION:** Because of inevitable delays in international procurement, the project should consider either (a) converting the provincial depots into facilities with permanent inventories or (b) expanding the role of the departmental depots in Ngaoundere and Ebolowa. At a minimum, the latter could carry a buffer stock of the most critical and most frequently used drugs, which could then be sold as needed to other departmental depots in order to minimize the probability of stock outages. Because the establishment of provincial

depots would permit more rapid processing of departmental requisitions, the project should completely reassess and if necessary revise the reorder cycle and the stock levels required at each level.

If it proves necessary to increase the initial stock of drugs at the depots and at the pharmacies, and if it is decided to postpone all or a portion of second wave implementation, some drugs intended for these facilities could be used for this purpose.

**RECOMMENDATION:** The project should compile essential drug lists more appropriate for hospitals at all levels. The MOPH should explore the possibility of changing the law restricting hospital drug sales to inpatients. The project should also give greater attention to improving prescriptive practices through the adoption of standardized treatment protocols or guidelines, provider training in their use and the promotion of more effective clinical supervision.

## 2. The Cost Recovery System

Growing concern over losses and theft have already prompted the project and the MOPH to initiate interim measures to minimize such occurrences. While they constitute an important first step, these measures must be reinforced. The project should take more definitive action to resolve this problem in the short run. In the long run, the project should simplify the cost recovery system and more closely monitor its operation.

**RECOMMENDATION:** The project should insist that all sites have bank or postal accounts. Future sites should not be allowed to participate in the project prior to establishing such accounts. The project should require the timely deposit of collections and the K of cash transactions through the use of checks or postal money orders, especially at the departmental and provincial levels, where large sums are involved.

**RECOMMENDATION:** The project should complete the hiring of a financial analyst as soon as possible since these skills are urgently needed. The project should also take steps to develop financial management expertise within the MOPH at the provincial, departmental and the arrondissement levels in order to enhance technical oversight of cost recovery activities to the extent possible.

**RECOMMENDATION:** Treasurers should be selected on the basis of their technical expertise. The project should recognize their dual role as COGE member and as financial manager of the pharmacy. It may be appropriate to provide some compensation for the latter.

**RECOMMENDATION:** The project should consider simplifying the composition of the committee prescribed for the monthly meeting since there is no evidence that such a meeting has ever taken place. If possible monthly meetings and supervisory visits should be planned to permit attendance by the supervisor. The monthly meeting must include a reconciliation of financial documents and cash on hand.

**RECOMMENDATION:** The project should consider alternatives for enforcing compliance with the monthly closure and reporting procedures through the imposition of positive and/or negative sanctions. One possibility would be to require that drug requisitions be accompanied by evidence of such compliance.

In the long run, system simplicity will be the key to its survival and functionality. Hopefully, the selection of more reliable suppliers will facilitate simplification of the pricing structure. Purchasing from the least expensive reliable source should permit the system to absorb minor price fluctuations at the provincial level.

**RECOMMENDATION:** It is strongly recommended that HIID analyze the operation of the current accounting system and take steps to simplify it to the extent possible while incorporating adequate provisions for internal control. The resulting system must be easier to understand and its procedures easier to follow than the current system.

The following are a few examples of factors to consider in redesigning certain aspects of the cost recovery system.

Reporting could be simplified by eliminating the operating statement (Compte d'Exploitation), which is poorly understood, incorrectly prepared, and not utilized for project management as originally intended. A simpler financial report reflecting cash flow, financial status and drug consumption plus evidence of compliance with internal control procedures would meet project management needs. The project should utilize such reports to analyze cross-sectional differences in health facility utilization, drug consumption and financial status, etc., as well as to monitor trends in such indicators over time in order to identify potential problems and to intervene as may be appropriate.

**RECOMMENDATION:** The project should review its current system of charges. If the project retains the curative consultation fee, or some version thereof, it should collect it in conjunction with the sale of drugs. This would minimize opposition to the fee and reduce the number of financial transactions by nearly 50%. The schedule of charges needed within a system of fully integrated care should also be examined and simplified if possible.

**RECOMMENDATION:** Finally, in keeping with the spirit of the Bamako Initiative, the project should consider adopting guidelines for local policy regarding indigent care which earmarks a percentage of revenues to finance the care of those who truly cannot pay.

### C. INTEGRATION OF HEALTH SERVICES

#### FINDINGS

The health services delivery strategy as revised by the MOH in 1989 includes the integrated delivery of preventive, curative, and health promotion services as opposed to the previous strategy of implementing selected child survival interventions. In addition, health centers are to provide continuity of care.

Services rendered by health centers towards the end of 1990 were rapidly decreasing as drug supplies were running out under the old system.

Field visits to Adamaoua and South Provinces confirmed that services are being provided under the new system. Curative services are provided on a daily basis in health centers and hospitals now that drugs have been made available (still limited in variety) through the new health care system.

Nutrition surveillance supplies (scales and growth charts), birth spacing device (condoms), oil stoves and sterilizers are available in almost all of the health centers thus making integration of some services possible

Functioning refrigerators with well maintained temperature records were found in all five of the health centers visited in Adamaoua Province (Nyambaka, Beka Gotta, Tibati, Dir and Sambolabo). In the South Province refrigerators were present but not functioning in Kye Ossi, Elog Batindi and Lonji. Bipindi's refrigerator was functioning but no record of temperatures were kept. Mobyettes were not distributed to the health centers in Tibati and Sambolabo in the North and three were broken down in Kye Ossi, Elog Batindi and Bipindi in the South.

Vaccinations are done in the health centers where vaccines can be conserved. They are also done by the Division of Preventive and Rural Medicine at fixed sites other than the co-financed centers and also in areas which they service through mobile operations. The vaccinations performed in the catchment areas of the co-financed health centers are not known to the centers and therefore are not included in their monthly reports.

Health education is reportedly done in most of the health centers in groups during prenatal clinics and individually during vaccination sessions. Health committees promote the new health

care system in varying degrees from community to community.

Health outreach services are provided by personnel from nearly half of the health centers visited by the evaluation team (the team visited 9 of the 17 health centers). Vaccinations and limited curative services are usually provided, but records (consultation register) are not always kept of the services provided and consultation fees are not collected in most cases. Drugs, however, are expected to be paid. Numbers of outreach vaccinations are usually recorded either in a log book or on a check sheet but there is no place on the monthly activity report form to distinguish outreach vaccinations from health center vaccinations. Nor can outreach consultations be distinguished from health center consultations on the monthly report form.

Organization, management and quality of services in the health centers have not yet received adequate attention. Although diagnosis and treatment aides are generally available, they are seldom referred to in the health centers. Supervising physicians rarely observe diagnostic and treatment practices during nurse's consultation sessions. Consultation fees are not always collected and drugs are sometimes sold on credit. Clinic registers are generally maintained but management reporting forms (monthly activity report forms) are not routinely completed or accurate in the health centers. (Management forms were not available to the health centers for several months because the printer could not honor the printing contract). On the other hand, the MOH monthly reporting forms that existed before the reorientation of health services were more readily available and appeared to be filled out more regularly.

All of the nurses in charge of health centers said they attend the health committee meetings. And all health center personnel said they accept the new system.

The same could be said about public acceptance of the new system. The public in general, as represented by the health committees, accepts the new health service system. However, many do not like to pay the consultation fee and often think they are paying a fee for a piece of paper (either a receipt or a treatment form) and they have difficulty understanding that the consultation fee is for service rendered and used to help pay operating costs of the center.

The public seems to accept the idea of paying for medicine as long as they feel it is reasonably priced. Patients occasionally compare health center drug prices with drug prices at private pharmacies or at religious mission pharmacies and complain when health center prices are higher.

Continuity of services is enhanced under the new system by providing an initial curative consultation for a fee of 200 CFA. The 200 CFA includes as many follow-up consultations as necessary

at no additional cost until the initial diagnosis is taken care of. Any additional drugs must be paid. Prenatal services are provided for the duration of the pregnancy for 600 CFA and an additional 1000 CFA for delivery (deliveries are often done at home to avoid the delivery fee). Pre-school consultation forms are given to those children who pay 400 CFA and the child is entitled to all preventive health consultations until s/he reaches school age.

## CONCLUSIONS

By reviewing the consultation register, the team was able to confirm that the reorientation of health care made it possible for those centers in the new system to remain active and to provide curative services especially for the high morbidity/mortality diseases such as malaria and diarrheal diseases.

Although health centers in Adamaoua Province for the most part have the necessary equipment, supplies and personnel to provide integrated curative, preventive and health promotion services, it is difficult to establish that preventive services are routinely and systematically offered because of the unavailability of a number of completed monthly activity report forms (management forms). Conservation of vaccine problems in the South Province limit the possibility, for the present, of providing preventive services under the new system.

Vaccination services appear to have lost some priority perhaps due to the tremendous efforts required for implementation of the new system. Vaccinations are not provided in a systematic manner but this should improve as soon as the new system is mastered. Prenatal services do not appear to have been interrupted under the new system and anti-tetanus vaccinations are still being provided for women of child-bearing age.

Vaccinations done by the Division of Preventive and Rural Medicine service and not included in co-financed health center reports does not permit the centers' monthly activity reports to correctly reflect vaccination coverage in their areas. This reflects as well that integration of services is still evolving.

Although most all health center personnel say they accept the new health care system, some doubt could be cast on the conviction of those personnel who do not routinely collect consultation fees. Perhaps they are not altogether convinced on this aspect of the new system.

The new health care system is not yet fully understood by many of the health center personnel, the pharmacy clerks, the supervisory personnel, the members of the health committees and the members of the health sub-committees for management.

## RECOMMENDATION

In order to keep from overburdening an already fragile health delivery system, it is recommended to temporarily not increase the specific health interventions beyond the original five - vaccinations, diarrheal disease control, malaria treatment, nutrition surveillance, and child spacing - until health center and supervisory personnel better understand and master the new health care system. This will become evident when the monthly activity report forms including the financial status pages are filled out completely and accurately and submitted regularly in accordance with the health center manual. Analyses of the report forms at the district and provincial levels will indicate when the centers are ready to expand activities.

### D. INFORMATION, EDUCATION AND COMMUNICATION (IEC)

#### FINDINGS

The central Health Education Service, situated under the Direction of Family and Mental Health, is divided into three Bureaus (Health Education, Production and Distribution of Audio/Visual Materials, and Research and Evolution of Educational Actions). Health education services are similarly situated in the two SESA provinces; and IEC services at both (central and province) levels are an integral part of the new health care delivery system which started with the Reorientation of Primary Health Care (ROPHC) in Cameroon.

At a national seminar in October 1989, MOH/IEC services with assistance from SESA played a major role in sensitizing MOH personnel and the different donor agencies represented in Cameroon on ROPHC. This collaborative IEC service team continued to provide similar seminars at the provincial and departmental levels to sensitize the communities and health service staff.

The first IEC technical assistance assignee provided by The Academy for Educational Development (AED), one of the three members of the USAID contracted consortium, served as a management trainer and coordinator of health promotion and communications until his contract expired in August 1990. USAID renewed this position in April 1991 by increasing the original level of effort and the post was filled by a social marketing specialist who arrived in May 1991.

Several short term consultants (8) provided technical assistance in training of trainers 1988, preparing training materials 1990, training 1990, development of community participation modules 1990, KAP studies - baseline data collection - health worker behavior analysis 1991, and household sentinel survey 1991.

During the absence of a long term IEC consultant a short term consultant from AED arrived in December 1990 to help develop an IEC implementation plan. This plan was reviewed and refined by people in the field in collaboration with the newly arrived social marketing specialist mentioned above.

A major objective of the implementation plan was to identify national and provincial counterparts to the IEC technical assistant. This has been done and a good working relationship exists not only among all the counterparts but among the counterparts and personnel in the mass media.

Although the new system of health care delivery is an MOH initiative and there is a high level of commitment to the new system, especially at the central level, the IEC team is still struggling to overcome the perception among many that ROPHC is American and therefore will last only as long as American assistance is present. One can detect, however, a gradual change in this perception.

Some major undertakings of the IEC services are:

development of a promotional and educational video (approx 25 minutes) explaining the new health care strategie for use during training, conferences and television broadcast;

multi-sectoral workshop on the new health system and IEC, January 1992, including Ministries of Youth/Sports, Social Affairs, Agriculture (community development) etc. to develop provincial IEC teams and a joint action plan.

regular national radio programs featuring health themes in French and local languages and the creation of radio listening clubs;

awareness seminars on the Reorientation of Primary Health Care at the central and provincial levels;

on-sight training in health centers on interpersonal communications;

standardization of messages for various CS interventions;

review of existing research and focus group discussions.

Focus group discussions (12) held in Adamaoua Province in October 1991 included community members, community health committee members and health service providers who made the following general comments:

- first choice of health care is self treatment at home, and then the health center;

- traditional healers are considered appropriate for certain diseases which are incurable by western medicine such as curses, polio, yellow fever, craziness, and epilepsy;
- fractures are also believed by many to be healed better and faster by traditional healers;
- other advantages to being treated by a healer -- prices are negotiable, bartering is possible and payment often due only when patient is cured;
- prices often are considered cheaper with the traditional healer but have been known to cost as much as 20-30,000 CFA (\$70-\$110);
- some committee members see their role as going from house to house to get the community to participate in the new system (members say they do not have time for this activity);
- complaints from some of the participants are that health centers are not equipped to do laboratory examinations and nurses are incompetent.

#### CONCLUSIONS

IEC activities played a major role in promoting the acceptance of a new health care system.

Sufficient numbers of central level health officials were convinced of the merits of the new health care system to permit the system to get underway.

There is sufficient host government commitment to make the new health initiative workable.

The community does not yet fully understand the new system and its role in the new system.

Probably the best promotional activity for the new health care system is more well-functioning health centers with adequate supplies and sensitive, caring personnel.

There remains yet a lot of IEC activity to be done to help the consumers and providers of health care understand and appreciate their respective roles.

#### RECOMMENDATIONS

Increase IEC activities on interpersonal relationships for health center personnel by producing videos (or other demonstrative methods) to be circulated to the health centers (similar to a Fairchild viewing machine).

After the drug supply issue is resolved and the centers are functioning more efficiently, increase community IEC activities (using the promotional video when possible) in the areas where the new health care delivery system is performing.

Continue ongoing monitoring of community's opinions about health services through focus groups or family sentinel surveillance activities.

Continue to increase the provinces' role in IEC activities.

Review all IEC messages to ensure that they are uniform and in harmony with the policies of the new health care system.

## E. OPERATIONS RESEARCH

### FINDINGS

The array of research and baseline data gathering studies conducted under the Project has been impressive. Exploitation of the follow-up baseline data survey conducted during the first half of 1991 (first survey conducted in October 1990) has not yet been completed.

Studies which have been completed, analyzed and drafted in a form possible for scientific publication are:

#### Utilization of Health Centers

(numbers, by month, of new patients by age and sex, follow-up visits, total visits, prenatal visits, deliveries and laboratory examinations)

#### Common Diagnoses and Prescriptions

(ten most frequent diagnoses and drugs most frequently used in the health centers)

#### Time/Motion Study

(one week observation of health center staff doing administrative (3.3%), clinical (17.5%), preventive (0.8%), hygiene (5.4%) or unproductive activities (73%))

#### Consultation Observation

(judgement on completeness of care, time required, quality of

reception and health education)

#### Health Worker Interview

(self assessment of professional status and function, in-service training, knowledge of size of catchment area, etc.)

#### Community Interview

(people leaving HCs were asked distance to HC, reason for visit, satisfaction, reason for dissatisfaction, knowledge of outreach activities, use of traditional healers, etc.)

