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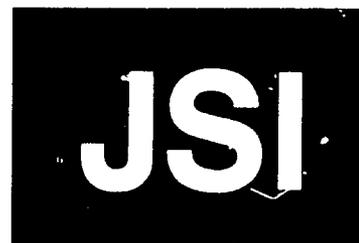
EVALUATION OF THE REFORM OF THE HEALTH DELIVERY SYSTEM PROJECT (RHDS)

Project No. 631-0072

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The team also acknowledges the hard work of the health center personnel and the members of the health and management committees in making primary health care services more accessible and available to the population of Cameroon.

EXECUTIVE SUMMARY

1. **Mission/Evaluation Title:** USAID/Cameroon, Reform of the Health Delivery System (RHDS), (Project No. 631-0072), Project Evaluation, April 1993.

2. **Purpose:** The goal of RHDS is to reduce infant, child and maternal mortality in selected areas of Far North Province by strengthening the health system to provide effective and sustainable services to women and children. RHDS is to implement the MOPH reorientation of primary health care (RPHC) strategy to:

- integrate preventive, curative and promotive services;
- assure continuity of care;
- decentralize health planning to the health district level;
- develop health areas each having a fully equipped health center;
- initiate cost recovery for the variable recurrent costs associated with PHC;
- establish a training of trainers approach to supervision and training; and
- promote community dialogue structures (health & management committees).

The **objectively verifiable indicators** for RHDS include:

- 30 community co-financed and co-managed health centers;
- a functional system for essential medicine management and supply;
- cost recovery systems operating in 30 health centers;
- a standardized health information system (HIS);
- a coordinating mechanism for PHC providers (public, private and government);
- vaccination coverage of 80% for BCG; 60% for measles, DPT, Polio; 30% Tetanus;
- prenatal and referral services provided in 80% of the health centers;
- family planning services provided in 60% of the health centers; and
- case management of diarrhea in 80% of health centers, growth monitoring/nutrition services in 70% of health centers; and 40 communities provided with safe water.

3. **Evaluation Purpose and Methodology:** The major objectives of this evaluation are 1) to assess project progress in implementing the MOPH's RPHC program and in attaining the expected project outputs, and 2) to assess the overall capability of Save the Children (SAVE) and CARE International in implementing and institutionalizing the RPHC program in the Far North Province. A team of four evaluators reviewed project documents; interviewed project and MOPH staff; visited five project-assisted, two church-supported, and one non-assisted health centers; and interviewed health committees and health center management committees.

4. **Findings and Conclusions:** The evaluation team found that RHDS got off to a slow start due to changes in key project personnel, poor coordination between SAVE and CARE, a project revision to align it with RPHC, a lack of a clear definition of health districts, confusion and delay in the procurement of medicines, one cholera and two meningitis epidemics, and the lack of an MOPH delegate for much of 1992. During the past year, however, RHDS has resolved most of these problems and established twelve functional co-financed and co-managed health centers. The comparison between project-assisted and non assisted health centers is dramatic. SAVE and CARE have demonstrated their capability to implement the RPHC strategy. The table on the next page summarizes project achievements.

5. **Recommendations:** The evaluation report is "recommendation driven." Recommendations are grouped by health systems development, health services development, and project management. Each recommendation is followed by a discussion of Findings and a description of Recommended Actions for its implementation. Recommendation 1.1, concerning the development of health districts, is the principle recommendation with broad action implications.

RHDS ACHIEVEMENT OF PROJECT OBJECTIVES

| PROJECT OBJECTIVES | LEVEL OF COMPLETION |
|--|--|
| #1: 30 community co-financed and co-managed health centers | <ul style="list-style-type: none"> ● 12 health centers functioning; ● 13 more centers ready for medicines ● no functional health districts ● need to consolidate into health districts before assisting additional health centers ● need for health center renovation by the COSA ● need for some additional equipment for some health centers from RHDS |
| #2: a functional system for essential medicine management and supply | <ul style="list-style-type: none"> ● drug management systems functioning ● most centers with outages of 3-5 drugs ● SAVE mini-depot functioning for all centers ● resupply of depot possible from Ngaoundere ● provincial depot to begin 1994 with CIM/SESA ● need for improved inventory control |
| #3: cost recovery systems operating in 30 health centers | <ul style="list-style-type: none"> ● cost recovery systems functioning ● improved control of finances required ● need to respect COSA & COGE autonomy |
| #4: an operational standardized health information system (HIS) | <ul style="list-style-type: none"> ● supervision and reporting systems functional ● supervision forms overly complicated ● supervision is primarily a control measure ● need to increase training aspect of supervision ● need to supervise outreach activities ● HIS should encourage health center analysis |
| #5: a coordinating mechanism for PHC providers (public, private and government) | <ul style="list-style-type: none"> ● Consortium approach was not effective ● Ad Hoc committee approach recently begun ● Need to coordinate at health district level ● Need to involve more private health centers |
| #6: vaccination coverage of 80% for BCG, 60% for measles, DPT, Polio, & 30% Tetanus | <ul style="list-style-type: none"> ● Maintenance of cold chain system is good ● Vaccination delivery system is good ● Estimated coverage of 50-60% ● Reporting system requires some fine-tuning |
| #7: prenatal and referral services provided in 80% health centers | <ul style="list-style-type: none"> ● Prenatal clinics functional in 12 centers ● Prenatal care is good drawing card for centers ● Maternity facilities need renovation by COSA ● need to diversify IEC methods |
| #8: family planning services provided in 60% of health centers | <ul style="list-style-type: none"> ● Family planning service only at Provincial Hop ● FP start-up planned for 1994 with Nat'l Family Health Project in 1994 (hospital and health center) |
| #9: case management of diarrhea in 80% of health centers, growth monitoring/nutrition services in 70% of health centers; and 40 communities provided with safe water | <ul style="list-style-type: none"> ● Case management of diarrhea is good ● ORS acceptance varies from center to center ● Growth monitoring/nutrition adequate ● IEC too dependent on use of flip-charts ● 33 of 40 community water systems completed ● some health centers without good water supply |

SUMMARY OF RECOMMENDATIONS

1. HEALTH CENTERS AND HEALTH DISTRICTS: Create at least two functional health districts around functional reference hospitals and health centers.

Twelve operational co-managed, co-financed health centers have been assisted by RHDS. The direct contact and supervision by RHDS with health centers, though justified given the circumstances, has created the impression that these health centers are part of a SAVE or CARE program, rather than part of a health district system. There are currently no functional health districts in the Far North, but there are several functional hospitals which could quickly become operational as health districts. RHDS should place a priority on the creation of functional health districts, before assisting additional health centers.

- Define the components of a health district based on national guidelines.
- Establish criteria for developing a functional health district.
- Reexamine (and reduce) the number of health districts for the province.
- Provide short-term in-country training for key health district personnel.
- Give the district the authority to manage its personnel on a trial basis.
- Develop long-term and short-term action plans for the health district.
- Take advantage of in-country experience in development of health districts.
- Establish a management structure (COSADI) adapted to the health district.
- Emphasize health district identity and management autonomy.
- Strengthen management and supervision systems of health districts.
- Focus RHDS (and provincial) supervision at the health district level.
- Transform RHDS coordinators into health district or project supervisors.
- Integrate church health centers into the districts sooner rather than later.

2. PROVINCIAL DEPOT AND LOGISTICS: In conjunction with MOPH, CIM and other donors, formulate and implement an action plan for establishing the provincial depot while continuing to use the SAVE/CARE mini-depot to resupply health centers. Improve the operation of the current drug distribution and inventory control system.

Delays have been encountered in the establishment of the provincial drug depot and in obtaining an initial stock of drugs for the health centers. As an interim measure, a SAVE/CARE mini-depot has been established to supply project-assisted health centers. Health committees are quite content with the current availability of medicines.

- Adapt CAPP system strategies from project SESA.
- Resupply the SAVE/CARE mini-depot by pooling drug orders with other agencies.
- Revise the journal to include daily drug consumption.
- Update stock cards daily for better control.
- Monitor drug consumption and inventories more closely.
- Phase in use of the Qmax-Qmin reordering system.
- Document modified procedures.
- Train staff in the use of the new procedures.
- Improve supervision to ensure that procedures are followed.

3. COST RECOVERY: Modify the accounting system to eliminate major weaknesses and to improve compliance with financial management procedures through more effective supervision.

There is a cost recovery system operating in 12 co-managed, co-financed health centers. Health center management committees are very active. A fee schedule has been introduced and a financial management system is in place, but contains deficiencies in financial planning, inadequate internal controls, and lack of compliance with accounting procedures.