Other studies in various stages of completeness are:

#### Health Center Utilization/Coverage Survey

(information from household surveys, focus group discussions and HC records were used to collect data on impact of illness on work performance, cost of care, willingness to pay, means to pay, perceptions on quality of care, prescription practices, knowledge of health care systems, use of alternative systems, accessibility of services, etc. (intermediate results and recommendations were reported to Project and final analysis are expected in 1992))

#### Knowledge Attitudes and Practices (KAP) Study

(health center staff were asked about malaria, vaccinations, diarrhea, health education, disease prevention, child spacing, etc; household members were asked about vaccinations, management of fever, monitoring children's weight, management of diarrhea, family planning, etc. (collection of data completed in June 1991 -- not yet entered into computer for final analysis))

### CONCLUSIONS

More emphasis has been placed on research and data collection studies than on day-to-day health management data collection.

### RECOMMENDATIONS

More emphasis should be placed on improving the routine day-to-day

data gathering for management of the new health care delivery system rather than expanding the research component of the Project.

Conducting focus group discussions with health workers and community members can provide critical data on the acceptance of the new health care delivery system and should be continued.

#### F. PROJECT MANAGEMENT - THE CONSORTIUM

##### FINDINGS

The USAID funded MCH/CS Project in Cameroon was contracted to a consortium of the Harvard Institute for International Development (HIID), Drew University and the Academy for Educational Development (AED). The inclusion of Drew University in the consortium is consistent with AID's practice of including historically black colleges and universities in international development work.

Universities were chosen as contractors to capitalize on their staff resources. Harvard has had considerable experience in international development and Drew University has had considerable experience in developing community health programs in the Watts section of Los Angeles. AED, which is not a college or university, has had considerable experience in developing information, education and communications (IEC) services in Africa.

Harvard University staff in collaboration with the MOH was responsible for the SESA Project design and then followed up with their staff resources by making several of their staff available for short term consultations. However, Harvard was not able to provide from among its staff any long term technical assistance to the Project in Cameroon -- which was USAID/Yaounde's wish in the contract. Harvard filled its Yaounde position of chief-of-party with a personal service contractor who remained for more than a year and a half and then filled that same position again immediately by another personal service contractor.

Drew University, likewise, made staff available for the design and implementation of the Project and provided short term consultancies from their staff as well. Drew was able to provide a long term technical assistant to the South Province almost from the beginning of the Project but the assistant is not from among Drew's staff.

The other technical assistant position in the province of Adamaoua to be filled from Drew University's staff has now been vacant eight months. Before that it was vacant for six months. Neither of the two assignees to Adamaoua Province came from Drew University's staff -- which was also USAID/Yaounde's wish in the contract.

AED has also had difficulties filling its IEC position with the Project in Yaounde. A management trainer filled the IEC position from nearly the beginning of the Project until July 1990. The

position was vacant for ten months and filled with a social marketing specialist.

The consortium agreed that they would all have equal input in managing the Project and decisions would be made by consensus, including staffing decisions.

The consortium maintains two functioning budgets and two bank accounts for the Project. Money that is to be used for renovation of pharmacies is to come from the Drew budget and is several months late. If the Project were ready to launch the second wave of health centers as scheduled (which it's not) implementation would be delayed.

Drew and AED employees on the Project are responsible to the Harvard employee.

Other than not being able to fill some Project positions in a timely manner and some decisions being long and drawn out, neither USAID nor the MOH had any major complaints about the consortium.

#### CONCLUSIONS

It is difficult to find long term technical assistants who speak French on the staff of large universities.

It is not only difficult to find long term technical assistants who speak French on the staff of smaller universities but it appears to be also difficult to recruit on a contractual basis long term technical assistants who speak French.

Reaching a consensus on management and personnel decisions among three members of a consortium must be also difficult. Sub-contracting may be preferable.

Managing two operational budgets in a Project seems to be redundant and inefficient.

#### RECOMMENDATION

If USAID continues in the university collaboration mode for the proposed follow-on assistance to the MOH's new health care delivery system, sub-contracting with a HBCU is not only desirable but mandatory when the overall contract exceeds \$500,000. The universities, however, should be able to effectively draw on their academic and research strengths to support the proposed assistance.

#### G. ANALYSES

## **1. APPROPRIATENESS OF APPROACHES TO ACHIEVEMENT OF PROJECT OBJECTIVES**

### **a. Project framework**

Project documents and Project and Ministry staff frequently refer to "the model" in discussing what the project is attempting to accomplish. Our sense is the project is operating with several models and strategies. These models and strategies are best discussed and analyzed separately since they are not dependent upon one other. The models are of two types: organizational models and a single cost-recovery model.

The organizational models are also of two types: those whose objective is to achieve decentralization of health services administration; and those whose objective is to achieve integration of health services at the delivery level in order to improve the quality of care.

The Project and the Ministry appear to be using two models to achieve decentralization. The first model is to decentralize within the Ministry of Health in order to make the arrondissement (district) the focus of health planning activities. This district approach is one which has been extensively promoted in recent years, particularly by the World Health Organization. This focus on the arrondissement also has important repercussions on the other existing levels of administration within the Ministry, mainly the departmental and provincial levels. Thus, any increase in activities and responsibilities of the arrondissement requires adjustments in the activities and responsibilities at departmental and provincial levels to assure that the appropriate organizational support is available to carry out the expected activities.

The second model of decentralization is taking place essentially outside the Ministry, although the Ministry is expected to "co-manage" its activities. This is accomplished through the creation of local and arrondissement health committees whose responsibilities include the management of funds collected from the cost recovery system as well as overseeing the general health and welfare of the community. For Cameroon, these are new administrative structures. In the planning and implementation to date, their legal status has not been established, nor is it yet clear what is their formal relationship with Ministry health structures and Ministry personnel. In actuality, we observed in the field that this relationship varies considerably--in the South province, particularly the pattern is more often self-management by the health committee with little or no Ministry input while in Adamaoua, the pattern is more usually one of either a negotiated relationship with occasional places where the health officials seem to be doing most of the work and making most of the decisions.

The second type of organizational model is directed at the integration of health services at the delivery level in order to improve the quality of care. This task, to be successful, involves the support of the coordination and cooperation of nearly the whole gamut of Ministry directorates and services operating at the provincial level (including pharmacies, preventive medicine, family health, statistics, etc.). Thus, it, too, requires important modifications of the operations of the provincial health authorities' activities and methods of organizing their work. Particularly it requires the integration of what have been essentially vertical services at many levels of the Ministry, particularly at the provincial and local levels.

Project and Ministry staff say they have not really begun to work on this aspect since they are concentrating on the cost recovery model. Nevertheless, the Project had taken some steps to develop integrated services, as early as 1989 at the time that the reorientation strategy was introduced, and some training has been carried out. In late 1990, the project began involving the entire provincial teams in common work plans and in weekly meetings of the EPP (provincial pharmaceutical team).

The cost-recovery/ drug supply model establishes a revolving fund which permits health centers and hospitals to purchase drugs and pay for a limited number of health services essentials such as vehicle fuel for supervision, kerosene for refrigerators.

The implementation strategies which the Project and the Ministry have adopted are both pragmatic and unusual. Several strategic decisions have been taken: a. to work on the cost-recovery system and only when that has been established to work on integrating health services at the delivery level; b. to focus on establishing the cost-recovery systems in the health centers and hospitals before implementing management support systems (logistics management, supervision, information system); c. to focus on conveying concepts and changing health worker behavior through training seminars as well as through the development of extensive documentation.

## **b. Appropriateness of Models and Implementation strategies**

### **(1). Organizational models**

**(a). Decentralization within the Ministry of Public Health:** Traditionally, decision making within the Cameroonian government has been highly centralized, and this has led to a recognition that local authorities were taking insufficient responsibility financially or organizationally for the promotion of health services in their areas. The Reorientation strategy to decentralize some aspects of planning and management to the arrondissement level is an appropriate step to improve this situation.

Any steps toward decentralization are probably useful. Our assessment is that there is some uncertainty about exactly what decentralization means: decentralization of which resources in personnel, equipment, and finances; decentralization to which level, province, department, or arrondissement; decentralization of what authority to plan, to manage?

This uncertainty is reinforced within the two project provinces by the project's own highly centralized approach in which local authorities are expected to follow a model where decisions are made at the central level. We conclude that although the model of decentralization is appropriate, the implementation of such a model needs to be considerably clarified to assist the government to shift from a highly centralized system of decision making to one more decentralized.

**(b). Decentralization to Community Institutions:** We were told that the rationale for shifting responsibility for managing the cost-recovery funds to the community was because this would encourage the community to be responsible for its health care and because one could not trust health personnel to manage these funds.

The notion of "community" as a political entity, is not one that appears to be well founded in Cameroon. As far as we can tell, Cameroon has not had much experience with voluntary community associations and what experience there has been, for example, with tontines, has not been encouraging. The two project provinces each have different styles of local organization, with much greater community cohesiveness and identity in Adamaoua than in the South where traditional sources of authority are in short supply. At any rate, much more is needed to be known about such experiences and the patterns of community organization before one can render a judgment on the appropriateness of such models for Cameroon.

Meanwhile, this decentralization model is actually creating new political and administrative institutions at a time of political change--a challenging situation. As of now, these institutions still do not have a legal basis. Although it was intended by the Ministry that the communities would "co-manage" the cost-recovery funds with the health sector, the pattern that appears to be emerging through the present texts and present functioning is one of "self-management" by a very few members of the executive board of the committees, some of whom are civil servants. With the exception of a few health center committees which include representatives from many villages at their meetings, the representativeness of the executive boards of these health and management committees and the amount of actual community participation remain in doubt. Thus, this model, so far, is not getting a fair test as it was designed.

**(c). Integration of health services:** In a country with limited resources, this model is entirely appropriate. Vertical health

service delivery is inefficient and cannot deliver continuity of care. Since the Project will only be beginning to emphasize this approach during the next year, it is too early to assess how it will function.

**(2). Cost-recovery/drug supply model. (See section VI. B.)**

**(3). Project Implementation Strategies:**

**(a). To Develop the cost-recovery system and then to develop integrated services:** In the current economic situation in Cameroon, a cost-recovery system is necessary in order to finance any other services the Ministry wishes to put in place. Therefore, this is an entirely appropriate strategy.

**(b). To establish cost-recovery systems in health centers and hospitals before implementing management support systems (logistics management, supervision, information system):** Although this strategy was not intentional, this is what resulted from project implementation activities. Although the Project has long recognized the need to set in place the organizational systems for orderly development, these were not functioning before the drug distribution system was implemented in 27 health facilities. We believe that many of the problems encountered, lack of information, lack of supervision, lack of compliance with new procedures, could have been avoided had the systems building been accomplished first.

**(c). To focus on conveying concepts and changing health worker behavior through seminars and training materials:** This strategy is good as far as it goes, but is insufficient to change health worker behavior on the ground. It needs to be supplemented by regular supervision which reinforces what is taught at the seminars, immediately after the seminars. The lack of follow-through gives a mixed signal to health workers that perhaps the ideas and techniques introduced at seminars are not taken seriously by the supervising authorities.

## **2. SUSTAINABILITY**

Since the project activities in cost-recovery are very young, we must for the moment limit our evaluation of sustainability to the project's potential for sustainability. The financial viability of the cost recovery/drug distribution system, as discussed in the second part of this section, will depend upon the overall economic situation of Cameroon over which the project has no control and as well as the project's ability to scale down its cost recovery targets to what is realistically feasible. If the project succeeds in doing this, and if the economy does not collapse much further, the potential for sustaining these cost-recovery centers is good.

a. Development of Health Infrastructure

One of the major factors for sustainability of USAID projects has been the ability of a project to integrate its activities into the host country's structures and to create during its lifetime a sense of host country "ownership."<sup>9</sup> We found that the central Ministry of Health considers the SESA project an essential element in its own strategy of the Reorientation of primary health services, a policy it adopted in early 1989. For central Ministry officials, the project serves as a means for them to accomplish their goals of developing a cost-recovery/drug distribution system and to decentralize the management of health services in order to improve the quality and quantity of health services available. The coordination and cooperation between the Project team leader and his counterpart, the Director of Preventive Medicine, appear virtually seamless. This is a considerable achievement.

At the operational levels, the national ownership is much less clear. In the provinces, the project is viewed as just another American project and not part of the Ministry's policies and programs. However, observers have noted similar problems with most other donor projects. The degree of integration and ownership is stronger in Adamaoua province than in the South where the expectation is often that when the project ends, all the associated activities will end.

This view is fueled in part by a rhetoric which stresses the need to train people in the project goals. Thus, those who have attended seminars are considered and consider themselves "in the project" while those who have not been similarly fortunate, say they have nothing to do with the project. This result is ironic, since most of the training has to do with orientation to the Ministry's policies, not to project policies. However, the perception is reinforced by a rhetoric which constantly refers to the "model" and to the modules as the source of guidance. These documents are perceived as project documents, not as Ministry documents.

This perception was evident not only from what we were told by provincial and local officials, but also by the fact that when questions about policy arise, they are addressed to project staff, not to Ministry staff. Thus, on two recent occasions, a clerk not receiving his salary from the COSA, and a nurse also having problems with the COSA and threatening to resign, both addressed their letters to the Project, not to the appropriate Ministry

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<sup>9</sup> This discussion of factors for sustainability draws on the study of 46 USAID projects by TJ Bossert, Can They Get Along Without US? Sustainability of donor-supported health projects in Central America and Africa, *Soc. Sci. Med.* 30 (9), 1990: 1015-1023.

officials.<sup>10</sup>

Another reason for the perception of the project as separate from Ministry activities is the separation of provincial coordinator's office from the provincial team. A kind of "we-they" mentality seems to have developed in the South province. We would conclude from this that more effort will be needed in the future to smooth the integration of the project at the provincial level into the Ministry.

Another factor favoring sustainability of project activities after a project ends, has been the contribution of the host country to project financing during its lifetime. In this project, the Government of Cameroon committed to providing financing for travel and per diem, operation costs of vehicles and provincial supervision starting in the project's fifth year (1991-92). It is not clear the extent to which these funds have been made available.

Another factor favoring sustainability is a strong training component. This has been a central focus for the project and should serve Cameroon in good stead. In the future, the project may find it preferable to shift to more on-the-job training to assure that skills learned in seminars are actually applied in the work place.

In summary, the potential for sustainable activities is evident in what has been undertaken so far. However, continued effort is needed to assure the viability of the cost-recovery system, to assure national ownership, to assure national financial contributions, and finally, to assure that training results in behavioral changes among health workers who will maintain systems development.

#### b. Financial Viability

The model. The project has formulated a financial model of the health center which projects utilization, revenues and costs for a given service area population. The model can be used to predict health center performance and can also provide a standard against which to compare actual performance. This model is described in ANNEX F.

Unfortunately, the project has not used this simple but powerful management tool on a regular basis to monitor the health centers

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<sup>10</sup> In the case of the clerk, who is an employee of the COSA, it is not clear what would have been the appropriate channels of redress. For a discussion of the questions of relationship between health personnel and the community committees, see the section on community participation

during the critical early operational phase. In fact, current Report of Monthly Activities (RMA) submission is too sporadic to permit the periodic monitoring of health center performance. The first evaluation of health center performance, "Evaluation Initiale de l'Introduction du Cofinancement..." was completed in November, 1991, eleven months after the start of co-financing activities. To perform this evaluation required a visit to each center since financial reports were either unavailable centrally or incorrectly filled out.

### FINDINGS

During the evaluation, the team collected revised reports and with the assistance of EPP staff, compiled enough information to perform the analysis summarized in Table V-1 and Figure V-1 on pages 62 A and 62 B and annex F, page 2. Data were obtained for all of the health centers visited and for other centers when available. It was decided not to perform a similar analysis of hospital pharmacies because their high sales volume and low overhead should assure their financial viability.

While conclusions are tentative given the quality of the data, the analysis suggests the following:

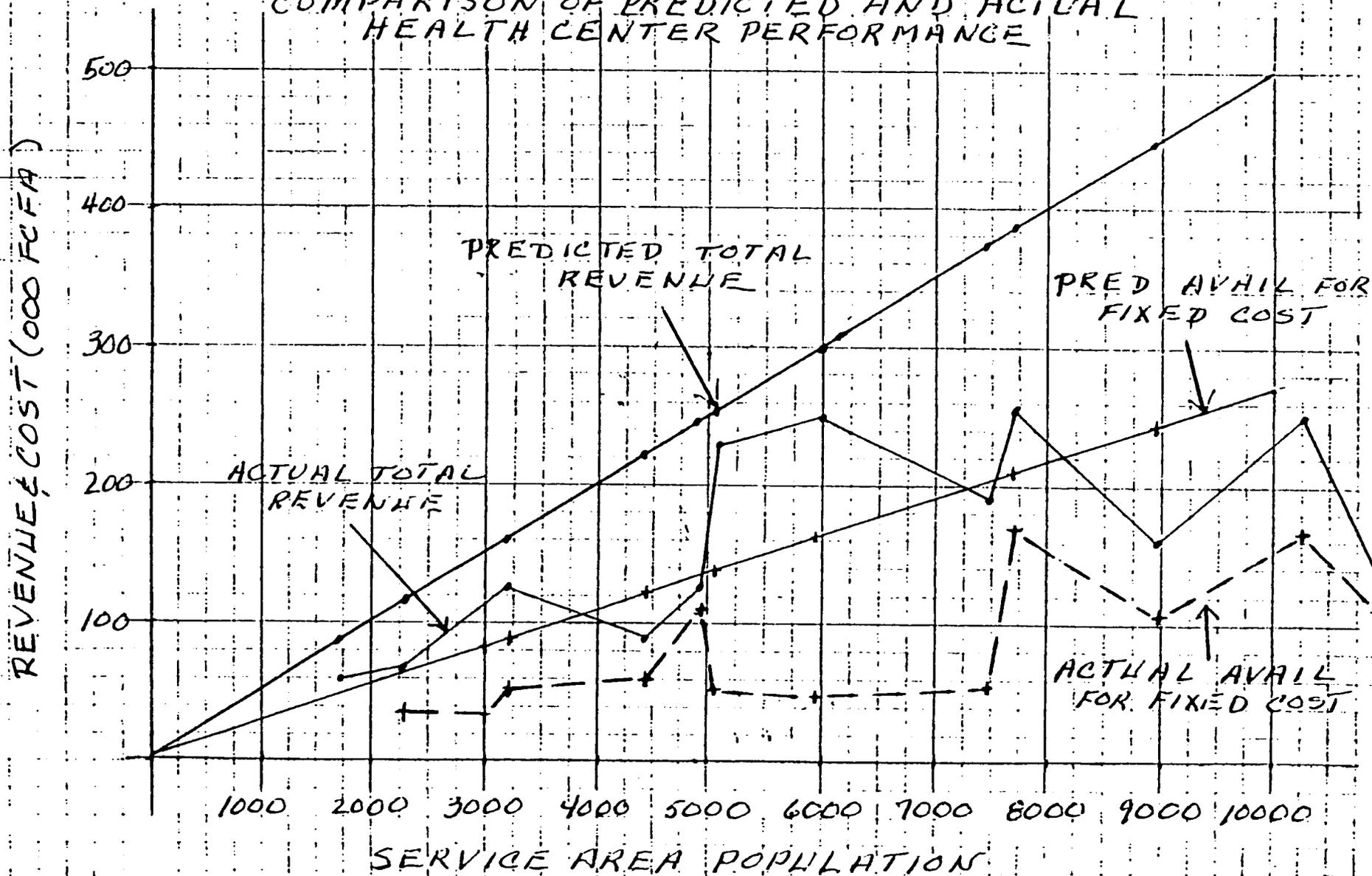
- Utilization is 25% below the projected rate of 240 NC/1000 population/year. This may be due in part to the fact that the model does not adjust population to account for other providers in the service area nor does it adjust for low population density and long travel times.
- Revenue/NC is estimated at 1770 FCFA, 30% below the predicted value of 2500 FCFA. This would suggest that case mix and/or prescriptive practices are different from those assumed when the project formulated its revenue projections. This is consistent with Litvack's observation that providers are prescribing less medication than needed for a full course of treatment in response to patient objections to current prices.
- Total Revenue. The combined effect of lower utilization and lower revenue per case has resulted in total actual monthly revenue 47% below the level predicted by the financial model. As shown in Figure V-1, most of this shortfall occurs in facilities serving populations greater than 5,000. The seven health centers serving populations ranging from 5,000 to 11,000 have average monthly revenues of about 200,000 FCFA regardless of actual service area population.
- Amount Available to Cover Fixed Costs. In the model, this amount is calculated by subtracting variable costs from total revenues. Because of the difficulty in reconstructing variable costs from the available reports, the "amount available" was estimated by using the average monthly cash flow balance for the period during which

TABLE V-1  
COMPARISON OF PREDICTED AND ACTUAL  
HEALTH CENTER PERFORMANCE

H. CENTER	POP	No/mo		REV/ NC	REV/ PRED	REV/ ACTUAL	AVAIL FOR PRED	FIXED COST ACTUAL
		PRED	ACT					
BEKAGOTO	2276	46	42	1650	113800	65034	61450	35925
TIB. PMI	7683	154	155	1665	384150	258390	207440	167980
SAMBOLABO	4847	97	64	1980	242350	127357	130870	109559
LOKOTE	10946	219	78	1735	547300	134756	295540	115092
KALALDI	8985	180	104	1520	449250	158682	243000	104841
DIR	10290	206	171	1485	514500	253198	277830	166946
MARTAP	2988	60	61	—	149400	—	80680	33608
NVAMBAKA	5945	119	84	2940	297250	247591	160510	54706
MEKAS	1691	34	34	1835	84550	60430	45660	—
KYE-OSSI	5099	102	83	2780	254950	229906	137670	56728
ELOG-BAI	3201	64	52	2370	160050	124085	86430	55006
LONDJI	4380	88	59	1520	219000	88985	118260	59870
BIPINDI	7464	149	170	1120	373200	190135	201530	58127

FIGURE V-1

COMPARISON OF PREDICTED AND ACTUAL HEALTH CENTER PERFORMANCE



the project did not pay the salary of the drug clerk. While this may understate the "amount available," it does provide an approximation of available funds.

### CONCLUSIONS

The analysis indicates that Tibati PMI, Dir and to a lesser extent, Kalaldi are in sound financial condition. Each of these centers sees more than 100 new cases per month. The only other center in the sample with comparable productivity, is Bipindi, but its average revenue per case is only 1120 FCFA, resulting in marginal financial status. Sambolabo and Lokoti reflect adequate average balances, but mean variable costs of less than 20,000 FCFA/ month raise some questions regarding data validity.

Three centers, Bekagoto, Martap and Mekas, appear to be in financial difficulty, with insufficient funds to cover the salary of the drug clerk and other fixed costs.

Nyambaka, Londji, Kye-Ossi and Elog-Batindi are generating sufficient revenue to cover the fixed cost estimate of 49,000 FCFA used by the project in its recent study, but about 25,000 FCFA less than needed to cover the 84,000 FCFA costs estimated in PROJECTION OF FINANCIAL DATA... Moreover, the last two centers mentioned have experienced a marked decline in utilization in recent months.

All of the health centers appear to be performing below expected levels. If the data have any validity, they suggest that a number of centers are struggling financially. If the data are incorrect, it is impossible to assess the current situation. In either case it is imperative that the project improve its information system and more closely monitor the health centers during this critical initial operational phase.

In evaluating health center performance, one must remember that the cost recovery system is not yet fully operational. Revenue per new case may increase when the centers have all of the drugs on the ME list. Resolving drug supply problems may also improve confidence in the "re-oriented" system and result in increased utilization.

It must also be recognized that one cannot assess financial viability out of economic context. USAID sums up the current economic situation, commonly referred to as "the economic crisis" in the following way:

"The substantial expansion of oil production beginning in 1978 further accelerated growth in GDP, which averaged 9% annually from 1980-81 to 1985-86. This long period of economic growth and rising incomes permitted the expansion of an inefficient public sector bureaucracy...

The decline in the world price of oil beginning in 1986

and the subsequent precipitous reduction in world cocoa and coffee prices beginning in 1987 have cut export earnings by almost one-third overall and resulted in an economic recession and financial crisis which the country is still struggling to overcome...

Fiscal measures have been insufficient to reverse the decline in tax revenues. The civil service has continued to increase from 160,000 in 1985 to 188,000 in 1990.

Medium-term prospects are for slow growth and continuing declines in per capita income, but even these modest growth projections may prove to be optimistic..."

In a recent document entitled "Principal Observations of Co-Finance System During Year Long Study," Jennie Litvack presents the following self-reported estimates of economic situation:

GROUP	SITUATION WORSE
Farmers	58%
Stockmen	76%
Tradesmen	70%
White Collar	50%

The study further points out that the "Reorientation..." is being introduced while the country is in the midst of an economic crisis during which health services utilization has declined dramatically.

While SESA health centers may attribute the drop in utilization to the lack of supplies, the decline is seen even where supplies are readily available. Demand for health services may be price inelastic, but it is sensitive to income. The drop in utilization is closely associated with declining personal income.

This assessment was echoed by the directors of private missionary hospitals in both Ngaoundere and Ebolowa, who stated that many people have depleted their savings and that a progressively greater number of patients are finding it difficult to pay for health care. As a consequence the financial status of the two institutions has declined in the past year.

Although SESA health centers may be doing relatively better than others, all health centers including those in the SESA project are experiencing lower utilization. In short, the current economic environment is not favorable to the success of projects like the Bamako Initiative or the "Reorientation..."

The range of activities to be financed through patient revenues is

more extensive than in many, if not most, cost recovery programs. Because supervision is an integral aspect of health services delivery and not a layer to be superimposed like frosting on a cake, it is questionable whether this activity should be dependent upon the availability of fee generated income. While this approach may provide a short term solution to the budgetary constraints confronting the MOPH, long run sustainability can only be achieved through public sector reform.

As is shown in ANNEX F, the estimated monthly cost of activities to be financed at the provincial, departmental and peripheral levels in the health center system described for Adamaoua Province is 7,600,000 FCFA. If the 45% revenue shortfall attributable to lower utilization and lower revenue per case is indicative of future trends, the Adamaoua system could find itself facing a monthly deficit of 3,400,000 FCFA, unless steps are taken to curtail planned activities. While this may represent a "worst case scenario," it is nevertheless highly probable that the project will not achieve its revenue targets. Unfortunately, there is no evidence that the project has formulated any contingency plans for responding to a revenue shortfall of any magnitude.

The conclusions of the financial assessment of the health centers conducted during this evaluation may be tenuous, but they are clearly consistent with observations made by the project's own consultants. At a minimum, they suggest the need for further study.

#### **RECOMMENDATIONS**

The project should consider scaling down cost recovery targets to more realistically reflect the current economic situation, and to reexamine and prioritize activities to be financed through cost recovery, since revenues may be insufficient to cover all activities currently planned. This is a complex process and will require considerable systematic planning and management.

In the longer run USAID should support World Bank efforts to assist the Government of Cameroon to achieve public sector reform.

SCOPE OF WORK

ARTICLE I - NAME:

The interim evaluation of the Maternal Child Health/Child Survival (MCH/CS) Project.

Basic Data:

Project Name: Maternal Child Health/Child Survival  
Authorization Number: 631-0056  
Life of Project Cost: \$11,500,000  
Date of Project Agreement: 8/10/87  
Project Activities Completion Date: 10/31/93

ARTICLE II - PURPOSE:

The major purposes of the interim evaluation of the MCH/CS Project are as follows:

to assess the project's achievements and potential for achieving its end of project status indicators by the project activities completion date; and

to identify, if feasible given the limited experience to date, the need for any future USAID assistance to achieve sustainable health systems in Adamaoua and South Provinces.

ARTICLE III - SPECIFIC OBJECTIVES:

A. Specific Objectives related to assessing the project's achievements and potential for achieving its end of project status indicators by PACD:

1. Verify if the PHC model based on shared community/state financing; community management of health centers; full integration of services; and decentralization of health planning, management, and supervision activities at the health district level is appropriate for Cameroon. In addressing this issue, the evaluation team should consider the following factors: the economic and social environments in Cameroon, the nature of the Cameroonian civil service, the state of the private health sector, and the population densities and infrastructures of the targetted provinces. Assess various other options for financing public health services given the potential for cost recovery demonstrated by the targetted populations.

2. Assess the adequacy and efficiency of the community co-financed and co-management PHC model as applied in Adamaoua and South Provinces. This will include the following:

- assess public acceptance of the project's PHC model. Assess the effectiveness of the community dialogue structures (community health and community management committees) established under the project in managing the medical supply and cost recovery systems, in co-managing health services, and in representing the population at large. Is the population actively participating in the community dialogue structures at the health center and the sub-divisional levels? Does the population accept the fees for service and drug charges? Does the population see any benefits to the new system? Assess the clarity, viability, and participant understanding of the institutional (i.e., legal, regulatory, procedural/structural) interface between private community health representatives and public sector health personnel at the health district and health center levels.

- assess health worker acceptance of the PHC model. Are health workers accountable to the populations they serve? Are health workers effectively supervised by health district health managers? Has health worker morale and performance improved since the introduction of the new system? Assess the appropriateness of the incentive systems under which public health care professional and community dialogue structures are operating in terms of their internal consistency, their compatibility with each other, and their compatibility with project objectives.

- assess the level at which the provincial medical supply system is functioning and whether it is sustainable. Does the system provide medical supplies and other items such as health forms and motorcycle parts to depots, hospitals, and health centers in a timely fashion? Are the ordering and stock management systems effective? Have measures been introduced to reduce inappropriate drug use? Are there standard diagnostic and treatment regimens and treatment "audits"?

- assess the cost sharing system installed under the project? Given revenue generation during the first year of the program, is it likely that the project's revenue targets can be achieved? (For example, can cost sharing revenues fund supervision and refresher training of health personnel in addition to the maintenance of the drug supply system?) Can the central MOPH provide the inputs (such as pre-service training) which is called for under the cost sharing system? Are drug prices appropriate or are they too high for the population to pay? Are the fees for service appropriate? Are there mechanisms being developed to assure medical care for indigents? Are there pricing strategies to attract clients to lower priced facilities (i.e., to dissuade primary care patients from utilizing hospital facilities)? Are revenue surpluses generated at health centers effectively utilized to improve health care? Have plans been developed or implemented to address the financial limitations faced by the smaller health areas (e.g., by subsidizing these areas by the surpluses of larger health areas or by surplus drug revenues collected at the provincial or divisional levels? Are there sufficient financial and accounting controls in place to assure the proper collection and utilization of fees?

- assess the potential of the project to effectively integrate the vertical child survival interventions of immunizations, control of diarrheal diseases (CDD), malaria control, growth monitoring, and child spacing into the PHC model? Can these vertical activities be integrated into the daily pre-natal, under five, and curative care consultations of the community co-financed and co-managed health centers? Can the information, supervision, and logistics requirements of these programs be effectively folded into the project's drug supply, provincial health information, and integrated supervision systems? Can these child survival services be effectively delivered to outlying areas through community-financed outreach efforts? Will increased utilization of health centers (due to increased availability of essential drugs and the improved quality of services) result in increased preventive coverage rates?