- Improve financial management via short term TA, training & project visits
- Continue development of the cost-based pricing system.
- Consider eliminating the consultation fee.
- Assist COSA's formulate policies regarding indigent care.
- Improve cash handling practices.
- Assure daily reconciliation of cash and receipts.
- Modify the accounting system to ensure tighter control.
- Document the new procedures.
- Train staff in the use of the new procedures.
- Improve supervision to ensure that procedures are followed.
- Encourage and assist COSA's and COGE's continue fulfilling their role.

4. TRAINING & CONTINUING EDUCATION: RHDS should reinforce supervision with continuing education while giving priority to training pilot health district teams.

RHDS has done a good job at providing the basic training required in the principles of primary health care, co-financing and co-management. However, in-service training during supervision visits should be strengthened. RHDS should build on this training to:

- Use each supervision visit as an opportunity for continuing education.
- Give highest priority to training health district supervision/training teams.
- Provide orientation/training for provincial health personnel.
- Use health center personnel and COGEs as resources for provincial training.
- Facilitate RPHC discussion/training for reference hospital personnel.
- Assure availability of materials/equipment to implement training skills.

5. HEALTH INFORMATION SYSTEM: Enhance the HIS system to permit and encourage health center analysis of information.

A standardized HIS is operating in 12 health centers. Baseline data has been collected and used effectively. A family registration system is in place, however, is not updated regularly. Monthly reporting compliance appears excellent. The monthly report of activities (RMA) is overly detailed. Obvious errors in reporting and inconsistencies with supervision reports are not always resolved.

- Test the usefulness of family registration in a few health centers.
- Revise HIS forms/strategy to encourage charting and interpreting summary indicators.
- Distinguish between registered and non-registered population in the HIS.
- Identify a few key indicators for health center analysis and tracking.
- Include review of the RMA's as part of the supervision visit.

6. SUPERVISION SYSTEM: Simplify the supervision protocols by using "supervision by exception."

Project staff are using supervision protocols to supervise the health centers of a regular basis. While the technical approach used in the protocols is sound, the system is overly complicated and could be streamlined by using a strategy of "supervision by exception." Supervision was perceived as supervision/control rather than as a supervision/training.

- Check equipment once or twice a year, not monthly.
- Increase financial supervision.
- Include a visit to an outreach activity as part of each supervision visit.
- Put more emphasis on the actions to be taken and their follow-up.
- Encourage an operations research approach by the health center.
- Encourage an attitude of in-service training by the supervisor.

7. IEC AND COMMUNITY DIALOGUE: RHDS should diversify its methods of IEC, community dialogue and outreach.

RHDS has successfully transmitted to the population the concepts of co-financing and co-management and mobilized COSA and COGE to manage health centers. RHDS needs to use IEC to enlarge the definition of "REO" beyond the sale of medicines. IEC techniques at the health center and at during outreach appear to be too heavily dependent on flip-charts. To expand this strong foundation of community participation RHDS should:

- Diversify approaches to IEC to decrease dependence on flip-charts.
- Expand outreach activities to include more than vaccinations.
- Obtain copies of IEC materials from sources like Zaire, TALC, etc.
- Reinforce community dialogue as a long-term development activity.
- Emphasize PHC components of RPHC in discussions at all levels.
- Experiment with non-monetary strategies to motivate health personnel.

8. IMMUNIZATIONS: RHDS should further improve vaccination coverage by clarifying reporting, monitoring and logistics procedures.

RHDS has significantly improved maintenance of the cold chain and the delivery of vaccinations through a mix of fixed and outreach sites. All health centers have established monthly objectives for vaccinations, however, most centers are including children from outside their health area in their reports. In order to further improve vaccination coverage RHDS should:

- analyze different strategies to optimize vaccination coverage
- establish a supply of frig. spare parts at the provincial depot or health district
- teach health center nurses to calculate and graph vaccination coverage
- help the MOPH develop a strategy for transport of vaccines from Yaounde

9. MATERNAL CARE & FAMILY PLANNING: RHDS should reinforce IEC and family planning at prenatal clinics and district hospitals.

There is an excellent participation in pre-natal clinics in almost all health centers. RHDS needs to use the popularity of the CPN as a once-in-a-pregnancy opportunity for IEC in maternal child health and family planning.

- Study the CPN patient flow to identify opportunities for increased IEC.
- Integrate family planning and NFH resources into the RHDS action plan.
- Establish full-service family planning at health district hospitals.

10. ENDEMIC DISEASE CONTROL & WATER/SANITATION: RHDS should continue to promote home solutions for treatment of diarrhea and search for ways to improve access to clean water.

The number of cases of diarrhea seen at the health center varies from 2-3 to 30-35 per month. This variation is due to the preference for treatment at home using a sugar-salt solution (SSS). Treatment protocols appear to be respected at the health center. Several health centers do not have good access to water because of dry wells. Every health center should have a good source of water and a VIP latrine.

- Continue IEC promotion of home treatment of diarrhea.
- Look for innovative IEC (like SSS songs) for combatting diarrhea.
- Pursue water and sanitation initiatives in community participation.
- Assist COSA in pursuing the drilling of functional village wells.
- Encourage COGE to build a demonstration VIP latrine at each health center.
- Encourage COGE to consider the rain catchment systems for some health centers.

11. TECHNICAL ASSISTANCE: RHDS should take a more assertive role in seeking opportunities for in-country and out-of-country visits to other projects and in obtaining technical assistance.

The technical capability of RHDS directors is quite good but needs to be complemented with help in specific areas. Neither SAVE nor CARE have provided sufficient short-term technical assistance or visits to other primary health care projects.

- Send RHDS directors to PHC conferences and to visit other projects.
- Organize visits to other programs for health district medical chiefs.
- Take more initiative in obtaining short-term technical assistance.

12. COORDINATION OF PARTNERSHIPS: RHDS and the Provincial Delegation should encourage coordination of partnerships within the health district, by provincial commissions, and by quarterly primary health care reviews.

RHDS internal and external collaboration has improved remarkably during the past year. The coordination consortium (CAISP) originally established by RHDS made other potential partner agencies hesitant to participate and was perceived as a second provincial delegation. RHDS and the provincial delegation have adopted a "commission" approach for coordination which appears to be functional. Given the renewed focus on health districts, it is important to recognize that a great deal of coordination must be encouraged at that level.

- Use the health district a focus and mechanism for coordination.
- Continue commissions rather than permanent committees.
- Set a cycle of PHC meetings with the health delegate.

13. ALLOCATION OF PROJECT RESOURCES: RHDS should reassess its current and extended resource allocation to maximize the percentage of resources invested in health systems (health districts and health centers).

The original RHDS project proposal was primarily to implement selected child survival interventions rather than health system development. Only about 10% of the original budget of RHDS (excluding local salaries) went to health system development. RHDS should prepare an action plan and revised budget to take into account the priority to create two functional health districts, and re-examine whether project resources will be sufficient to realize the objective of 30 functional health centers by the end of the project.

- Assess how many health districts could quickly become functional.
- Reassess the number of health centers to assist given current resources.
- Prepare a action plan/budget (OPG + matching funds) by June 1, 1993.
- Divide budgets by health system development and project management.
- Complete phasing out project supported salaries to animators/supervisor.
- Transform RHDS coordinators into health district or project supervisors.

ACRONYMS AND ABBREVIATIONS

| | |
|----------|--|
| ADRA | Adventist Development and Relief Agency |
| ARI | Acute Respiratory Infections |
| BCG | Vaccine for Tuberculosis |
| CAPP | Centre d'Approvisionnement Pharmaceutique Provinciale |
| CARE | Care International |
| CIAME | Centre d'Interimaire et Approvisionnement des Medicaments Essentiels |
| CIM | Centre d'Institute Medical of Belgian medical cooperation |
| COGE | Comité de Gestion / Management Committee |
| COSA | Comité de Santé / Health Committee |
| COSADI | Comité de Santé du District/ Health District Committee |
| CPN | Pre-Natal Clinic |
| DFMH | Directorate of Family and Mental Health |
| DMPR | Directorate of Preventive Medicine and Rural Health |
| DPT | Diphtheria, Pertussis, and Tetanus Immunization |
| EC | European Community |
| FCFA | Franc de la Communauté Financière Africaine (Cameroon currency) |
| GTZ | German Technical Cooperation |
| HA | Health Area |
| HMIS | Health Management Information System |
| HPN | Health, Population and Nutrition (office in USAID) |
| IEC | Information, Education, and Communication |
| JSI | John Snow International |
| LOP | Life of Project |
| MAR | Monthly Activity Report |
| MCH | Maternal Child Health |
| MOPH | Ministry Of Public Health |
| NFHP | National Family Health project |
| NGO | Host Country Non-Governmental Organization |
| ONAPHARM | National Office of Pharmaceuticals |
| OCEAC | Organisation de Coordination Pour La Lutte Contre les Endemies en Afrique Centrale |
| OPG | Operational Program Grant |
| ORS | Oral Rehydration Solution |
| ORT | Oral Rehydration Therapy |
| PACD | Project Activity Completion Date |
| PHC | Primary Health Care |
| PHD | Provincial Health Delegate |
| PVO | International Private Voluntary Organization |
| RHDS | Reform of the Health Delivery System project |
| RPHC | MOPH Reorientation of Primary Health Care policy |
| SAVE | Save the Children Federation |
| SESA I | Soins d'Enfant Sud et Adamaoua (MCH/CS I) |
| SESA II | Santé dans l'Extreme nord, Sud et Adamaoua (MCH/CS II) |
| SSS | Sugar-salt home-made oral rehydration solution |
| TA | Technical Assistance |
| UNICEF | United Nations International Children's Emergency Fund |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |

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Chapter I. INTRODUCTION

A. PROJECT BACKGROUND

In August 1990 USAID approved a three year \$2.6 million Operational Program Grant (631-0072) to Save the Children Federation (SAVE) and CARE International (CARE) to "strengthen the capacities of both community and public and private health services in the delivery of primary health care to mothers and children in the Far North Province of Cameroon." The goal of the Reform of the Health Delivery System (RHDS) project was to reduce overall child and maternal mortality in four departments of the Far North by developing the program areas of five child survival interventions, health care financing, health planning services delivery, and program management and coordination.

The project was redesigned in 1991 to bring it in line with the new Ministry of Public Health (MOPH) policy of Reorientation of Primary Health Care (RPHC) which encourages local communities to take greater responsibility for their health care through cost recovery and co-management of health centers. Specifically the project's centralized, vertical approach needed to be replaced by a decentralized, integrated strategy focused on improvement of health systems and community involvement in the management of health care. In addition, the decreasing MOPH budget available for rural health meant that the cost recovery component of the project needed to be significantly expanded.

B. PROJECT GOAL, PURPOSE, AND INDICATORS

The **goal** of RHDS is to reduce infant, child and maternal mortality in four departments of Far North Province.

The stated **purpose** of RHDS is to strengthen the health system so that it provides effective and sustainable services to women and children. This is to be accomplished by implementing, in four departments of the Far North, the following MOPH's RPHC strategy:

- PHC will include the integrated delivery of preventive, curative and promotive services rather than be limited to the implementation of selected child survival interventions. Services will be organized to assure the continuity of care.
- Health **care** planning will be de-centralized to the health district level.
- Activities will be concentrated in project-supported health areas each having a fully equipped health center.
- Cost recovery will aim to recover many of the variable recurrent costs associated with the delivery of PHC.
- Supervision and training will be conducted in the following pyramidal fashion: from the province to the department, from the department to the health districts, from the health districts to the health centers; from the health centers to the village health posts

- Dialogue structures (health committees and health management subcommittees) will be developed to permit the community co-management and co-financing of PHC.

The **objectively verifiable indicators** related to the project purpose and RPHC implementation strategy are:

- #1- Thirty community co-financed and co-managed health centers in the four targeted Far North departments are operational in accordance with the national RPHC strategy
- #2- A provincial drug supply depot and logistical operating system in place for the four project-supported departments
- #3- A model cost recovery system operating in 30 health centers
- #4- A standardized health information system (HIS) operating in 30 health areas
- #5- A coordinating Consortium of PHC providers (public, private and government) functioning in the Far North province
- #6- Vaccination coverage rates in the 30 health centers of 80% for BCG, 60% for measles, DPT3, Polio3, and 30% Tetanus Toxoid
- #7- Adequate prenatal and referral services provided in 80% of the health centers
- #8- Adequate family planning services provided in 60% of the health centers
- #9- Adequate case management of diarrhea provided in 80% of health centers, growth monitoring services and nutrition education and referral services provided in 70% of health centers; and 40 communities provided with safe water supply.

C. EVALUATION OBJECTIVES

The detailed scope of work for this evaluation is included as Annex E. The major purposes of this evaluation are to assess:

- 1) project **progress** in achieving its stated objectives
- 2) project **progress** in implementing the MOPH's RPHC program
- 3) the overall capability of SAVE and CARE in implementation of the RPHC

Specific questions related to this purposes are to assess:

- whether the MOPH's RPHC program is appropriate for the Far North;
- the overall effectiveness of project-assisted health centers;
- public and health worker acceptance of the RPHC program;
- project's medical supply system;

- the cost recovery system;
- the quality of supervision and health information system;
- the effectiveness of the project's child survival interventions;
- the project's information, education and communication (IEC) program;
- the effectiveness of community-based PHC activities;
- the project's role in MOPH efforts to control epidemics;
- plans for developing viable health districts; and
- the quality and effectiveness of technical assistance and coordination by SAVE and CARE with each other and with the MOPH and other partner agencies.

D. TEAM COMPOSITION AND METHODOLOGY

The evaluation team consisted of four persons - two consultants contracted by USAID through John Snow, Inc. (JSI), one representative from the MOPH Direction of Preventive Medicine, and one representative from the Far North Provincial Delegation.

The team spent two days in Yaounde reviewing the evaluation scope of work, meeting with partner agencies, and in preparing the evaluation methodology. Twelve days were spent in the Far North Province. The evaluation team reviewed project documents, met with MOPH, SAVE and CARE representatives, interviewed project managers, held discussions with health committees (COSA) and health center management committees (COGE), and made site visits to project-assisted and non-assisted health centers. The following facilities were visited:

- two health centers assisted by SAVE (Mindjivin and Moutourwa)
- three health centers assisted by CARE (Mozogo, Kerawa, and Mémé)
- one public non-assisted health center (Damav)
- two private non-assisted health centers (Lara and Djinglia)
- one private hospital proposed as a district hospital (Koza)
- two departmental supervision offices (Mokolo, Mora)

Based on the findings, a list of recommendations, observations and recommended actions was prepared by the team and reviewed in a joint meeting attending by USAID, MOPH, SAVE and CARE representatives. Briefings were also held with USAID and the MOPH in Yaounde. A completed first draft was reviewed with USAID and revised before the team's departure.

The team decided that the evaluation should be "recommendation driven." This approach begins with a succinct recommendation, follows with discussion of the Findings which led to the recommendation and concludes with Recommended actions to facilitate the implementation of the recommendation. Recommendations are grouped by health system development, health services development, and project management.

Chapter II. EVALUATION FINDINGS AND RECOMMENDATIONS

A. HEALTH SYSTEM DEVELOPMENT

Recommendation 1: HEALTH CENTERS AND HEALTH DISTRICTS: Create at least two functional health districts around functional reference hospitals and health centers.

Findings:

Twelve operational co-managed, co-financed health centers have been assisted by RHDS. The lack of a clear definition of health district by the MOPH prevented RHDS from creating functional health districts. The direct contact and supervision by RHDS with health centers, though justified given the circumstances, has created the impression that these health centers are part of a SAVE or CARE program, rather than part of a health district system.

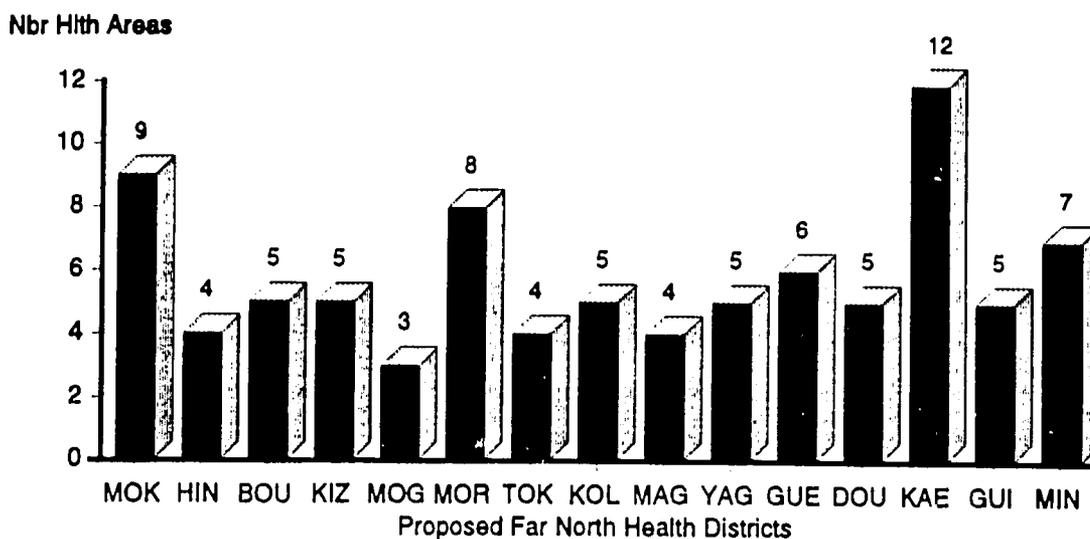
There are currently no functional health districts in the Far North, but there are several functional hospitals which could quickly become operational as health districts. RHDS should place a priority on the creation of functional health districts, before assisting additional health centers. The ideal health district should include:

- a clear definition on decentralization of authority and responsibility;
- a delimitation of responsibility by defined geographical zone;
- a local capacity for planning related to epidemiology and social conditions;
- integration of all health activities for individuals, family and environment;
- a definition of an information system, referral and counter-referral;
- a capacity for training and continuing education of all health personnel;
- intersectoral coordination with education, economy, and civil works;
- intrasectoral coordination of state and NGOs to promote efficient coverage
- promotion of community dialogue and participation

The RPHC strategy called for health districts at the arrondissement level, but because many arrondissements have catchment populations of less than 10,000, the development costs of a reference hospital and health district for each arrondissement were considered to be too high.