- assess the potential of the project's information, education, and communication (IEC) program to increase community participation in the community co-financed and co-managed PHC program; increase health center utilization; improve immunization, child spacing, oral rehydration, and growth monitoring coverage rates; and promote improved health practices?

- assess the effectiveness of the project's decentralized health planning efforts. Have the decentralized health district plans been realistically drafted, linked to financial resource capability, effectively implemented, supervised by provincial and divisional levels, and evaluated. What progress has been made towards instituting annual planning at the divisional and provincial levels? Assess the quality of a sample of district health plans in terms of the clarity of priorities articulated, the degree they address the major health problems of the district, and their compatibility with the technical capacity of health facilities, health personnel, and available financial resources.

3. Assess how effectively the project coordinates with the PHC programs implemented by the other major donors. Are experiences shared in the areas of health information systems, drugs logistics systems, training strategies and materials, supervision systems, etc. Has the project effectively collaborated with other projects and donors to reduce broad health sector financing constraints?

4. Assess the effectiveness and efficiency of the contractor consortium of the Harvard Institute of International Development (HIID), the Academy of Educational Development (AED), and Drew University in providing timely inputs in support of the project, in fielding a qualified technical assistance team, and in providing effective, timely, and coordinated home office support to the project. Has the consortium been an effective mechanism to provide technical assistance and organizational support to the project?

B. Specific objectives related to assessing, if feasible, the need for any future USAID assistance to achieve sustainable health systems in Adamaoua and South Provinces.

1. Assess whether fully sustainable health systems with near universal coverage are possible in Adamaoua and South Provinces. Assess whether further external donor assistance will be beneficial and cost effective in moving towards the goal of sustainable health systems with near universal coverage in Adamaoua and South Provinces.

2. If future external donor assistance appears warranted following the conclusion of the MCH/CS Project, propose potential areas of intervention. Propose strategies to achieve the following:

- the provision of primary health care to health areas in the two project provinces which are not covered by functioning health facilities.

- the effective integration of private (mainly religious) health facilities into the community co-financed and co-managed health system (e.g., would religious facilities be willing or able to organize and share decision making with community health and management committees in their catchment areas, participate in provincial information and supervision systems, and further preventive care objectives in outlying areas?).

ARTICLE IV - TASKS:

In order to meet the specific objectives outlined in Article III above, the evaluation team will undertake the following tasks:

- BDAYS US**
- 2 WEEKS YAOUNDE**
- 4 WEEKS ADAMAOUA**
- 4 WEEKS SOUTH PROVINCE**
- A. Review key project documents including the Project Paper, Project Paper Supplement, the 12 PHC training modules, the health center manual, the needs assessment and baselines studies, supervision and health information system protocols, etc. (1 day in the United States).
  - B. Meet and interview members of the contractor consortium (HIID, AED, and Drew University) (2 days in the United States).
  - C. Develop an evaluation methodology and draft evaluation protocols and questionnaires for the field phase of the evaluation.
  - D. Conduct in-depth meetings with USAID, MOPH, contractor personnel and other donors (UNICEF, German Cooperation, Belgian AID, French Cooperation, UNFPA, etc) on all aspects of the MCH/CS Project and the reorientation of PHC (2 weeks in Yaounde for items C and D).
  - E. Conduct field trips to Adamaoua and South Provinces. Observe and assess the following:
    - the composition, responsibilities, and performance of provincial health teams;
    - the composition, responsibilities, and performance of health district teams;

- the drug and medical supply system including in-country suppliers, provincial warehouses, divisional depots, health center pharmacies, drug system forms, and accounting systems.
- the composition, responsibilities, and performance of community dialogue structures including health center community health and management committees, sub-divisional health and management committees.
- the effectiveness, acceptance by the population, and quality of care and outreach provided by community co-financed and co-managed health facilities.
- the quality and timeliness of the supervision and health information systems from the provincial to the divisional, the divisional to the sub-divisional, and the sub-divisional to the health center levels.
- the elaboration, appropriateness, implementation, and supervision of of district health plans;
- all other aspects of the reorientation of PHC in these provinces.

(4 weeks total: 2 weeks each in Adamaoua and South Provinces).

E. Draft and discuss recommendations with USAID, MOPH, and contractor personnel. Prepare final report. (1 week in Yaounde)

#### ARTICLE V - LEVEL OF EFFORT

A. Health Planner and Team Leader	39 days
B. Health Economist/Financial Analyst	39 days
C. Institutional Analyst/Social Scientist	39 days

#### ARTICLE VI - REQUIRED REPORTS

The contractors will be required to produce the following report:

- A. Draft Findings, Conclusions, and Recommendations: (4 working days prior to departure)
- B. Final Report: (French and English 30 copies, due not later than 30 days following departure of Contractor team).

Time Period: O/A November 1 - December 15, 1991 (Six days work week is authorized).

LIEU	PERSONS CONTACTED	TITLE
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	GETACHEW DEMISSE	Project Mgr, Drew Univ.
	MARK LIDIARD	Vice President, AED
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	BOB SHOEMAKER	Project Devel. Officer
	RICHARD GREENE	Project Officer
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GEORGE VISHIO	Health Specialist	
SESA PROJECT	DR. CLAUDE BODART	Chief of Party
	DOROTHY MADISON-SECK	Provincial Coord., South
	JOAN SCHUBERT	Social Marketing, IEC
MOH	DR. OWONA ESSOMBA RENE	Directeur, DMPR
	DR. NCHARRE CHOUAIBOU	Directeur Adj., DMPR
	DR. KAMWA MATHIEU	Directeur, DMH
	DR. AWASUM NIBA	Directeur, DSFM
	DR. MBAMBA SAMUEL	Directeur, DEPS
	PROF. KAPTUE LAZARRE	Inspecteur General
UNICEF	DR. OSSENI RAIMI	PHC Officer
GTZ	DR. SCHMIDT EHRY BERGIS	Coord. National, SSP
PRITECH	HUGH WATERS	CDD Officer
	AGMA PRINCE	Regional Coordinator
PROVINCE D'ADAMAOUA	GOUVERNEUR DE LA PROVINCE	
	SECRETAIRE GENERAL DE LA PROVINCE	
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	DR. DAOUDA MOUSTAPHA	Chef, EPP
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	DR. MAMOUDOU	Chef, SPMH
	DR. HAMIDOU IBRAHIMA	Directeur, Hôp. Provincial
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	M. BETCHEM	Chef, Bureau Statistiques
	M. OUMAROU DAVID	Surveillant Gén. Hôp Prov.
	M. AMADOU DEWA	President, COGEAR
	M. HAMAOUNDE KOULAGNA	Commis, dépôt Départ. Vina
	M. ALHADJI	Commis Pharmacie Hôpital
	M. LAOUANE	Trésorier COSAAR
DR. ARNE HEGGHEIM	Coord. d'Arrond. des SSP	
DR. OUMAROU	Médecin-Chef Hôpital Prot. Directeur, Hôpital Prot.	

	M. PABLO	Approvisionnement. Hôp. Prot.
CENTRE DE SANTÉ DE NYAMBAKA	6 PERSONNELS DU CENTRE DE SANTÉ HAMOA DALAILOU ALFA BASSIROU COMMIS DU CENTRE DE SANTÉ	Président du COSA Président du COGE
CS DE BEKA GOTTO	4 PERSONNELS DU CENTRE SANTÉ COMMIS DU CENTRE DE SANTÉ	
CS DE DIR	3 PERSONNELS DU CENTRE DE SANTÉ 10 MEMBRES DU COSA ET COGE	
MEIGANGA	PREFET DU MBERE SOUS PREFET DE MEIGANGA M. ABOUBAKARI M. YAYA M. BABA OUMAROU M. DOGARI ABRAHAM M. IBRAHIM Mlle MIRANDA	Vice Prés., COSAAR Secrétaire, COSAAR Vice Prés., COGEAR (Dep.) Commis, dépôt provincial Coordinateur des SSP Volontaire du Peace Corps
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CS DE SAMBALABO	M. KOULAGNA M. ATAPNTOUHEYOU MOUSSA M. KATAR ANDRE M. BABA ABDOULAH MEMBRE DU COSA MEMBRE DU COGE	Infirmier, Chef Infirmier Aide Soignant Commis Vice Président Commissaire de Compte
PROVINCE DU SUD	GOUVERNEUR DE LA PROVINCE DR. NGOUFOR DR. EYANGO DR. BELL DR. MOUANGE DR. ONDOA M. MENDOUGA COSAAR ET COGEAR D'EBOLWA	Délégué Prov., Santé Pub. Chef, SPMR Chef, EPP Chef, SPMH Cons. Médical Hôp. Prov. Chef, Serv. Prov. Af. Gen
CS DE KYE-OSSI	L'INFIRMIER-CHEF DU CS M. OYONO NKOULOU S. M. EDZOZOUÉ A. MADAME LE CHEF DE VILLAGE DE KYE-OSSI	Président du COGE Trésorier du COGE

ANNEX B: P. 3 OF 3

HOP. PROT. DR. ETYA'ALE Directeur de l'Hôpital  
D'ENONGAL

BENGBIS SOUS PREFET  
Chef, SS d'Arrond.  
Commis  
Trésorier du COGE  
Coord. SSP

SANGMELIMA DR. MBAM MBAM L. Chef, Dépt. Dja et Lobo  
M. EVINA LUCAS Respons. Dépt. Stat.  
M. NDZIE ESSAMBA MARCEL Chef, Dépt. Dja et Lobo  
M. ZEH MBOZO'O P. Président du COGEAR  
Mme BIOMO née BIKIE Trésorière du COGEAR  
MBOZO'O AKONO Secrétaire du COGEAR  
MBIA MBIA JEAN Chef, Bur. S., Dja/ Lobo  
GARRY MICHAEL Volontaire, Peace Corps  
COMMIS DEPOT PROVINCIAL  
COMMIS PHARM. DE L'HOP.  
EFFEMBA LAURENT Coord. d'Arrond. des SSP

KRIBI PREFET DE L'OCEAN  
MADOLA ALBERT Président du COSAAR  
MPOUM JEAN-PAUL Secrétaire du COSAAR  
COMMIS DU DEPOT DEPT.  
COMMIS DE LA PHARM DE L'HOP  
DR. ZAMEDJO EDA Chef Serv., Dépt. Océan

CS DE 2 PERSONNELS DU CS  
ELOG-BATINDI COMMIS DE LA PHARMACIE  
CS DE M. NJOCK Infirmier Chef du CS  
LONDJI M. NKUONGNYUNGU F. Président du COSA  
M. SABITCHOUGA D. Vice Président du COSA  
BAPITE V.de P. Commis du CS

CS DE 4 PERSONNELS DU CS  
BIPINDI M. AMILLY SAMUEL Président du COGE  
M. TSAMA ETIENNE Trésorier du COGE  
M. NGIAMBA ISAAC Commis du CS  
M. ESSIAN ROBERT Coord. des SSP Lolodorf  
DR. OSAH PASCAL Chef, SS d'Arr Lolodorf  
Mlle TICO SUZANNE Volontaire, Peace Corps  
M. BEH ETIENNE Econome Lolodorf  
M. KOUMA ADOLPHE Compt.-Matières Bipindi

SESA Project Field Staff, **History of Project SESA**, Yaounde, October 1991

1. Project Paper Amendment (extends PACD to 1993 and adds \$2 million); dated March 18, 1991
2. Project SESA, **Seminaire de Formation des Equipes d'Arrondissement, Modules 1-12**. Edition Septembre 1990. Teaching modules on planning and management for regional teams
3. Memo To Dr. Owona from Dr. Bodart, 8 Juillet 1991, **Sujet: Nouvelles Tarifications pour le cofinancement**
4. **Projet SESA, Gestion des Ressources Financieres et des Medicaments du Depot Pharmaceutique**, Edition Aout 90.
5. **Projet SESA, Gestion des Ressources Financieres et des Medicaments par L'equipe Provinciale Pharmaceutique**, Edition Aout 90.
6. **Projet SESA, Gestion des Ressources Financieres et des Medicaments de l'hospital**, Edition Aout 90.
7. **Projet SESA?? Grille pour la supervision du S.S. Dept.** No date. (This is a long questionnaire for general supervision, includes whether an implementation plan exists, financial and logistic management, vaccinations, laboratories, community participation, etc.)
8. **Projet SESA?? Grille de Supervision du C,S./Gestion Des Finances et Medicaments**. No Date.
9. **Ministere de la Sante Publique, Direction de la Medicine Preventive et Rurale, SESA/GTZ/CIM/AFVP, Methodologie pour la Mise au Point de grilles de Supervision des Centres de Sante**, Seminaire sur la Confection des Grilles de Supervision, Yaounde, 12-15/02/91.
10. **MSP, Rapport Mensuel d'Activites**. (Is this the report used by health centers to report data? Is this the national report?)
11. **Rainer Sauerborn, Propositions pour un systeme d'information de la gestion pour le projet SESA, HIID, Yaounde 9-10-91**
12. no author, **Report of a Field Study to Establish the Baseline for Future Activities of Project SESA**, January 1990.
13. **Jennie Litvack, USAID Debriefing**. No date (Spring-summer?? 1991??)  
(Report of baseline study on health seeking behavior at co-financed health centers, household surveys and use of facility based utilization data--this is clearly a preliminary report.

14. **Projet SESA. Etude de Base, Mars 91, Protocole d'Etude** (This is proposal for a baseline study. How does it relate to 12 and 13 above?)
15. **Projet SESA??**. Implementation of the Monitoring Tool for the Reorientation of Primary Health Care in Adamaoua and the South Provinces of Cameroon (An Early Warning System). **Project Duration June 1991-June 1993**. No Date. (Author may be Maria Madison) (This is a complex monitoring system that is proposed and was criticized by Brinkman in a memo in a trip report in that appears in the appendices of the Project Quarterly report for April-June 1991.)
16. No Author. **Aire de Sante dans la Province du Sud: Tableau**. No Date. (Perhaps the subdivisions of catchment areas of South prefecture?)
17. No Author, No Title. (List of health facilities in Adamaoua province??)
18. No Author, **The Reorientation of Primary Health Care in Cameroon**. No Date. (2 pages of table showing steps, purpose, who is responsible, who is the target.)
19. No Author, **Activites des Formations**. No date. "Rappel, Reunion de Sensibilisation du COSAAR, Mois de decembre 1990...." (List of training activities of SESA project in 1990-1991. Not clear whether this is proposed training or what was held.)
20. MSP. **Manuel du Centre de Sante**, Edition Septembre 90. (Large reference document for health centers on procedures for care and management. Drafted by project SESA?? How used??)
21. **Projet SESA, Manuel du Comite de Sante d'Arrondissement**, Edition aout 1990. (Training Document??)
22. **Projet SESA, Manuel du Comite de Sante de l'Aire de Sante**. Edition juin 1990.
- 23, **Rene Owona Essomba, Malcolm Bryant, and Claude Bodart**, The Reorientation of Primary Health Care in Cameroon. Harvard Institute for International Development, **Development Discussion Paper, 357**, No Date.
- 24a. **Projet SESA, SESA Work-plan**, July 1990-June 1991. No date. (Annexe 10 of something)
- 24b. **Projet SESA, Annual Work Plan**, July 1991-June 1992, June 1991. Yaounde
25. Memo To Richard Greene from Claude Bodart, October 11, 1990: Subject: Cost description by levels for the drug supply system.

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26. USAID, Yaounde, Project Implementation Report for Maternal Child Health/Child Survival Project, 8/30/91

27. MSP. Loi No 90/062 du 19 decembre 1990, accordant derogation speciale aux formations sanitaires publiques en matiere financiere.