The Bertoua seminar of July 1992 proposed the delimitation of 123 health districts consisting of one or more arrondissements. This included a proposition of 15 health districts for the four departments of the Far North assisted by RHDS. The current proposal is that these 15 health districts would comprise 87 health centers or approximately 6 health centers per health district (see graph on page 5). In comparison South Province plans for six districts with an average of 18 health areas per health district while Adamaoua Province's six districts would have an average of 13 health areas per district. This raises the question of whether it is a good use of resources to establish a reference hospital and supervision team for a health district comprising only 3 or 4 health areas even if the total population is more than 50,000. Given the high population density and the relatively good road infrastructure of the Far North, it would be easier, and more cost effective, to develop one health district comprising 10 health centers, rather than two districts of 5 health centers. The provincial delegation and RHDS should re-examine the number of health districts planned for the Far North and, assuming geography and infrastructure permits, reduce the number of health districts.

NUMBER OF HEALTH AREAS FOR FAR NORTH HEALTH DISTRICTS



as part of the health district. A third seminar is planned to discuss the organization of the health district team. Such seminars are important to provide general guidelines and demonstrate national support for the health district concept. However, national seminars should not, at this stage in the development of health districts, attempt to standardize the components and management structures. This would simply reinforce the existing centralized control by the MOPH and discourage the creation of decentralized health districts.

Wisely, however, the Bafoussam seminar recommended that each partner agency should strive to create at least one functional health district. The implementation of this recommendation, which equates with Recommendation 1 of this evaluation, will encourage the development of several health district models rather than impose one model from the national level. This will place the initiative for developing health districts where it belongs, and if accompanied by a delegation of authority in management of personnel and finances, will permit the health district concept to become firmly established. RHDS can play an important role in this process by creating at least two functional health districts during the next year.

Recommended Actions:

- Define the components of a health district based on national guidelines.
- Establish criteria for developing a functional health district.
- Reexamine (and reduce) the number of health districts for the province.
- Provide short-term in-country training for key health district personnel.
- Give the district the authority to manage its personnel on a trial basis.
- Develop long-term and short-term action plans for the health district.
- Take advantage of in-country experience in development of health districts.
- Establish a management structure (COSADI) adapted to the health district.
- Emphasize health district identity and management autonomy.
- Strengthen management and supervision systems of health districts.
- Focus RHDS (and provincial) supervision at the health district level.
- Transform RHDS coordinators into health district or project supervisors.
- Integrate church health centers into the districts sooner rather than later.

Recommendation 2: **PROVINCIAL DEPOT AND LOGISTICS:** In conjunction with MOPH, CIM and other donors, formulate and implement an action plan for establishing the provincial depot while continuing to use the SAVE/CARE mini-depot to resupply health centers. Improve the operation of the current drug distribution and inventory control system.

Findings:

2.1 The Depot. Delays have been experienced in the development of the provincial drug depot and in obtaining an initial supply of drugs for the health centers. At Rhumsiki in September 1991, all parties agreed that while the project would provide health centers with their initial stock of drugs, the MOPH Provincial Health Delegation would assume responsibility for setting up a provincial drug depot.

Lack of progress to date in establishing the depot and the lack of funds for the purchase of drugs have been the source of constant concern. The latter problem appears to be at least partially resolved by the commitment of the European Community (EC) to assist in developing the depot by providing drugs and technical assistance through CIM. However, this process will take several months. According to one member of the Provincial Health Delegation and other key personnel, the new system may not be operational until the Spring of 1994.

2.2 The Initial Drug Supply. The project experienced serious problems in obtaining its initial supply of drugs under the OPG grant. In December 1991, shortly after the OPG was restructured at Rhumsiki, the project submitted a drug order intended to supply 20 health centers to the International Dispensary Association (IDA). This order was subsequently cancelled because it did not comply with USAID procurement policies. After negotiations with USAID contracts officer, the project was allowed to submit its order to UNICEF. This "initial drug order" has recently arrived, nearly 18 months after the original submission.

In response to mounting community pressure, the project utilized "matching" funds private funds to procure some drugs through GTZ and in September 1992, opened eight of the twenty health centers originally scheduled to open in January 1992. An additional four centers became operational in January 1993. As an interim measure, SAVE has set up a small depot to resupply its centers while CARE-assisted health centers have been resupplying themselves through local sources, LABOREX and PHARMACAM. The latter have recently started to purchase drugs through the mini-depot. It is planned that the mini-depot will start to resupply itself through Ngaoundere in order to obtain drugs at lowest cost. RHDS will phase out the mini-depot when the provincial depot becomes fully operational.

2.3 The Drug Supply System.

a. The Essential Drugs List. The formulation by the project of an essential drugs list is an important first step in improving prescriptive practices since it indirectly discourages the use of drugs not on the list. Studies conducted by SESA have revealed some serious problems in prescriptive practices, including the use of inappropriate medications for certain illnesses and over-prescribing in others. Differences in average drug costs per case among health centers with similar caseloads in SESA and in this project indicate that staff training in the use of essential drugs and in the use of therapeutic guidelines may be necessary to rationalize drug prescription.

b. Storage. Drug storage facilities were adequate in most health centers visited. The pharmacies were reasonably clean and orderly, with adequate provisions for security. Drugs were arranged in alphabetical order and expiration date as prescribed by policy. However, the drug storage area at the MOZOGO health center was extremely hot because of poor ventilation. Staff agreed to install vents to improve air circulation.

c. Initial Drug Stock. According to various project estimates, initial health center drug stocks of about three months would permit a bi-monthly resupply cycle with a one month buffer stock. The depot inventory should be equivalent to estimated consumption during a 3-6 month period. Thus, a minimum drug stock of 6 months is needed. Because initial stocks were below this level, health centers must resupply themselves 1-2 times per month. This problem was exacerbated during the first months of operation when utilization was considerably higher than anticipated. By contrast, centers which have received drugs donated by the Japanese find themselves with an excess supply of certain products. Unless some way of redistributing these products can be found, they could become outdated before they are utilized.

d. Inventory Control. In all facilities visited, the drug clerk updates inventory control cards on a weekly basis, with positive or negative entries made on all cards. A random check revealed close correspondence between stock on hand and quantities shown on the inventory control cards. However, tracking drug utilization is a tedious process because the inventory control system lacks a daily drug consumption journal. To their credit, all drug clerks had fashioned make-shift forms for computing drug consumption. In some cases, these forms were destroyed after use, thereby making verification difficult. The use of a combined cash journal/drug consumption record would provide better documentation, permit daily updating of inventory control cards and ensure tighter control.

e. Resupply. As described above, initial stock levels were inadequate to permit health centers to adopt a two month resupply cycle as had been planned. As a consequence, health centers obtain supplies 1-2 times per month. Because of small buffer stocks and delays in requisitioning drugs, most health centers visited were out of 3-6 drugs out of a total of about 30 items. While maximum and minimum stock levels were specified on most inventory control cards, it was evident that the Qmax, Qmin system is not being used effectively.

f. Emergency Drugs. Most health centers have established an emergency drug supply (stock d'urgence) for use during off-duty hours and on weekends. While this system appears to be functioning as intended, its performance should be closely monitored.

Recommended Actions:

- Adapt CAPP system strategies from project SESA.
- Resupply the SAVE/CARE mini-depot by pooling drug orders with other agencies.
- Revise the journal to include daily drug consumption.
- Update stock cards daily for better control.
- Monitor drug consumption and inventories more closely.
- Phase in use of the Qmax-Qmin reordering system.
- Document modified procedures.
- Train staff in the use of the new procedures.
- Improve supervision to ensure that procedures are followed.

Recommendation 3: **COST RECOVERY: Modify the accounting system to eliminate major weaknesses and to improve compliance with financial management procedures through more effective supervision.**

Findings:

There is a cost recovery system operating in 12 co-managed, co-financed health centers. Funds generated through consultation fees and the sale of drugs are used to resupply the health centers with drugs, to pay the salary of the drug clerk and to cover other operating expenses.

A great deal has been accomplished since the inception of the project. However, the evaluation of the financial management system has revealed that procedures and practices must be improved to ensure the effectiveness of cost recovery activities. Findings and conclusions regarding the operation of various aspects of the cost recovery system are summarized below.

3.1 The Fee Schedule. When the first group of health centers became operational in October 1992, it was overwhelmed by a caseload nearly four times greater than the target utilization rate of 0.25 new cases per capita. The new system was subjected to severe strains as small initial drug supplies were rapidly depleted and health center staff over-extended.

This initial surge in utilization is attributable to the novelty affect, pent-up demand and the heavy inflow of patients from contiguous service areas without functional health centers. Over the past six months, utilization has dropped significantly, with most centers now reflecting rates in the 0.15 range.

While users of the health centers have expressed general satisfaction with the system, it is unclear why utilization is not higher. There is specific opposition to the consultation fee of 150 FCFA for health service area residents and 250 FCFA for non-residents. There has been lack of uniformity in the application of these fees across the five health centers visited. Some COGE members indicated that opposition to these fees was in part responsible for the decline in health center utilization.

3.2 Cost-Based Pricing. Until recently, drug prices have been set arbitrarily with a mark-up of about 25% to cover the transportation cost of drugs, but not the other operating costs of the mini-depot. An additional mark-up was included to cover certain operating costs of the health center pharmacy. A percentage of this margin was earmarked for specific activities, e.g., 10% for the salary of the drug clerk. This approach made no attempt to relate prices and system revenues to operating costs.

The project has recently developed pricing procedures based on drug consumption and operating costs. This represents a major step in the right direction. However, it is essential that this methodology be refined and used as an integral component of the financial planning and management process. The range of activities to be financed through cost recovery under the RPHC strategy is extremely broad and whether this approach is fully sustainable in Cameroon has yet to be demonstrated. It is therefore critical that utilization and revenues be closely monitored and expenditures adjusted accordingly to ensure the financial soundness of the system.

3.3 Indigent care. The project and the Provincial Health Delegation have not yet formulated policy guidelines regarding indigent care. None of the health centers visited had adequately addressed this issue. Yet, a household survey conducted in Adamaoua Province by Project SESA concluded that "not enough money to buy prescription" was the most frequently cited reason (29% of all responses) for not using health centers. It was the opinion of several COGE members that a similar situation exists in the Far North Province. While poverty is relative in the Third World, it is essential that the project encourage and assist COSA's in formulating policies regarding health care for those who truly cannot afford to pay. Ideally, such a scheme would be community-based rather than financed through patient fees.

3.4 Cash Handling. Most health centers have set up bank or postal accounts, and all have impressive strong-boxes. However, because three persons must be present to open the strong-boxes, it is as difficult to put money in as it is to take it out. As a consequence, money is kept in unlocked drawers, stored in old drug boxes and taken home by drug clerks and treasurers. Money is occasionally borrowed from the till. There has been at least one case of embezzlement. In short, compliance with cash handling procedures has been extremely lax. The basic principle of minimizing the amount of cash accessible in the system has been frequently ignored. There is an obvious need to exercise tighter control on cash.

3.5 The Accounting System. An accounting system has two basic functions. First, the system must accurately document financial transactions and reflect financial status. Second, the system must incorporate adequate internal control mechanisms in order to minimize the risk of error, loss or theft. These include minimizing access to cash, depositing daily receipts intact, proper documentation, frequent and consistent reconciliation of accounts and periodic independent verification. By these standards, the internal controls in the RHDS cost recovery system are inadequate and need to be improved. This conclusion is supported by the following observations.

a. Receipt books. Access to unused receipt books was not controlled and books were not used in numerical sequence, thereby facilitating "parallel" sales by the drug clerk. In one health center, the drug clerk frequently did not include totals on individual receipts and/or did not give receipts to patients. In another health center, multiple transactions were combined onto single receipts.

b. Cross-referencing. Receipts are pre-numbered, but the numbers are not always used for cross-referencing with journal entries. Receipts are not cross-referenced with patient registers, thereby making reconciliation difficult.

c. Daily reconciliation. In most cases, the daily reconciliation performed by the nurse and the drug clerk consists of checking the addition on receipts and the journal. This total is not compared with the amount of cash actually collected during the day.

d. Depositing daily receipts intact. Daily collections are usually co-mingled with collections from previous days, making the reconciliation described above difficult. In some cases, purchases are paid for directly from collections. Money turned over to the treasurer does not necessarily relate to the exact amounts collected during one or more days. As a consequence, it is impossible to trace collections from the individual receipt to the journal, to the deposit of funds into the bank or postal account.

e. Monthly closure. As evidenced by discussions with COGE members and a review of documentation, there is good community participation in the monthly closing of the books, the reconciliation of the inventory and the preparation of the monthly financial report. However, in many health centers, it is extremely difficult if not impossible to verify the information found in the monthly reports because of the problems in documentation described above. In at least two health centers there are serious discrepancies in financial reporting and possible losses.

f. Monthly expenditure planning and control. While most COGE's prepare monthly expenditure plans, actual expenditures are frequently inconsistent with these plans. Expenditures paid for directly from collections are difficult to trace. In general, the documentation of expenditure approvals, verification of expenditure and documentation of purchases needs to be improved.

Recommended Actions:

- Improve financial management via short term TA, training & project visits
- Continue development of the cost-based pricing system.
- Consider eliminating the consultation fee.
- Assist COSA's formulate policies regarding indigent care.
- Improve cash handling practices.
- Assure daily reconciliation of cash and receipts.
- Modify the accounting system to ensure tighter control.
- Document the new procedures.
- Train staff in the use of the new procedures.
- Improve supervision to ensure that procedures are followed.
- Encourage and assist COSA's and COGE's continue fulfilling their role.

Recommendation 4: TRAINING & CONTINUING EDUCATION: RHDS should reinforce supervision with continuing education while giving priority to training pilot health district teams.

Findings:

RHDS has done a good job at providing the basic training required in the principles of primary health care, co-financing and co-management. Training from three days to two weeks was provided for the health center chief nurse, the nurse-aide, the members of the health committee and health center management committee. This training has permitted the personnel to organize and manage health center activities. This was demonstrated in that:

- all centers had map of the health area showing villages and outreach points;
- all centers had village maps showing household position and number;
- all centers had a monthly schedules for health center and outreach activities;
- all centers were completing and submitting monthly reports;
- a few centers had job descriptions or organigram of health center personnel; and
- a few centers had graphs to monitor the level of activity.

Health center nurses demonstrated a good level of competence. All nurses understood how to correctly estimate the number of children in the 0-11 month age group, how to calculate the number of children requiring vaccines in order to attain a coverage of 60%, and how to establish a monthly objective to vaccinate "X" number of children in order to attain their objective. Nurses clearly understood the difference between calculating the percentage of their monthly objective (which they report monthly) and vaccination coverage (which they are not calculating).

The evaluation team found that some training occurred before materials/equipment were available for their implementation and that opportunities for in-service training were not being taken during supervision. Supervision was perceived as supervision/control rather than as a supervision/training. RHDS project personnel appear to be placing more emphasis on training seminars and not enough on training during supervision. It is not always necessary to organize a training seminar to initiate a new idea, e.g. graphing health indicators. Project personnel could "train" supervisors in this technique during a one-day meeting, who would devote part of their supervision visit to a one-on-one "training" in graphing of indicators.

While this might seem as a more time-consuming process, as opposed to teaching everyone at the same time, it has several distinct advantages. First it saves money by reducing the number of training seminars. Second, it develops the role and self-worth of the supervisor as someone who comes to teach, rather than simply to inspect. Third, supervision/training increases the opportunity for dialogue that can uncover additional problems and solutions.

Provincial and hospital levels have received little or no training in RPHC since funding is not yet been made available. The evaluation team suggests that RHDS explore ways to begin this "training" through informal discussions, presentations and meetings. For example, RHDS could invite the members of a well functioning COGE to help facilitate discussion of the principles of co-financing and co-management with provincial health personnel.