28. Projet SESA, Quarterly Report for the period April 1, 1991 through June 30, 1991. July 12, 1991.

Other documents

Martyn Teyha Sama, An Evaluation of Peace Corps' role in the Maternal and Child Survival Project Adamaoua and South Provinces - Cameroon (SESA - Project), January 7-February 1 [1991??]. (we have only executive summary and table of contents)

USAID/HIID- Contract No. 631-0056-C-00-7096-00, 10/6/87.

USAID Cameroon, Cameroon MCH Project, 1987-1992: Project Paper, August 7, 1987.

**SUPERVISION (NIVEAU provinciale de supervision)**

1. Qui sont les personnes responsables de la supervision  
Depots? hopitaux? CS?  
Equipes de supervision d'arrondissement?  
Qui est-ce que vous supervisez?
2. Lesquelles sont vos sources primaires d'informations sur ce qui se passe dans les depots, hopitaux, centres de santés quant au qualité et quantité de travail?
3. Recevez-vous les rapports mensuels d'activité (RMA) du projet? RMAs general? De quelles formations?  
Les exploitez-vous?  
Les analyses (tableaux?) sont-ils disponibles aux superviseurs? Avec quel delai?  
Les-utilisez-vous dans votre supervision? Quels éléments?
4. Y a-t-il un calendrier de supervision (modele)?  
Qu'est-ce que le calendrier actuel depuis Janvier 91?  
Qui a fait la supervision?  
La grille de supervision, l'utilisez-vous?  
Depuis quelle date?  
Quel est la contene de la supervision?  
Gestion des finances?  
Equipements?  
Activités? qualité de soins? Quantité de soins?  
Relations avec le comité de santé?
5. Y a-t-il des rapports du supervision? Ou? Est-ce qu'on peut les voir?
6. Que fait-on avec les informations recueillies pendant la supervision? Par exemple....
7. Quels problèmes avez-vous identifiés lors des supervisions?  
par exemple...
8. Quelles actions avez-vous pris suivant l'identification des problemes? par exemple...
9. Est-ce que vous donnez du feedback aux ceux que vous supervisez? Exemples?
10. Combien de temps avez-vous passé dans chaque formation lors de votre dernière tournée de supervision?
11. Quelle formation avez-vous reçu en supervision et gestion?  
Est-ce que cette formation vous est utile dans votre travail? quels éléments? Assez pratique?  
Qu'est-ce qui vous manque comme connaissance ou qu'est-ce que vous aimerez connaître (theorique ou pratique) de plus pour bien faire votre travail de supervision?  
Avez-vous eu occasion de consulter les manuels que vous avez reçu lors des séminaires? Quand? Pour quel raison?
12. Quels sont les points forts et les points faible du systeme de supervision actuel?

INFORMATION.

Equipe de supervision: delegue?

1. Quels rapports recevez-vous regulierement?  
RMA? RAM projet? Autres?  
Les exploitez-vous?
2. Comment vous utilisez les rapports/syntheses pour  
la supervision?  
la gestion (autre)?  
la planification? exemples?
3. Est-ce que vous donnez du feedback sur les informations  
vous recevez aux niveaux plus bas? En quelle forme?
4. Avez-vous prepare une carte sanitaire? Vous sert-elle  
dans votre travail de gestion? De planification?

Coordinateur provincial du DEPS

5. Quels RMA recevez-vous de qui? Transmis comment? *de la secteur privé*  
Frequence?  
Depouillement? Synthese?  
Analyses? Rapports? Envoyees a qui?
6. Combien de staff dans votre bureau avec quelle  
qualifications?
7. Faites-vous le recueil d'autres informations?  
Lesquelles? En faites-vous les analyses? Exemples?
8. Qui s'en sert de vos informations, rapports? au niveau  
de la province? Au niveau d'arrondissement? Exemples?
9. Les superviseurs (provinciaux, d'arrondissement)  
utilisent-ils les informations que vous produisez. Comment?
10. Avez-vous une carte sanitaire?

01/12/2001 09:30

## I-PROVINCE

### GESTION DU PROJET

1. Combien de vehicules/motos dans la province? Total?  
Projet?  
Combien sont en etat?  
Systeme d'allocation?
2. Quel est le staff du projet? quelles sont leurs taches?  
Quelles sont les ressources disponibles du projet au niveau  
de la province?  
per diem? carburant?
3. Qui gere les fonds du projet?  
Comment sont fait les decisions des allocations des  
ressources?
4. Quels sont les points forts et faible du travail du  
personnel expatrie?  
Chef d'equipe? Coordinatrice? Formateur? IEC?  
Est-ce que la manque d'un coordinateur regional pose un  
probleme?
5. Est-ce que les activités du projet dans la province sont  
vues comme  
"Le projet americain."  
Si OUI, Par qui? Pourquoi?

### QUESTIONS GENERALES: AUTRES

#### Gouverneur:

1. La mise en oeuvre du nouveau systeme de cofinancement et  
co-gestion s'est-elle bien passée?  
Le travail des comités est-il efficace?  
Etes-vous membre du comité? Participez-vous aux  
reunions? Lesquelles? quand?

#### Delegue/equipe de province:

2. Quel est le role des autorités administratives dans le  
nouveau systeme?
3. L'affectation du personnel pose-t-elle des problemes pour  
les activités du projet?
4. Les formations privés (missions) participent-elles dans  
la planification de la santé de la province? Comment?  
Envoit-elles les RMA à la province? A qui?

Amir D. P. 4013

PRO. NCE

APPROVISIONNEMENT EN MEDICAMENTS

1. Reception des bons de commande departementaux (frequence, delai, autres problemes).
2. Soumission des bons de commandes aux fournisseurs (frequences, etc.).
3. Reception et stockage des medicaments et fournitures (conformete aux commandes).
4. Distribution des stocks aux depots.
5. Selection des meilleurs fournisseurs (cout, qualite, delai).
6. Programmation des inspections annuelles des unites.
7. Elaboration des rapports annuels.
8. Impressions du systeme (forts points, points faibles).
9. Formation adequate?
10. Manuel disponible? Comment utilise?
11. Recommandations.
12. Autres commentaires.

Annex D: (p. 52)

## PROVINCE

### RECOUVREMENT DES COUTS

1. Compte bancaire (rapports, disponibilites des fonds).
2. Soumission des factures aux depots.
3. Reception des paiements (delai, autres problemes).
4. Paiement des fournisseurs.
5. Systeme de comptabilite et controle interne.
6. Directives sur la tarification et le salaire des commis.
7. Estimation des couts pour chaque niveau.
8. Impressions du systeme (forts points, points faibles).
9. Formation adequate?
10. Manuel disponible? Comment utilise?
11. Recommandations.
12. Autres commentaires.

Annex D: P. 6 of 17

SESA - EVALUATION MI-TERM, NOV

## DECENTRALISATION

### TOUTE LES NIVEAUX

- 1 Plan annuel de travaille existant?
- 2 Qui a ecrit le Plan?
- 3 Vous suivez le Plan?
- 4 Avez vous change le Plan?
- 5 Quelles sont les strategies du Plan?
- 6 Quelles sont les objectifs du Plan?
- 7 Quelles sont les points faibles et forts de la decentralisation?
- 8 Quelles est le role dan. la decentralisation de le Ministere de la SP au niveau central?
- 9 Comment est ce que vous obtenir les medicament?

Annexe D. 2. 7 of 10

NIVEAUX PROVINCIAL, DEPARTEMENTAL ET DISTRICTAL

INTEGRATION

- 1 Les visites de supervision sont polyvalent?
- 2 Les grilles de supervision sont polyvalent?
- 3 Sensibilisation communautaire, combien de fois? Comment? Quel sujets?
- 4 Qui est responsable pour le CIE?
- 5 Combien de temps dediquez vous au projet?

PARTICIPATION COMMUNAUTAIRE

- 1 Date committee organise?
- 2 Comment etait le committee organise (mechanisme)?
- 3 Formation recu? dure de formation? par qui?
- 4 Combien des membres? combien remplace?
- 5 Titres des officieaux gouvernementaux qui sont parti de committee?
- 6 Combien de reunion? Nombre qui assiste en moyen? Minutes garde?
- 7 Combien fois? President consulte avec les membres hors des reunion?
- 8 Les points faibles et forts de le nouveaux system?
- 9 Problems identifies par le comm? Actions pris pour resoudre?
- 10 Quel sont les plaints recu sur CS (service, prix, personnel)?
- 11 Comment peut le comm. aider a augmenter le frequentation aux CS?
- 12 Suggestions pour ameliorer le nouveau system de SSP?
- 13 Combien rapports recus des comis? Recus des CS?
- 14 Combien fois membres assist le supervision; visite officmt CS?

Journal de 2.8.91

## II DEPT / ARRONDISSEMENT

### SUPERVISION

1. Qui sont les personnes responsables de la supervision  
Depots? hopitaux? CS?  
Qui est-ce que vous supervisez?
2. Lesquelles sont vos sources primaires d'informations sur ce qui se passe dans les depots, hopitaux, centres de santés quant au qualité et quantité de travail?
3. Recevez-vous les rapports mensuels d'activité (RMA) du projet? RMAs general? De quelles formations?  
Les exploitez-vous?  
Les analyses (tableaux?) sont-ils disponibles aux superviseurs? Avec quel delai?  
Les-utilisez-vous dans votre supervision? Quels éléments?
4. Y a-t-il un calendrier de supervision (modele)?  
Qu'est-ce que le calendrier actuel depuis Janvier 91?  
Qui a fait la supervision?  
La grille de supervision, l'utilisez-vous?  
Depuis quelle date?  
Quel est la contene de la supervision?  
Gestion des finances?  
Equipements?  
Activités? qualité de soins? Quantité de soins?  
CDD?, Chaine de froid? Protocoles de traitement?  
Relations avec le comité de santé?
5. Y a-t-il des rapports du supervision? Ou? Est-ce qu'on peut les voir?
6. Que fait-on avec les informations recueillies pendant la supervision? Par exemple....
7. Quels problèmes avez-vous identifiés lors des supervisions?  
par exemple...
8. Quelles actions avez-vous pris suivant l'identification des problemes? par exemple...
9. Est-ce que vous donnez du feedback aux ceux que vous superviser? Sous quelle forme?
10. Combien de temps avez-vous passé dans chaque formation lors de votre dernière tournée de supervision?  
Qu'est-ce qui était le contenu de la supervision?
11. Quelle formation avez-vous reçue en supervision et gestion?  
Est-ce que cette formation vous est utile dans votre travail? quels éléments? Assez pratique?  
Qu'est-ce qui vous manque comme connaissance ou qu'est-ce que vous aimerez connaître (theorique ou pratique) de plus pour bien faire votre travail de supervision?  
Avez-vous eu occasion de consulter les manuels que vous avez reçu lors des seminaires? Quand? Pour quel raison? Exemples??
12. Quels sont les points forts et les points faibles du systeme de supervision actuel?
13. Comment tournent les centres que vous supervisez? bien?

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Annex D: P. 2, 3, 4

## II-DEPT/ARRONDISSEMENT

### GESTION DU PROJET

1. Combien de vehicules/motos dans la Dept/arr.? Total?  
Projet?  
Combien sont en etat?  
Systeme d'allocation?
2. Quelles sont les ressources disponibles du projet a votre niveau?  
per diem? carburant?
3. Qui gere les fonds du projet?  
Comment sont fait les decisions des allocations des ressources?
4. Quels sont les points forts et faible du travail du personnel expatrie?  
Chef d'equipe? Coordinatrice? Formateur? IEC?  
Est-ce que la manque d'un coordinateur regional pose un probleme?
5. Est-ce que les activités du projet dans la province sont vues comme  
"Le projet americain."  
Si OUI, Par qui? Pourquoi?

### QUESTIONS GENERALES: AUTRES

Prefet/sous-prefet:

1. La mise en oeuvre du nouveau systeme de cofinancement et co-gestion s'est-elle bien passée?  
Le travail des comités est-il efficace?  
Etes-vous membre du comité? Participez-vous aux reunions? Lesquelles? quand?

Medecin-chef/Equipe d'arr.

2. Quel est le role des autorités administratives dans le nouveau systeme?
3. L'affectation du personnel pose-t-elle des problemes pour les activités du projet?
4. Les formations privés (missions) participent-elles dans le planification de la santé dans votre district? Comment?

### INFORMATION

Quelles sont vos sources d'information sur les activités des centres de santé? Quels rapports recev-vous?  
Frequence?

Annex 2 of 10 of 13

DEPO. DEPARTEMENTAL

APPROVISIONNEMENT EN MEDICAMENTS

1. Conditions de stockage (proprete, organisation, securite).
2. Stocks perimes?
3. Ruptures de stocks (frequence, duree, raison).
4. Fiches de stocks a jour?
5. Soumission des bons de commande a la province.
6. Reception des medicaments (conformite aux commandes, delai).
7. Distribution des stocks aux hopitaux et CS.
8. Impressions du systeme (forts points, points faibles).
9. Formation adequate?
10. Manuel disponible? Comment utilise?
11. Recommandations.
12. Autres commentaires.
13. Monthly reports

Annex 2: p. 123

DEPOT ..RTEMENTAL

RECOUVREMENT DES COUTS

1. Compte bancaire (rapports, disponibilité des fonds).
2. Reception des paiements des hopitaux et CS.
3. Soumission des paiements a la province.
4. Audit annuelle?
5. Impressions du systeme (forts points, points faibles).
6. Formation adequate?
7. Manuel disponible? Comment utilise?
8. Recommendations.
9. Autres commentaires.



Annexe 5: P. 124, 19

SESA - EVALUATION MI-TERM. NOV 91

## DECENTRALISATION

### TOUTE LES NIVEAUX

- 1 Plan annuel de travaille existant?
- 2 Qui a ecri le Plan?
- 3 Vous suivez le Plan?
- 4 Avez vous change le Plan?
- 5 Quelles sont les strategies du Plan?
- 6 Quelles sont les objectifs du Plan?
- 7 Quelles sont les points faibles et forts de la decentralisation?
- 8 Quelles est le role dan la decentralisation de le Ministere de la SP au niveau central?
- 9 Comment est ce que vous obtenir les medicament?

Annex 7: p. 3 of 19

NIVEAUX PROVINCIAL, DEPARTEMENTAL ET DISTRICTAL

INTEGRATION

- 1 Les visites de supervision sont polyvalent?
- 2 Les grilles de supervision sont polyvalent?
- 3 Sensibilisation communautaire, combien de fois? Comment? Quel sujets?
- 4 Qui est responsable pour le CIE?
- 5 Combien de temps dediquez vous au projet?

PARTICIPATION COMMUNAUTAIRE

- 1 Date committee organise?
- 2 Comment etait le committee organise (mechanisme)?
- 3 Formation recu? dure de formation? par qui?
- 4 Combien des membres? combien remplace?
- 5 Titres des officieaux gouvernementaux qui sont parti de committee?
- 6 Combien de reunion? Nombre qui assiste en moyen? Minutes garde?
- 7 Combien fois President cconsult avec les membres hors des reunion?
- 8 Les points faibles et forts de le nouveaux system?
- 9 Problems identifies par le comm? Actions pris pour resoudre?
- 10 Quel sont les plaints recu sur CS (service, prix, personnel)?
- 11 Comment peut le comm. aider a augmenter le frequentation aux CS?
- 12 Suggestions pour ameliorer le nouveau system de SSP?
- 13 Combien rapports recus des comis? Recus des CS?
- 14 Combien fois membres assist le supervision; visite officmt CS?

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Annex 2: p. 1-2/3

### III CENTRE DE SANTE

#### SUPERVISION

1. Avez-vous reçu la supervision depuis Janvier 1991?  
Quand? Dates?  
Qui est venu?  
Quel était le contenu de la supervision?  
Gestion des finances?  
Equipements?  
Activités? qualité de soins? Quantité de soins?  
CDD?, Chaine de froid? Protocoles de traitement?  
Relations avec le comité de santé?  
Combien de temps a-t-on passé chez vous?
2. Est-ce que le superviseur a assisté à une séance de travail  
Est-ce qu'on a suivi le traitement de la diarrhée?  
Exemples?
3. Avez-vous reçu du feedback du superviseur?  
Est-ce que des problèmes ont été identifiés par le superviseur? Exemples?  
Le superviseur a-t-il proposé des solutions?  
Le problème est-il résolu?
4. Laisse-t-on le grille de supervision chez vous?
5. Ce système de supervision vous est-il utile? comment?  
Comment peut-on l'améliorer?

6. *supervision of Ax & Sy during consultation*

#### INFORMATION

1. Qu'est-ce que vous faites comme collecte de données?  
Fiches? Registres?
2. Quels Rapports faites vous à partir de ces données?  
Fréquences? A qui les envoyez-vous?
3. Comment vous servez-vous des fiches/registres dans votre travail?  
Pour planifier? Exemples...  
Pour gérer? Exemples...
4. Comment vous servez vous des rapports que vous remplissez?
5. Recevez-vous du feedback sur les rapports vous envoyez?  
De qui?  
Des superviseurs?
6. Combien de temps vous faut-il pour remplir le RMA projet?  
Quand est-ce que vous le faites?  
Quels problèmes rencontrez vous dans le remplissage?
7. Avez-vous reçu la formation sur la collecte des données?  
Sur quelles données? Quelle sorte de formation?
8. Avez-vous reçu la formation dans le remplissage des rapports? Par qui? Quand? Vous sert-il?
9. De quels outils de gestion, quels documents vous servez vous pour suivre la vaccination? les soins prénatales?  
p.e. échancier? cahier?
10. Quels sont les points forts et faibles du système d'information actuel?

Annex D: p. 15 of 19

### III-CENTRES DE SANTE

#### GESTION DU PROJET

1. Combien de vehicules/motos avez-vous? Total?  
Projet?  
Combien sont en etat?  
Systeme d'allocation?
2. Quelles sont les ressources disponibles du projet a votre niveau?  
per diem? carburant?
3. Qui gere les fonds du projet?  
Comment sont faites les decisions des allocations des ressources?
4. Quels sont les points forts et faibles du travail du personnel expatrié?  
Chef d'équipe? Coordinatrice? Formateur? IEC?  
Est-ce que la manque d'un coordinateur regional pose un probleme?
5. Est-ce que les activités du projet dans la province sont vues comme  
"Le projet americain."  
Si OUI, Par qui? Pourquoi?

#### QUESTIONS GENERALES: AUTRES

Chef responsable admin.:

1. La mise en oeuvre du nouveau systeme de cofinancement et co-gestion s'est-elle bien passée?  
Le travail des comités est-il efficace?  
Etes-vous membre du comité? Participez-vous aux reunions? Lesquelles? quand?

Infirmier responsable

2. Quel est le role des autorités administratives dans le nouveau systeme?
3. L'affectation du personnel pose-t-elle des problemes pour les activités du projet?
4. Les formations privés (missions) participent-elles dans la planification de la santé dans votre aire de santé?  
De quelle manière?

Annex 2: 16 of 19

CENTRE DE SANTE

APPROVISIONNEMENT EN MEDICAMENTS

1. Conditions de stockage (proprete, organisation, securite).
2. Stocks perimes, non-utilizes?
3. Ruptures de stocks (frequence, duree, raison).
4. Necessité de referer les patients aux pharmacies privees.
5. Systeme de stocks d'urgence.
6. Fiche d'utilisation et de cash. Fiches de stocks à jour?
7. Soumission des bons de commande.
8. Reception des medicaments (conformité aux commandes, delai).
9. Stocks initiaux adequats?
10. Besoin de medicaments pas inclus sur la liste des ME?
11. Fonctionnement du systeme <sup>en</sup> dans l'absence du commis et/ou le trésorier.
12. Impressions du systeme (forts points, points faibles).
13. Formation adéquate? -
14. Manuel disponible? Comment utilise?
15. Recommandations.
16. Autres commentaires.

Annex D: p. 17 of 19

## CENTRE DE SANTE

### RECOUVREMENT DES COUTS

1. Bareme de tarification standard? Affiche?
2. Tarifs appropriés? Acceptés par la population?
3. Politique de credit ou d'exception, e.g., pour les indigents?
4. Compte bancaire ou postale? Disponibilite des fonds (solde)?
5. Recus prenumerottes?
6. Reconciliation des factures et recettes journalieres?
7. Rencontre hebdomadaire avec le COGE.
8. Clôture mensuelle de la comptabilite.
9. Disposition des recettes intactes?
10. Plan de depenses mensuelles.
11. Depenses conformes au plan? Fonds suffisants?
12. Documents financiers à jour?
13. Utilisation des rapports mensuels.
14. Role et responsabilite du tresorier.
15. Impressions du systeme (forts points, points faibles).
16. Formation adequate?
17. Manuel disponible? Comment utilise?
18. Recommandations.
19. Autres commentaires.

Annex D: 0.182

## NIVEAU CENTRAL DE SANTE (CS)

### INTEGRATION

- 1 Combien de personnel et donner les titres.
- 2 Est ce qu'il y a une description de tous les postes?
- 3 Est ce qu'il y a une balance, frigo, sterilisateur, four~~ne~~, moto?
- 4 Combien en stock des condoms, fiches maternels, cartes vacc enfant, cartes vacc TT, rapports mensuel d'activites, vaccin anti-rougeoleux, DTC, polio, BCG, TT, aiguilles BCG, aiguilles DTC, diluant BCG, diluant, rougeole, chloroquine, ORS, antibiotiques, carburant moto, petrole four~~ne~~? Le montant en stock reasonable?
- 5 Les inventaires sont à jour? Le fiche temperature est à jour?
- 6 Tous vaccs pratiqués le meme jour? Combien<sup>10</sup> jours par semaine?
- 7 Tous~~le~~ les jours ORT? Rx malaria? Education sanitaire?
- 8 Dx et rx protocoles exist~~ent~~<sup>nt</sup>, Le Manual CS, utilisez vous? Quand?
- 9 Tous~~es~~ les rapports mensuel~~s~~ d'activites exist~~ent~~<sup>nt</sup>
- 10 Décrire les activités éducation sanitaire.
- 11 La strategie avance~~e~~<sup>e</sup> est-elle pratique? Combien de postes? Combien de fois? Et quel service?

### PARTICIPATION

- 1 Date que le CS commence avec la re-orientation?
- 2 Population dans l'aire de santé?
- 3 Nombre des nouveaux consultations depuis re-orientation?
- 4 Nombre de DTC-polio 1 et 3 administré~~s~~<sup>s</sup> depuis ré-orientation?
- 5 Politique de payment pour les indigents?
- 6 Les services intégrés sont acceptes quand le 2eme ou 3eme acte/geste augment le pris? Les tarifs sont acceptables?
- 7 Tous les medicaments sont achetés suivant la prescription?
- 8 Personnel accept~~e~~<sup>e</sup> nouveau system? Assiste dans les reunions des committé~~s~~<sup>s</sup>?

Annex 2: P. 19 of 19

SESA - EVALUATION MI-TERM - NOV 91 (SUD)

CS de \_\_\_\_\_ ARR. \_\_\_\_\_ DEPT. \_\_\_\_\_  
Date de re-orientation \_\_\_\_\_ Pop. de l'aire sante \_\_\_\_\_  
Nnbr personnel \_\_\_\_\_ Titres \_\_\_\_\_  
Descriptions des postes? \_\_\_\_\_ Descriptions polyvalent? \_\_\_\_\_  
Existant et fonction? balance \_\_\_\_\_; frigo \_\_\_\_\_; sterilisateur \_\_\_\_\_;  
rechaud \_\_\_\_\_; moto \_\_\_\_\_; fiche temperature \_\_\_\_\_ et temp. present \_\_\_\_\_.  
Temperature sur le fiche le plus haute \_\_\_\_\_ et le plus bas \_\_\_\_\_.  
Combien en stock: carte vacc enfant \_\_\_\_\_; fiche CPS \_\_\_\_\_; rapp  
mensuel d'activite \_\_\_\_\_; vacc TT \_\_\_\_\_; vacc DTC \_\_\_\_\_; polio \_\_\_\_\_;  
rougeole \_\_\_\_\_; BCG \_\_\_\_\_; diluent BCG \_\_\_\_\_; seringue BCG \_\_\_\_\_;  
aiguille BCG \_\_\_\_\_; seringue/aiguille autre \_\_\_\_\_/\_\_\_\_\_; SRO \_\_\_\_\_;  
chloroquine \_\_\_\_\_; condom \_\_\_\_\_; penicln \_\_\_\_\_; autre antibiot \_\_\_\_\_.  
Nmbre utilise mois passe: SRO \_\_\_\_\_; chloroq \_\_\_\_\_; VAR \_\_\_\_\_.  
Inventaire de vaccin \_\_\_\_\_? a jour \_\_\_\_\_? rupture \_\_\_\_\_? perime \_\_\_\_\_?  
Plan annual \_\_\_\_\_? Combien supervision \_\_\_\_\_? Dx/rx inclus \_\_\_\_\_?  
Manual de CS avec dx. et rx protocole exist \_\_\_\_\_ et utilise \_\_\_\_\_?  
Journalier: TRO \_\_\_\_\_? Rx. palu \_\_\_\_\_? Vacc \_\_\_\_\_? Ed. Sanitaire \_\_\_\_\_?  
Depuis reorientation: Nnbr nouv consult \_\_\_\_\_? DTC-1 \_\_\_\_\_? DTC3 \_\_\_\_\_?  
Fee de consultation toujours paye? \_\_\_\_\_  
Politique indigent? \_\_\_\_\_  
Personnel accept nouv system \_\_\_\_\_ et assist reunion committee \_\_\_\_\_?  
Strategy avance \_\_\_\_\_? combien postes \_\_\_\_\_? combien fois visite \_\_\_\_\_?  
quels services \_\_\_\_\_? registre \_\_\_\_\_? revenue \_\_\_\_\_?  
Nmbre de RMA complete \_\_\_\_\_ Combien credit de la Govt \_\_\_\_\_?  
Decrivez activites Ed. Sanitaire. Points forts et faible formation.  
visites par les membres des committee \_\_\_\_\_?

**CAMEROON PROJECT SHORT-TERM CONSULTANTS**

Name	Dates	Task
Marlene Abrial	6/13/91 - 7/5/91	Economic analysis
Pierre Ayomo	5/13/91 - 6/7/91	Financial analysis
Uwe Brinkmann	9/6/90 - 9/28/90 9/13/91 - 9/23/91	Design of malaria strategy
Malcolm Bryant	3/7/88 - 11/88 1/21/89 - 2/10/89 9/9/89 - 9/30/89 5/13/90 - 5/23/90 4/22/91 - 5/12/91	Project management
Getachew Demisse	6/14/88 - 6/21/88 3/29/91 - 4/21/91	Launching of project; administrative
Gilles DesRochers	2/9/89 - 3/1/89	Cost recovery - data collection and analysis
Paultre Desrosiers	4/7/91 - 4/28/91	Candidate for Provincial Coordinator
Lori diPrete	8/1/89 - 9/30/89'	Design of supervision protocols
Bernard Guyer	6/27/88 - 7/19/88	Work on EPI
Albert Henn	3/7/88 - 4/1/88	Project management
Kasela Pala Mambwe	3/22/90 - 4/30/90	Prepared training materials for health teams
Rosalyn King	5/3/89 - 5/24/89 9/18/90 - 10/18/89 10/3/90 - 11/9/90	Drug supply and pricing; project management
Mark Lediard	5/19/89 - 6/5/89	Project management
Maria Madison	6/15/91 - 8/15/91	Household sentinel survey
Jean de Malvinsky	2/12/90 - 3/2/90	IEC; developed community participation modules
Friedrich von Massow	1/8/90 - 2/13/90	Design of pharmacy supply system

Name	Dates	Task
George Mbeh	3/1/91 - 5/31/91	Collection of baseline social data; conducted KAP evaluation and analysis of health workers' behavior
Charles Myers	4/22/91 - 5/12/91	Project management
Rose Njia	7/8/89 - 11/9/89	Prepared economic review; worked on drug pricing
Marydean Purves	11/5/90 - 12/14/90	IEC; designed two-year workplan
Rainer Sauerborn	9/9/91 - 10/4/91	Project management
Joan Schubert	5/13/91 - 6/91	Training
Don Shepard	10/1/89 - 10/15/89	Economic and pricing analysis
Richard Shiyntum	4/23/90 - 5/12/90	Training in MOH PHC coordinators on operation, maintenance and repairs of project motorcycles
Ralph Stone	9/25/88 - 10/31/88	Training of trainers
Dr. Toumi	3/10/88 - 10/25/88	Training of trainers
Mr. Yah	2/4/90 - 6/4/90	Developed accounting model

**CAMEROON PROJECT LONG-TERM PERSONNEL**

Name	Dates	Position
Jim Sonneman	1/1/88 - 8/16/89	Chief of Party
Claude Bodart	8/20/89 - present	Chief of Party
Bob deWolfe	2/88 - 7/90	Management Trainer
Jennie Litvack	8/15/90 - 8/14/90	Economic Study
Joan Schubert	5/91 - present	IEC
Dorothy Madison-Seck	4/88 - present	Provincial Coordinator, South Province
Regina Dennis	4/88 - 7/89	Provincial Coordinator, Adamaoua Province
Marie Alexandre	2/2/90 - 4/15/91	Provincial Coordinator, Adamaoua Province

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Information contained in a SESA paper entitled PROJECTION OF FINANCIAL DATA FOR HEALTH CENTER, and related documents have been used to produce a simplified version of the model shown in Figure V-2. While numbers have been rounded to simplify exposition, most values are within 1-2% of those used by SESA.

The model projects revenues by applying utilization rates for various services and associated fees to the target area population. In this simplified version, revenues are estimated at 2500 FCFA/new case (NC), of which 1875 FCFA are from drugs and 625 FCFA are from fees.

Variable costs, mostly drugs, are estimated at 1150 FCFA/NC. Several estimates of monthly fixed costs are found in the various project documents, ranging from a low of 49,000 FCFA in Bodart's recent assessment of health center viability, to a high of 84,000 FCFA/month in the above cited paper. These costs cover the salary of the drug clerk, maintenance, transportation, outreach activities, training, supplies and related categories.

As shown in Figure V-2, for a population of 8,000, one would expect about 160 new cases per month, which would generate revenues of 400,000 FCFA and variable costs of 184,000 FCFA, leaving 216,000 FCFA to cover fixed costs.