Recommended actions:

- Use each supervision visit as an opportunity for continuing education.
- Give highest priority to training health district supervision/training teams.
- Provide orientation/training for provincial health personnel.
- Use health center personnel and COGEs as resources for provincial training.
- Facilitate RPHC discussion/training for reference hospital personnel.
- Assure availability of materials/equipment to implement training skills.

Recommendation 5: HEALTH INFORMATION SYSTEM: Enhance the HIS system to permit and encourage health center analysis of information.

Findings:

A standardized health information system (HIS) is operating in 12 co-managed, co-financed health centers. The project has conducted baseline surveys and has used these data for program planning. The HIS consists of two major components, the monthly report of activities (RMA) and the family registration system.

5.1 The Family Registration System. Most health centers have completed a family census of their health service area. Data on each family are recorded on a family card (fiche familiale). However, these cards are not being updated on a regular basis as originally planned. In some cases, the COSA, which is supposed to obtain data on births, deaths, in-migration and out-migration is unwilling to perform this task without some form of compensation. While some health centers use the system on a limited basis, e.g., to check whether a family is registered, the system is not being used as had been intended.

While the system requires a great deal of work to maintain, it could be a valuable tool for the planning and delivery of health services. At a minimum, the family registration system could be used as a tickler file for the immunization program. At the other end of the spectrum, the system could be used for tracking a variety of information on health status, including chronic illnesses such as TB, and for planning most of the preventive health services provided by the health center.

It could also serve as a database for tracking major causes of early childhood deaths or for conducting mini-surveys on such issues as why people choose not to use the health center or fail to get their children vaccinated.

The basic question is whether this potentially useful system is consistent with health center resource availability and level of sophistication. One must also ask if there are easier and less labor-intensive ways of accomplishing some of these functions.

5.2 The Monthly Activity Report. Compliance with monthly reporting requirements appears to be excellent at most health centers. Some of the data reported is used effectively. For example, revenue data are routinely tracked to assess health center performance. However, it is unclear why some information is reported and if it is utilized. Obvious errors in data month after month and the non-reporting of certain data fields would indicate that some of the data reported is not used. In the March 1993 RMA only 2 of 7 CARE-assisted health centers reported the number of new cases in the service area (NC/AS). This would indicate that trends in health center utilization, a critical factor underlying system viability, are not being closely monitored.

The current RMA is a complex and very detailed document. Data fields are not organized in the most logical sequence. For example, data on child care and health are interspersed with data on maternal health, rather than being sub-aggregated into child and maternal health sections. Moreover, the formats of the source documents (registers, fiches, etc.) and of the report were not designed to simplify data acquisition, compilation, analysis and reporting.

The project could make better use of the data routinely reported. A weighted total of various types of consultations could provide a measure of health center workload. This could be used in conjunction with staffing data, e.g., person-days, as an index of health center productivity and to provide a sounder basis for assessing staffing needs.

There are also a number of simple calculations which could provide valuable insight into the financial health of the centers. For example: $\text{Drug revenues}/\text{Cost of drugs sold} = \text{Effective Mark-up}$; $\text{Value of inventory}/\text{Cost of drugs sold} = \text{number of months of drugs in stock}$.

The project is examining differences in drug costs per new case among the health centers. The differences could be indicative of variances in prescriptive practices since the centers treat fairly similar caseloads.

The examples cited above are intended to be illustrative. The project must identify its own needs and devise a system which meets these needs. The project should organize and format data in a way which simplifies the analysis of key indicators at the health center level. This approach provides the health center with instant feedback rather than fostering dependence on higher organizational levels for performance data.

Recommended actions:

- Test the usefulness of family registration in a few health centers.
- Revise HIS forms/strategy to encourage charting and interpreting summary indicators.
- Distinguish between registered and non-registered population in the HIS.
- Identify a few key indicators for health center analysis and tracking.
- Include review of the RMA's as part of the supervision visit.

Recommendation 6: SUPERVISION SYSTEM: Simplify the supervision protocols by using "supervision by exception."

Findings:

Project staff are using supervision protocols to supervise the health centers. While the technical approach used in the protocols is sound, the system is overly complicated and could be streamlined by using a strategy of "supervision by exception."

A review of project documentation and site visits conducted by the evaluation team have confirmed that project staff are conducting supervision visits to the health centers on a regular basis, approximately once per month. These visits have successfully identified some operational problems and in some cases have prompted the initiation of appropriate corrective action.

However, there are significant differences in performance across the health centers visited during the evaluation, at least some of which are attributable to ineffective supervision. Inconsistencies were found in what supervisors consider a problem, both across health centers and within the same center from one month to the next.

One reason for these inconsistencies is the lack of qualitative performance standards. While quantitative targets exist for certain activities, e.g., immunization, the health centers lack activity plans, diagnostic, therapeutic and prescriptive guidelines, and documented administrative procedures, which provide guidance to the staff, serve as benchmarks by which to assess performance and which can be used by supervisors as the basis for corrective action through immediate on-site training and TA.

Supervisory protocols (grilles de supervision), which should simplify supervision, are complex and highly detailed. The problem is analogous to that discussed above regarding the HIS. The forms attempt to capture an excessive amount of information, and in the process bury key findings in a morass of trivia. For example, in assessing the cleanliness of the facility, the supervisor must note the presence or absence of every piece of cleaning equipment. Similarly, the supervisor must list the range of diagnostic and therapeutic services and inventory the equipment on a monthly basis. As one health center nurse stated, the supervisor already knows the answer to most of the questions and could have completed the form without visiting the center.

Clearly, it is not necessary to perform this type of oversight on a monthly basis. Some aspects of health center operation can be monitored once or twice per year. Of considerable value would be a comprehensive annual visit which assesses the status of the physical plant and the equipment, plans corrective action, e.g., repair or replace, reviews activities of the past year, outlines the general strategy for the coming year and identifies key issues on which to focus, e.g., broadening the scope of outreach activities, improving prescriptive practices, improving financial management and inventory control or improving health center cleanliness.

There is a need to simplify the protocols and to eliminate information of marginal or no value. The project should adopt a strategy of "supervision by exception", which focuses on identifying deviations from expected performance and generally accepted norms, which proposes corrective action and which follows up to ensure that these actions have been undertaken. The supervisor should review information already available, e.g., the RMA's and previous supervisory reports prior to the supervision visit.

The project should encourage an operations research approach in which health center personnel explore alternative solutions to operational problems. Finally, the project should begin to explore innovative ways in which to recognize and reward superior performance.

Recommended Actions:

- Check equipment once or twice a year, not monthly.
- Increase financial supervision.
- Include a visit to an outreach activity as part of each supervision visit.
- Put more emphasis on the actions to be taken and their follow-up.
- Encourage an operations research approach by the health center.
- Encourage an attitude of in-service training by the supervisor.

2. HEALTH SERVICES DEVELOPMENT

Recommendation 7: IEC AND COMMUNITY DIALOGUE: RHDS should diversify its methods of IEC, community dialogue and outreach.

Findings:

RHDS has successfully transmitted the concepts of co-financing and co-management to Health Committees (COSA) and Health Center Management committees (COGE). Community dialogue (sensitization) is said to have been established with more than 90% of the population around the twelve functional health centers. The "unsensitized" 10% are those communities where family registration has not yet taken place.

It is apparent, in discussions with COSA and COGE, that the themes of co-financing and co-management are well understood, and that these groups are actively managing the health center. Nearly all the members of the COGE participate in the weekly review of the health center's financial status. This is an area in which RHDS is doing better than SESA whose COGEs, in November 1992, were losing enthusiasm, especially after some of their responsibilities for financial management were curtailed and centralized to the provincial level.

However, when asked to define what is primary health care one COSA president said that we should ask the nurse such a technical question. However, when the same person was asked to define "REO" (Reorientation of Primary Health Care) he immediately began expounding on the principles of co-financing and co-management. RHDS needs to use IEC to enlarge the definition of "REO" beyond the sale of medicines. Getting COSA and COGE to focus on vaccination coverage, village sanitation, health center renovation, water supply as part of "REO" may also help them perceive a greater satisfaction in their work.

IEC techniques at the health center and at during outreach appear to be heavily dependent on flip-charts (boite d'images) on subjects such as intestinal worms, schistosomiasis, and nutrition. While nurses have received training in other IEC techniques, they rarely mention of any technique besides flipcharts when queried about IEC. This is not unusual, but RHDS needs to work to diversify the IEC repertoire of the health personnel. The evaluators were pleased to learn that RHDS already has a seminar scheduled to be facilitated by the SESA IEC expert.

Outreach activities (*stratégies avancées*) are generally perceived by the population and the health workers as **decentralized** posts for vaccination. These activities are an excellent starting point for outreach, **but RHDS should encourage (and reward) those nurses who expand into other community based activities** such as village sanitation and/or any long-term development activity.