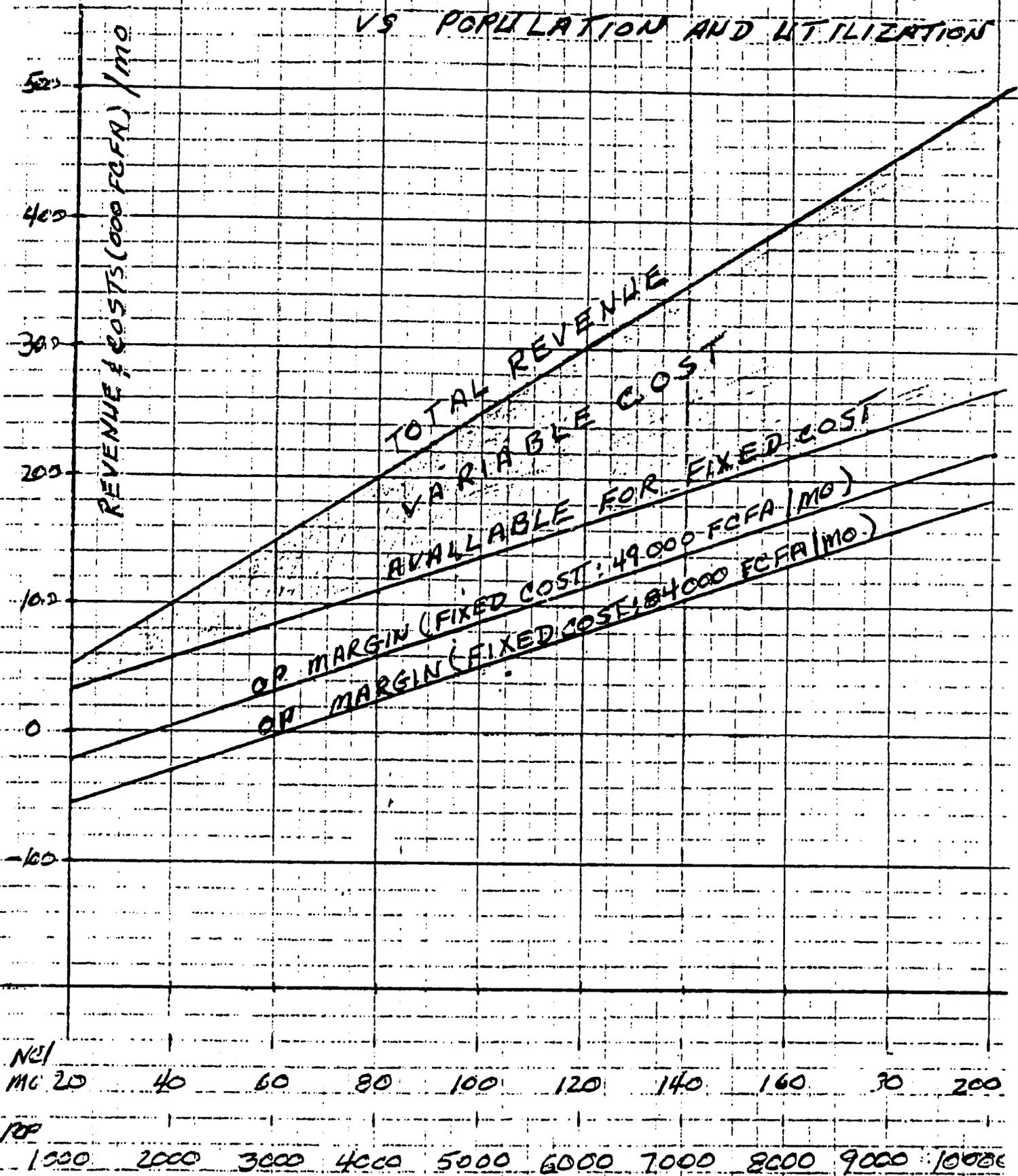
The graph also illustrates that a minimum population of about 3,000 is needed to support estimated fixed costs of 84,000 FCFA. Flexible application of the model, e.g., opening the health center three days per week with outreach, etc., the remaining two days would reduce fixed costs and thereby permit the facility to break even while serving a smaller population.

The SESA Report of Monthly Activities (RMA) can provide the information necessary to compare actual health center performance with that predicted by the model. This information can be used to intervene on a timely basis if performance diverges from predictions or deteriorates. The model can also be "fined tuned" to reflect actual utilization, revenues and costs for a given site and thereby serve as a more precise budgeting and control mechanism.

In another document entitled MATERNAL CHILD HEALTH/CHILD SURVIVAL PROJECT, SESA has estimated the operating revenues and costs of a system of 52 financially viable, co-managed and co-financed health centers in Adamaoua Province. Projections are based on a utilization rate of 0.25 NC/person/year and on drug consumption data from CIM, the Belgian project in Cameroun. In this case the "average" health center reflects the following characteristics:

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REVENUES, COSTS AND OP. MARGIN/MO  
VS POPULATION AND UTILIZATION



POPULATION.....5,000  
 NC/MONTH.....100  
 REVENUE/NC.....2350 FCFA  
 REVENUE/MONTH....235,000 "  
 VAR COST/MO.....165,000 "  
 FIXED COST/MO.....70,000 "

Again, numbers have been rounded to simplify the presentation, but values closely approximate those used by SESA. Projected monthly operating revenues and costs for the system are shown in the following table.

**PROJECTED MONTHLY REVENUES AND COSTS FOR ADAMAOUA PROVINCE  
 (FCFA: 1991 PRICES)**

COST DESCRIPTION	PROVINCIAL	DEPARTMENTAL	PERIPHERAL
DRUG CLERKS	40,000	200,000	1,300,000
SUPERVISION	550,000		
DRUG ORDERS	75,000	30,000	380,000
INSPECTIONS	145,000		
ADMINISTRATION	70,000	100,000	
MAINTENANCE	390,000	25,000	465,000
TRAINING	380,000		100,000
COLD CHAIN		20,000	190,000
DRUG LOSS	520,000	520,000	520,000
DEPRECIATION	580,000		
ANNUAL MEETING	50,000		
MISCELLANEOUS	180,000	30,000	590,000
EMERGENCY FUND	150,000		
TOTAL FIXED COSTS	3,130,000	925,000	3,545,000
VARIABLE COSTS	4,520,000	7,650,000	8,575,000
TOTAL COSTS	7,650,000	8,575,000	12,120,000
TOTAL REVENUES	7,650,000	8,575,000	12,120,000

The total fixed costs for the activities listed above at the provincial, departmental and peripheral levels are estimated at 7,600,000 FCFA per month. These costs would be covered by the 168% mark-up on drugs and supplies (4,520,000 FCFA X 268% = 7,600,000 FCFA).

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**ANNEX G: OPERATION OF THE DRUG DISTRIBUTION & COST RECOVERY SYSTEM**

The operating procedures for the drug distribution and cost recovery system are described in the following paragraphs.

1. Drug procurement. Health center and hospital pharmacies, as well as departmental drug depots, are provided with an initial stock of drugs and supplies. Additionally, price lists are established for the sale of drugs at the community, departmental and provincial levels. These lists are revised as necessary. Maximum and minimum inventory quantities ( $Q_{max}$  and  $Q_{min}$ ) based on the consumption rate of each product are established and periodically updated for each pharmacy and departmental drug depot. Every two months, the pharmacies reorder drugs and supplies from the depots to raise their inventory to the maximum quantity specified for each product. Requisitions are prepared at the monthly meeting attended by the head of the health unit, the drug clerk, the treasurer, the president of the COGE and other individuals as specified in the HEALTH CENTER MANUAL.

In a similar manner each depot replenishes its stock by submitting requisitions to the provincial depot, which in turn transmits each departmental order to suppliers selected on the basis of product quality, cost, and turnaround time. These suppliers send individually packaged departmental shipments to the provincial depot from which they are delivered to or picked up by each departmental depot. The provincial depot maintains no permanent inventory, serving only as a transit point. There is no provision for the verification of the orders at this level. At each level, payment accompanies the requisition, thereby eliminating the need for a billing system.

2. Inventory control. The inventory control system is relatively straightforward. The group which prepares the periodic drug and supply orders is also responsible for assuring that quantities received are consistent with those requisitioned and that inventory control cards are updated to reflect these quantities.

After filling a prescription, the drug clerk posts the amount of each drug dispensed into the utilization and cash journal. At the end of each day, the clerk calculates the total amount of each item dispensed and updates the appropriate inventory control cards, entering daily consumption and the balance remaining. There are procedures for the periodic reconciliation of these balances with stock actually on hand.

3. Accounting. Accounting procedures, with their provisions for internal control, are necessarily more complex than the inventory control system.

- a. Patient transactions. For each new episode of care the patient pays a consultation fee to the drug clerk, who issues a receipt. Upon presentation of the receipt, the patient is treated by the health care provider, who in most cases prescribes one or more drugs. The drug clerk fills the prescription, collects the fee, issues a receipt and posts the amount collected into the utilization and cash journal. A cross-referencing system permits reconciliation of the patient register, the prescription slip and the receipt.
- b. Daily closing. At the end of each day, the drug clerk calculates net receipts and with the head of the health unit reconciles cash actually on hand with the total of receipts issued. These funds are turned over at least weekly to the treasurer, who is responsible for their safekeeping in either a bank or postal account.
- c. Weekly meeting. The head of the health unit, the drug clerk and the treasurer meet at least weekly to reconcile receipts, expenditures and cash on hand. At this meeting a sample of inventory control cards is also reconciled with stock actually on hand. If the treasurer is absent for more than two weeks, s/he is temporarily replaced by another COGE member.
- d. Monthly meeting. As described on page 94 of the HEALTH CENTER MANUAL, the head of the health unit, the drug clerk, the treasurer, two COGE members and two COSA members (maximum au compte) meet at the beginning of each month to reconcile stock and cash on hand with documents, to prepare the monthly cash flow statement (Rapport Mensuel de Tresorerie) and operating statement (Compte d'exploitation), to compare actual and planned expenditures, to formulate an expenditure plan for the current month, and to authorize the procurement of additional supplies.
- e. Other procedures. While somewhat less complex, similar accounting and internal control procedures exist at the departmental and provincial levels.

ANNEX H: SUMMARY OF SITE VISIT FINDINGS: FINANCIAL MANAGEMENT

The following are mostly exceptions to prescribed procedures:

Ngaoundere Hospital Community Pharmacy

11/12/91 site visit:

- No bank account
- Some object to price schedule, go elsewhere
- No policy for indigents
- Daily receipts co-mingled, no daily reconciliation
- Weekly meetings with treasurer only
- No monthly expenditure planning
- Monthly meetings inconsistent with closure protocols
- Internal controls not fully complied with

Nyambaka Health Center

8/91 EPP inspection:

- Inventory reconciliation shows some losses

11/13/91 site visit:

- No bank/postal account
- Objections to price increase, e.g., Paracetamol 20-125 FCFA
- No policy for indigents
- Monthly meeting: COGE president, treasurer and head of health unit only
- No monthly expenditure plan
- Financial reports every two months
- Internal controls not fully complied with

Bekagoto

8/91 EPP inspection:

- RMA incorrectly prepared
- Consultation fee not collected consistently

11/14/91 site visit:

- No bank/postal account
- Resistance to consultation fee, not always collected
- Some COGE members never come
- Treasurer thinks money belongs to government
- Funds transferred to treasurer monthly
- Daily reconciliation with treasurer
- No cross-referencing
- No forms for monthly reports
- Internal controls not fully complied with

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Tibati Hospital, Health Center and Depot

8/91 EPP inspection:

- Frequent outages
- No loss of drugs
- Hospital, health center and depot funds commingled

11/15/91 site visit:

- 1 postal account for three entities, funds commingled
- No credit, no exceptions
- No separate documentation for the three entities
- Hospital and depot have never submitted financial report
- Need to reconstruct records
- Three treasurers in 11 months
- COGE meets monthly, but does not follow internal control procedures
- No monthly expenditure plan
- Confusion between hospital and depot prices on requisitions
- "Depot surplus is buried somewhere"
- Cannot tell from which account drug clerk is being paid
- Internal controls not fully complied with

Dir Health Center

8/91 EPP inspection:

- Minor drug losses
- Some resistance to consultation fee
- Good overall compliance with internal control procedures

11/15/91 site visit:

- Poor attendance by drug clerk
- Good community participation
- PCV overly involved?
- Needed to replace treasurer after two month absence
- Good compliance with most internal control procedures

Meiganga Hospital

11/15/91 site visit:

- No monthly closure since 7/91
- Treasurer has borrowed from postal account

Banyo Hospital and Depot

8/91 EPP inspection:

- Several drug losses
- Inventory control cards not current

11/16/91 site visit:

- No bank/postal account
- Hospital and depot funds commingled
- Complaints about price increases
- Unauthorized expenditures by drug clerk
- No daily reconciliation of accounts
- Money to treasurer twice monthly
- COGE does not function; PCV and clerk do work of treasurer
- No expenditure records
- No monthly expenditure plan
- Internal control procedures not complied with

Sambolabo Health Center

8/91 EPP inspection;

- Drugs missing
- Inconsistency between inventory control cards and journal
- Receipts altered to show lower amount
- Theft of 280,000 FCFA

Kye-Ossi Health Center

7/91 EPP inspection:

- Inappropriate expenditures for COSA
- Poor internal control procedures

11/22/91 site visit:

- Bank account
- Patients consider fees too high, go elsewhere
- Consultation fees not collected since 8/91
- No credit; 2% of receipts reserved for indigents
- Concern over deficit since 8/91
- Board members want "motivation"
- No monthly meetings since 2/91
- No cross-referencing
- No daily reconciliation
- No inventory reconciliation
- Money in unlocked drawer in non-secure room
- Internal control procedures not complied with

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Ebolowa Depot

8/91 EPP inspection:

- Gross discrepancies in bookkeeping
- Documents destroyed
- Theft of 1,000,000 FCFA
- Poor oversight by COGEAR
- Possible complicity between clerk and treasurer

11/23/91 site visit:

- COGEAR president is private pharmacist; conflict of interest?
- Drug clerk stated that COGEAR president attempted to purchase drugs from her
- Per Dr. Bell, large sales since 8/91 appear suspicious
- Internal control procedures not complied with

Ebolowa Provincial Hospital

9/91 EPP inspection:

- Steady increase in revenues
- Problems with bookkeeping

11/21 site visit:

- Bank account
- Fees considered reasonable
- No credit, no exceptions
- Drug sales restricted to inpatients
- Daily reconciliation by clerk only
- No weekly reconciliation
- COGE not involved, no monthly meeting
- Monthly reports by drug clerk and treasurer only
- Internal controls not complied with

Bengbis Hospital

9/91 EPP inspection:

- Inventory verification
- Low use of ME drugs by staff
- Problems with requisitions, many outages
- Some bookkeeping problems

11/25/91 site visit:

- No bank/postal account
- Price of some drugs, e.g., Mebendazole, considered too high
- Cash on hand not reconciled with documents
- COGE has met only twice since 1/91
- Internal controls not complied with

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Sangmelima Hospital

11/26/91 site visit

- Bank account
- Treasurer very reliable, but considers system too complex
- Treasurer wants more training on internal control
- Good record keeping, but some pencil entries
- Some prices higher than private pharmacies
- No exceptions for indigents
- Daily reconciliation by clerk only
- Monthly meeting of drug clerk, treasurer and PCV only
- Internal controls not complied with

Sangmelima Depot

11/26/91 site visit:

- No bank/postal account
- Good bookkeeping, but some pencil entries
- Drug clerk has borrowed funds, wants raise
- Surplus inadequate to cover current salary
- Poor COGE participation in monthly meetings
- Internal controls not fully complied with

Kribi Hospital

8/91 EPP inspection

- Good revenues (20,000 FCFA/day)
- Extremely poor record keeping
- Gross inconsistency between cash flow and operating statements - -

11/27/91 site visit:

- No daily closure, reconciliation
- Receipts not turned over to treasurer weekly
- Monthly reports done by clerk, are grossly incorrect
- Only 4 COGE meetings since 1/91
- No monthly expenditure plan
- Monthly expenditures poorly documented
- Poor treasurer performance
- COGE president states that he does not understand system
- Internal controls essentially nonexistent

Kribi Depot

8/91 EPP inspection:

- New drug clerk since theft
- Bookkeeping procedures not being followed
- System beyond ability of treasurer
- Theft of nearly 1,000,000 FCFA
- Poor supervision

11/27/91 site visit: See Kribi Hospital

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Elog-Batindi Health Center

8/91 EPP inspection:

- Concern over recent price increases,  
e.g., Metronidazole has increased from 12,000-69,000  
FCFA/1000
- Low receipts due to absenteeism
- credit sales to COSA, etc.
- Unauthorized, poorly documented expenditures
- Poor record keeping, reports incorrect
- No monthly expenditure planning
- Poor COGE involvement
- Monthly meetings inconsistent with procedures
- Internal controls extremely poor

11/27/91 site visit:

- Bank account
- Credit sales
- Consultation fee not collected since 8/91
- No cross-referencing
- Poor record keeping, reports incorrect
- No expenditure planning, unauthorized expenditures
- Deficit, question of viability
- Internal controls grossly inadequate

Londji health Center

8/91 EPP inspection:

- Situation similar to Elog-Batindi
- COGE inactive
- COSA president abuses his privilege,  
e.g., personal use of mobylette, office in center
- Unauthorized, inappropriate expenditures
- COSA president buys drugs, keeps change

11/27/91 site visit:

- COGE inactive
- Only 4 "monthly meetings" since 1/91
- COSA president doing monthly closing for 7-10/91 when  
evaluation team arrived one day early
- No monthly expenditure planning
- Unauthorized, inappropriate expenditures
- Treasurer has deposited funds in his personal account  
status of funds is unknown
- Internal controls grossly inadequate

Bipindi Health Center

8/91 EPP inspection:

- Credit sales of approximately 50,000 FCFA
- Poor record keeping
- COGE has not met since 6/91

11/28/91 site visit:

- Cross-referencing not used
- No exceptions for indigents
- "Many who cannot pay no longer come"
- Credit sales to COSA, etc.
- COGE plans to take 5% of revenues
- Inventory reconciliation impossible because of credit sales
- No monthly expenditure planning
- Monthly closure procedures not used
- Reports incorrect
- COGE: "We do not understand the system"
- Internal controls not complied with

Province du Sud : Indicateurs sur la mise-en-œuvre du Projet

	NTEM								NTEM							
	Édipon Dépt	Hép	Ambou	Kye Dssi	Sangmelima Dépt	Hép	Benguir	Mekos	Kribi # Dépt	Hép	Elog- but.	Loalji	Lolo- dorf	Bi- pindi	Afag- bosa	NTEM Olohrze
Nbre Rapports Mensuels remplis complètement Jan-Oct →	NA	NA	NA	0	NA	NA	0	9	NA	NA	0	0	0	0	0	?
Nbre Rapports Trésoriers - Comptes d'exp. remplis Jan-Oct →	10	8	9	10	8	8	10	6	4	9	7	9	3-4	10	?	2
COSA officiellement reconnu juridiquement →	+	+	-	+	-	-	-	-	-	-	-	-	-	-	-	-
Compte bancaire ou postale →	+	+	+	-	-	+	-	-	+	+	+	-	-	+	+	+
Nbre Réunions du COSA depuis Janvier →	4	4	3	3	0	0	?	?	3	3	1	2	0	1	1	1
Nbre réunions COGE mensuelles de Olohrze (Jan-Oct) →	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Suivi du COGE/Annus de toutes procédures de contrôle →	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Fuites de fonds ou malversation (montant) →	1m				90.000				500.000			?	128.000	1	101.000	3
Ventes au crédit (montant) →							Oui				Oui	Oui	33000	50.000	-	Oui
Autres ventes des fonds récupérés →	50.000				90.000			500.000								
Ruptures de Stock-médicaments →	-	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Ruptures de Stock: Fiches-papierie →	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Réçu la supervision au moins 3 fois →	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
Nbre moyen/mois de nouveaux Cas Jan-Oct →	114	114	?	83	114	114	107	?	114	114	52	58	+	170	57	
Recettes moyennes par mois →											159,344	95,134		196,135		
Pharmacies Aménagées et sécuritaires	+	-	+	-	+	+	-	-	+	-	+	+	-	-	-	-
Depenses Médicaments/Depenses																

2 Tous le travail fait par Comris.  
 1 Différence entre solde à reporter et montant dans la caisse.  
 3 Manque de la caisse du trésorier.

NA = Non applicable

+ Pas de Rapports

ANNEX J: COMPILED LIST OF ALL RECOMMENDATIONS

It is recommended that:

1. USAID begin shortly to plan for a follow-on project that will extend cost recovery systems throughout the two provinces and provide assistance to the Government of Cameroon to strengthen its health institutions;
2. the project focus on larger systems development in the short term; when that essential component has reached an acceptable level, we recommend the project turn to extending its scope both in terms of increasing the number of health facilities participating in the cost-recovery system and in terms of expanding the capacity of health centers to deliver integrated quality health care;
3. the project develop and support methods for Ministry personnel to provide on-the-job training to reinforce the materials available from the seminars and documents. We recommend this training for all levels of health workers: from provincial teams to assist them with planning and management tasks; to health center nurses to assist them with their whole range of activities.
4. project staff reinforce their role as technical advisors and trainers when working with their counterparts and when carrying out analyses of project activities.
5. project and Ministry staff focus their activities on modifying modestly the information system and make it operational for data collection, transmission, and analysis. Specifically, we propose the following:

Data collection: Tailor the data collection instruments to the report form by improving format and use of curative care register (allow place for old cases so total center activity can be calculated); assure that there are appropriate data collection instruments for vaccinations, preventive consultations, and all outreach activities, as well as for logistics management (motos, vehicles, fuel).

Train health workers using the provincial and arrondissement supervisors to use data collection instruments and to fill out correctly reporting forms. Training of maximum 1-2 days followed by on-the-job training and supervision during the next month.

Supervise data collection twice a month for next three months; once a month for the following three months. After that, review of the information system should be a part of regular supervisory visits.

Make minor modifications in existing RMA-projet: We recommend that calculation of coverage be simplified; that a standard population denominator be used, preferably by carrying out the long-planned family censuses; Addition of a few indicators of logistics management (moto km. fuel) and all outreach activities.

Clarify and enforce transmission requirements: We recommend that centers not be delivered new shipments of drugs unless their reports are up-to-date and transmitted to the appropriate levels.

We recommend that health centers fill out three reports of which one stays at the center and one is destined for the provincial level. The destination of the third report depends on how the Ministry resolves the relationship of the departmental and arrondissement supervisors. Currently, the departments collect reports. This would be a useful level of analysis for Department-wide planning. If the Department's functions are to be phased out, then the arrondissement is the appropriate level.

Training for data analysis: We recommend on-the-job training for provincial teams, particularly DEPS representative; for the supervisory teams; and for the health centers to turn the data into useful tools. e.g. at health center level, training to graph coverage, medication utilization, analyze outreach activities.

On the job training in management decision making and problem-solving for the Provincial team: We recommend that the project provide more technical assistance to these teams to help them develop management skills to devise revised plans, order drugs, assess and carry out supervision; assess resource needs and allocations. These tasks should be undertaken by the provincial coordinator.

6. the development of a national information system not distract project and Ministry staff from laying the bases of a functioning information system in the two provinces. Resources other than this project should be sought to support the development of this much needed national information system. We support USAID's decision to provide long-term assistance to the development of this national system. When it is completed, it should be installed in the two provinces;

7. provincial funds be used to purchase RMA-projet reports and that they be provided free of charge to health centers.

8. supervisory and management systems receive immediate attention from Project and Ministry personnel. Specifically, we recommend that provincial and arrondissement supervisors receive on-the-job training to improve their capacity to supervise and train health workers; schedules for supervision need to be mandated and followed; content of supervision needs to be expanded; quality of supervision (attentiveness, knowledge) needs to be improved. These tasks should be undertaken with support from supervisors at the central level;

9. USAID continue to support the initiative of the World Bank in assisting the Government of Cameroon to reform the civil service.

10. the Project assist the Ministry of Public Health to review the system of incentives within the Ministry. A study of incentives should explore alternative ways of restructuring the "quote part" that could offer financial incentives also to health workers and not only to clinical physicians.

11. the Project assist the Ministry to study three organizational issues. These studies should be of the actual organizational patterns as they exist, identifying how and by whom activities are carried out and decisions are made. They should not be theoretical models: 1. The tasks and responsibilities of departmental and arrondissement teams to assess in what ways there is overlap and redundancy between them and to assist in making decisions as to the appropriate administrative level on which to focus supervisory and information gathering activity. 2. The tasks, responsibilities, and authority of physician chiefs and nurse coordinators in supervisory activities to assess how the latter can be more effectively supported in their work. 3. The tasks and responsibilities of the provincial teams, within the team and their supervisory relationship with departmental, arrondissement, and health center personnel;

12. in the provinces, at the operational level, Project activities and resources be more closely tied in with the Provincial team's activities, with the Project provincial staff serving under the Délégué as advisor to the entire Provincial team. We also recommend strongly that provincial teams be allowed greater flexibility in adapting the cost recovery model to the exigencies of the terrain without having to refer inevitably to the project's central direction. This recommendation, if followed, would also be in the interests of the Ministry's stated policy of decentralization;

13. USAID and the Ministry monitor closely the actual availability of the counterpart funds that the Ministry makes available for project activities at the provincial level. This should be done through quarterly reviews of the expenditures in the provinces, departments, and arrondissements;

14. the Project assist the Ministry immediately to begin studies on the legal status of the community health committees to assess what are their rights and obligations in managing funds; whether they have any obligations to the Ministry of Public Health under present statutes; what if any are their relationships with provincial development committees; what contractual relationships can such community organizations enter into. Such a study should end with an analysis of the options for the future status of these community committees. Should they be advisory, rather than management committees, giving the community the opportunity to have input into how funds are spent without having to deal with daily financial management?
15. the Project assist the Ministry to study the experience of community organizations in Cameroon. Have there been other successful organizations which have managed community funds? Under what circumstances? Is the cultural environment suitable for this model of community participation?
16. the Project and the Ministry move to a higher priority the aspect of quality of care and incorporate it into its supervisory policies. As a start, the supervisory protocols for integrated health care developed by the Project in 1989, should be reviewed to see what can be usefully applied. We recommend that the Project, when it trains, do so with integrated and not vertical programs. We also recommend that diarrheal disease control training, which has been amply ventilated in the two provinces, be of low priority except in supervisory visit training when it is necessary;
17. rather than launching a second wave all at once, the Project and Ministry proceed pragmatically and assure first that all conditions are met before a health center is brought into the cost-recovery system. These conditions should include first an analysis of the center's potential viability based on its population and the number of new cases it had during the preceding year as well as potential competition from private centers. This analysis should be carried out by provincial team members with assistance from the Project staff;
18. conditions precedent for a second wave center also include:
- renovation and security of pharmacy;
  - well trained supervisory team;
  - active and well trained health and management committees and pharmacy clerk;
  - bank or postal accounts;
19. Project staff, USAID, and the Ministry carefully review stated end of project objectives and revise them to conform with the reality of what can be attained;

20. the Project take immediate steps to resolve the drug resupply problem. The MOPH should proceed with plans to train provincial staff in international procurement procedures as soon as possible. The project must closely monitor the initial implementation of these new procedures to ensure that procurement is proceeding as planned. The system should maintain the capability to procure drugs and supplies from the least expensive and most reliable source, whether the supplier is domestic or foreign;
21. because of inevitable delays in international procurement, the project should consider either (a) converting the provincial depots into facilities with permanent inventories or (b) expanding the role of the departmental depots in Ngaoundere and Ebolowa. At a minimum, the latter could carry a buffer stock of the most critical and most frequently used drugs, which could then be sold as needed to other departmental depots in order to minimize the probability of stock outages. Because the establishment of provincial depots would permit more rapid processing of departmental requisitions, the project should completely reassess and if necessary revise the reorder cycle and the stock levels required at each level. And if it proves necessary to increase the initial stock of drugs at the depots and at the pharmacies, and if it is decided to postpone all or a portion of second wave implementation, some drugs intended for these facilities could be used for this purpose;
22. the project compile essential drug lists more appropriate for hospitals at all levels. The MOPH should explore the possibility of changing the law restricting hospital drug sales to inpatients. The project should also give greater attention to improving prescriptive practices through the adoption of standardized treatment protocols or guidelines, providing training in their use and the promotion of more effective clinical supervision;
23. the project insist that all sites have bank or postal accounts. Future sites should not be allowed to participate in the project prior to establishing such accounts. The project should require the timely deposit of collections and minimize the number of cash transactions through the use of checks or postal money orders, especially at the departmental and provincial levels, where large sums are involved;
24. the project complete the hiring of a financial analyst as soon as possible since these skills are urgently needed. The project should also take steps to develop financial management expertise within the MOPH at the provincial, departmental and the arrondissement levels in order to enhance technical oversight of cost recovery activities to the extent possible;
25. treasurers be selected on the basis of their technical expertise. The project should recognize their dual role as COGE member and as financial manager of the pharmacy. It may be appropriate to provide some compensation for the latter;

26. the Project consider simplifying the composition of the committee prescribed for the monthly meeting since there is no evidence that such a meeting has ever taken place. If possible monthly meetings and supervisory visits should be planned to permit attendance by the supervisor. The monthly meeting must include a reconciliation of financial documents and cash on hand;
27. the Project consider alternatives for enforcing compliance with the monthly closure and reporting procedures through the imposition of positive and/or negative sanctions. One possibility would be to require that drug requisitions be accompanied by evidence of such compliance;
28. HIID analyze the operation of the current accounting system and take steps to simplify it to the extent possible while incorporating adequate provisions for internal control. The resulting system must be easier to understand and its procedures easier to follow than the current system; e.g., eliminating the operating statement (Compte d'Exploitation) which is poorly understood, incorrectly prepared, and not used for Project management as originally intended;
29. the Project utilize such revised reports to analyze cross-sectional differences in health facility utilization, drug consumption and financial status, etc., as well as to monitor trends in such indicators over time in order to identify potential problems and to intervene as may be appropriate;
30. the Project review its current system of charges. If the project retains the curative consultation fee, or some version thereof, it should collect it in conjunction with the sale of drugs. This would minimize opposition to the fee and reduce the number of financial transactions by nearly 50%. The schedule of charges needed within a system of fully integrated care should also be examined and simplified if possible;
31. in keeping with the spirit of the Bamako Initiative, the Project should consider adopting guidelines for local policy regarding indigent care which earmarks a percentage of revenues to finance the care of those who truly cannot pay;
32. the Project improve performance of health center personnel by increasing IEC activities on interpersonal relationships through production of videos (or other demonstrative methods such as battery operated viewing machines) to be circulated to the health centers;
33. after the drug supply issue is resolved and the centers are functioning more efficiently, increase community IEC activities (using the promotional video when possible) in those areas where the new health care delivery system is operational;

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34. the Project continue ongoing monitoring of community's opinions about health services through focus groups or family sentinel surveillance activities;
35. the Project continue to increase the provincials' roles in IEC activities;
36. the Project review all IEC messages to ensure that they are uniform and in harmony with the policies of the new health care system;
37. since considerable and valuable data has been collected through operational research, emphasis should now be placed on improving routine day-to-day collection of data for effective management of the new health care delivery system;
38. to help assure sustainability, the project should consider scaling down cost recovery targets to more realistically reflect the current economic situation, and to re-examine and set priorities for activities to be financed through cost recovery, since revenues may be insufficient to cover all activities currently planned. This is a complex process and will require considerable systematic planning and management;
39. for the sake of new health care service sustainability, USAID should support World Bank efforts to assist the Government of Cameroon to achieve public sector reform;
40. if USAID continues in the university collaboration mode for the proposed follow-on assistance to the MOH's new health care delivery system, sub-contracting with a HBCU is not only desirable but mandatory when the overall contract exceeds \$500,000. The universities, however, should be able to effectively draw on their academic and research strengths to support the proposed assistance.