Recommended Actions:

- Diversify approaches to IEC to decrease dependence on flip-charts.
- Expand outreach activities to include more than vaccinations.
- Obtain copies of IEC materials from sources like Zaire, TALC, etc.
- Reinforce community dialogue as a long-term development activity.
- Emphasize PHC components of RPHC in discussions at all levels.
- Experiment with non-monetary strategies to motivate health personnel.

Recommendation 8: IMMUNIZATIONS: RHDS should further improve vaccination coverage by clarifying reporting, monitoring and logistics procedures.

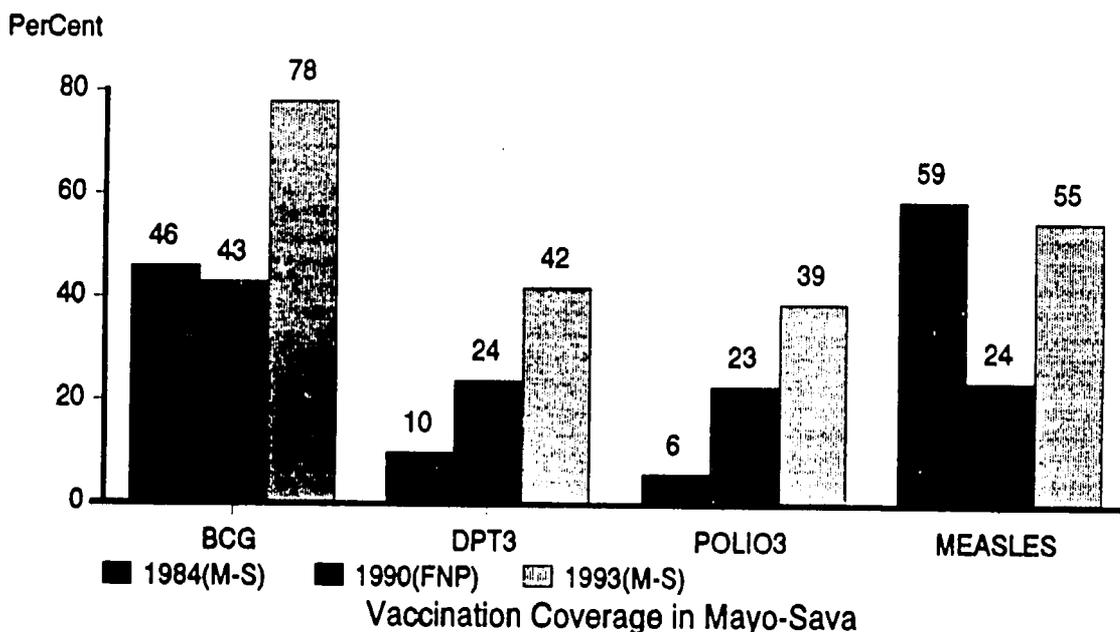
Findings:

RHDS has significantly improved maintenance of the cold chain and the delivery of vaccinations through a mix of fixed and outreach sites. The project has had difficulty in obtaining spare parts for refrigerators provided by UNICEF. This required a trip to Nigeria to locate the needed parts.

All health centers have monthly objectives for vaccinations (see Training above). Most centers are including children from outside their health area in their reports. This was estimated to be 20% of the children seen in one health center. RHDS should revise the HIS to distinguish between "inscrits" and "non-inscrits" and to permit nurses to monitor vaccination coverage. Including a graph as part of the monthly report (and posted on the wall) is one approach.

It is difficult to calculate project vaccination coverage as data is available for only 3-6 months and includes "non-inscrits". However, if the current level of activity is maintained, the RHDS should attain vaccination coverage of around 50-60% by the end of 1993.

A vaccination coverage survey, financed by UNICEF, was conducted for the Mayo Sava department in February 1993 by OCEAC (Organisation de Coordination Pour La Lutte Contre Les Endemies en Afrique Centrale). This survey included 30 clusters of 7 children 12 to 23 months of age. Results for Mayo-Sava (see graph below) show significant progress when compared to Mayo-Sava (1984) and to the Far North Province (1990).



Recommended Actions:

- analyze different strategies to optimize vaccination coverage
- establish a supply of frig. spare parts at the provincial depot or health district
- teach health center nurses to calculate and graph vaccination coverage
- help the MOPH develop a strategy for transport of vaccines from Yaounde

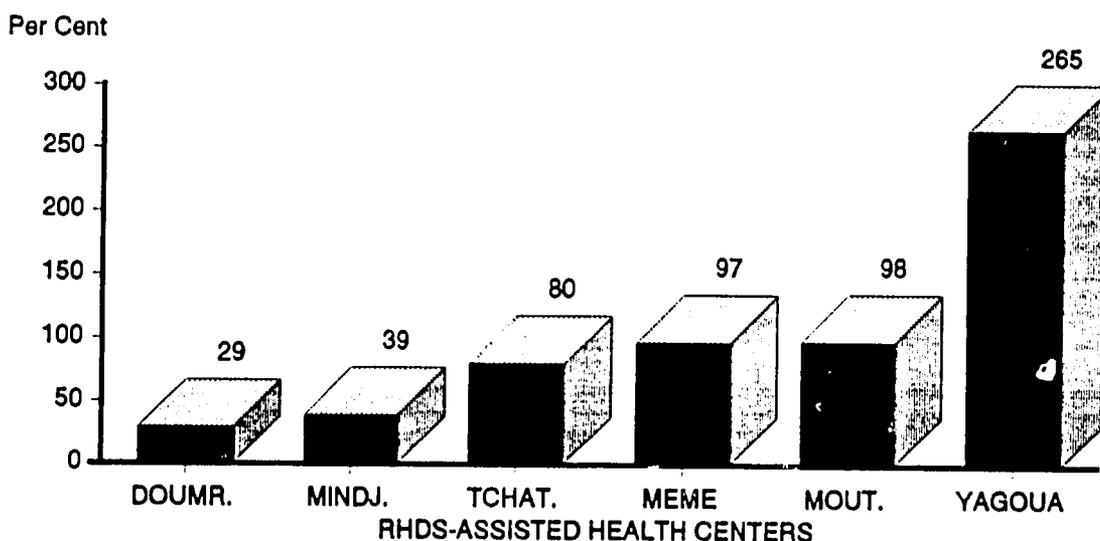
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Recommendation 9: MATERNAL CARE & FAMILY PLANNING: RHDS should reinforce IEC and family planning at prenatal clinics and district hospitals.

Findings:

There is an excellent participation in pre-natal clinics in almost all health centers. The graph below shows coverage rates for six health centers after four months of operations. One would expect a health center to see 8.25% (100%/12 months) pregnant women on any one month and a coverage rate of around 33% after four months. The fact that the rates are well above the expected level for most centers indicates that the health centers are attracting women to the CPN from surrounding non-functional health areas. Yet while the CPN is extremely popular, most women only attend the CPN once or twice during their entire pregnancy.

CPN COVERAGE RATES IN RHDS-ASSISTED HEALTH AREAS



RHDS should examine the patient flow during the CPN to identify moments when waiting women could be drawn into innovative IEC, rather than simply providing the standard flipchart lecture before the CPN begins.

Except for the sale of condoms, family planning services are practically non-existent at the health center level. The National Family Health (NFH) project is to conduct a needs assessment in May 1993 to identify a family planning training site and assess the demand for training. RHDS should assure that family planning is fully integrated into the health district and health center, and not developed as a vertical program. RHDS should establish full service family planning at reference hospitals, perhaps involving the nurses at the maternity.

Recommended Actions:

- Study the CPN patient flow to identify opportunities for increased IEC.
- Integrate family planning and NFH resources into the RHDS action plan.
- Establish full-service family planning at health district hospitals.

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Recommendation 10: ENDEMIC DISEASE CONTROL & WATER/SANITATION: RHDS should continue to promote home solutions for treatment of diarrhea and search for ways to improve access to clean water.

Findings:

RHDS is to be commended for assisted the MOPH in dealing effectively and promptly with one cholera and two meningitis epidemics during the past year.

According to monthly reports the number of cases of diarrhea seen at the health center varies from 2-3 to 30-35 per month. According to RHDS this wide variation is due to the preference for treatment at home using a sugar-salt solution (SSS). While treatment protocols appear to be respected at the health center, it is reported that many people simply do not like the taste of oral rehydration solution (ORS).

According to RHDS, two types of diarrhea are recognized locally - diarrhea with and without blood in the stool. The latter cases are reportedly brought to the health center for treatment, while the former are usually treated at home using SSS made from sugar cubes, a bottle-cap measure of salt, and a little lemon flavoring. The RHDS project staff are satisfied with the competence for home treatment with SSS, and prefer to encourage IEC in prompt home treatment with SSS rather than insist on treatment at the health center. In addition to encouraging proper home-treatment and case-management of diarrhea, increased efforts could be made to prevent diarrhea by increasing levels of measles vaccine coverage, hand washing, and improved domestic hygiene.

Water and sanitation is a PHC component often neglected by health personnel, as they do not usually receive much training in this area. However, discussions with COSA and COGE revealed that problems of water and sanitation were among the highest priorities. Outreach activities should be expanded to include water/sanitation. Not only do water and sanitation efforts contribute to a reduction of diarrhea and infant mortality, they are also an excellent opportunity for community empowerment and health education. This makes water and sanitation a good entry points for expanding community development.

One COSA reported that while several attempts have been made to drill wells in their village, the construction firm would go no deeper than 45 meters since that is the depth that they were contracted to drill. It is known that water exists at a depth of 85 meters, yet no one has been able to convince the drilling team to accept to put in one well of 90 meters rather than drilling two dry wells of 45 meters. While this is perhaps an overly simplistic view of the situation, it does seem to be an area where CARE and SAVE's expertise in community development should be working on some sort of solution, perhaps using their matching funds.

Several health centers do not have good access to water because of dry wells. Every health center should have a good source of water and a demonstration VIP (Ventilated Improved Pit) latrine, preferably made from local materials. This should be a matter for the COGE.

Recommended Actions:

- Continue IEC promotion of home treatment of diarrhea.
- Look for innovative IEC (like SSS songs) for combatting diarrhea.
- Pursue water and sanitation initiatives in community participation.
- Assist COSA in pursuing the drilling of functional village wells.
- Encourage COGE to build a demonstration VIP latrine at each health center.
- Encourage COGE to consider the rain catchment systems for some health centers.

3. PROJECT MANAGEMENT

Recommendation 11: TECHNICAL ASSISTANCE: RHDS should take a more assertive role in seeking opportunities for in-country and out-of-country visits to other projects and in obtaining technical assistance.

Findings:

Long-term technical assistance within RHDS is primarily that of the two project directors Dr. Luke Nkinsi (SAVE) and Dr. Inrombé Jermias (CARE). The evaluation team was impressed by the competence and devotion of these two men. They complement each other nicely in background and skills. Dr. Nkinsi's previous work in Zaire within a health zone is extremely useful in promoting the development of health districts while Dr. Inrombé's intimate knowledge of the Far North Province, and particularly RHDS area, is essential to establishing a good rapport with the population.

Both directors could profit from participation in primary health care conferences and short-term visits to other developing health districts in Cameroon. Visits to other health districts should also be organized for the medical directors of the health districts chosen to become operational by the end of the project.

The approved project budget called for short-term technical assistance (consultants) of \$338,000. This was reduced by 40% in April 1992 by a requested project revision to \$200,000. Yet there is little evidence that the project took advantage of even this reduced level of funding.

The most recent short-term assistance was an internal evaluation conducted by CARE in order to prepare for the current external evaluation. The internal evaluation conducted by Man-Ming Hung in February 1993 was well done and documented nearly all the same project strengths and weaknesses found by the current evaluation. This is the kind of technical assistance which should have been programmed and planned for in advance by SAVE and CARE as an interim internal evaluation, rather than in response suggestions made during a USAID visit in December 1992.

In general, the evaluation team feels that both SAVE and CARE have not taken sufficient initiative either in obtaining short-term technical assistance or in making visits to other primary health care projects to exchange lessons learned and special skills. The following areas have been identified during the evaluation as ones in which additional technical assistance is desirable:

- diversification of IEC strategies (with SESA);
- collaboration with church managed medical work;
- cost recovery and financial management systems;
- management of essential medicines; and
- supervision and HIS.

Recommended Actions:

- Send RHDS directors to PHC conferences and to visit other projects.
- Organize visits to other programs for health district medical chiefs.
- Take more initiative in obtaining short-term technical assistance.

Recommendation 12: COORDINATION OF PARTNERSHIPS: RHDS and the Provincial Delegation should encourage coordination of partnerships within the health district, by provincial commissions, and by quarterly project reviews.

Findings:

The original design of RHDS called for the creation of a consortium of primary health care agencies called CAISP (Cellule d'Appui aux Initiatives des Santé Publique). CAISP was to assist the Provincial Health Delegation in the training of personnel, collaboration among partners (public and private), and designing/implementing a standardized health information system.

RHDS did establish CAISP administered by a CAISP director and two deputy directors. This format, which was dominated by SAVE and CARE, made other potential partner agencies hesitant to participate. The CAISP came to be perceived as a second provincial delegation and became a source of friction between SAVE and CARE. For example, there was considerable discussion about whether the necessity and efficacy of the CAISP having its own separate budget to carry out CAISP-related activities. In brief, the CAISP became more of a problem than a solution, and was wisely discontinued.

With the arrival of a new provincial delegate in late 1992, there has been a renewed effort for coordination under his leadership. A commission for coordination met to discuss coordination of efforts in the areas of Health Information System, program planning, coordination of assistance, and management of epidemics. Several sub-commissions have been proposed to pursue coordination in the areas of supervision, establishing a provincial pharmacy, training, and Health Management Information Systems. Each commission is to be led by the chief of the service most concerned with that area of expertise, e.g. the chief of preventive medicine will head the commission for supervision. The sub-commission to standardize supervision protocols met in February 1993 and produced a proposal for standardized supervision protocols.

The evaluation team commends RHDS and the provincial delegation for adopting the "commission" approach, and recommends a continuing of this format rather than trying to establish a permanent coordinating committee or consortium.

Given the renewed focus on health districts, it is important to recognize that a great deal of coordination must be encouraged at that level. For example, in a health district like Koza there are at least three different managers of health centers (public, catholic and protestant) and several agencies already providing inputs (e.g. CARE and ADRA (Adventist Development and Relief Agency)). Coordination of these partners in developing the health district of Koza should be evident in the development of the health district action plan.

Relations between SAVE and CARE, which were strained at some times, are currently very positive. This is largely due to the efforts of Dr. Nkinsi and Dr. Inrambe to work together. RHDS needs to sustain this working relationship while make a concerted effort to establish a habit of regular communication through project reviews with the provincial delegation. It has been suggested by the SAVE country representative that a quarterly review of the project with the provincial delegation be used to establish a cycle of contacts.

Recommended Actions:

- Use the health district a focus and mechanism for coordination.
- Continue commissions rather than permanent committees.
- Set a cycle of PHC meetings with the health delegate.

Recommendation 13: ALLOCATION OF PROJECT RESOURCES: RHDS should reassess its current and extended resource allocation to maximize the percentage of resources invested in health systems (health districts and health centers).

Findings:

The original RHDS project proposal was primarily to implement selected child survival interventions rather than health system development. Only about 10% of the original budget of RHDS (excluding local salaries) could be classified as being directed at system development.

The revision of RHDS in 1991 in line with RPHC placed a greater emphasis on objectives of health system development, but did not include a budget revision.

The current budget format does not permit easy identification of what equipment is being purchased for project management from equipment for health system development, i.e. for health centers.

Each of the major budget line items should be broken down into detailed line items and grouped by project management and health system development. For example the purchase of a photocopier machine for a health district should be listed under equipment: health system while a photocopier machine for the SAVE office would be listed under Equipment: Project Management. This method permits the calculation of the percentage of project investment which is being made in the development of the health systems. As a general rule of thumb, a budget for a health system development project should program at least 50% of its budget for health system development.

Given the current extension of RHDS until April 1994 and the additional \$400,000 programmed from USAID, it is now an excellent time to develop a detailed action plan and budget. This budget must take into account the priority to create two functional health districts, and re-examine whether project resources will be sufficient to realize the objective of 30 functional health centers by the end of the project. RHDS should complete a first draft of this plan and budget (including the matching funds) by June 1, 1993.

CARE's budget now includes salaries or supplements to a number of community development animators and animator supervisors. It is planned that these would be phased out by July 1993. Given the eventual elimination of the departmental level, it is recommended that these coordinators (health center supervisors) be integrated into the health district team, i.e. as MOPH, not RHDS personnel. Depending on the plan of action developed, there may be justification for transferring one coordinator to the SAVE and/or CARE office.

Recommended Actions:

- Assess how many health districts could quickly become functional.
- Reassess the number of health centers to assist given current resources.
- Prepare a action plan/budget (OPG + matching funds) by June 1, 1993.
- Divide budgets by health system development and project management.
- Complete phasing out project supported salaries to animators/supervisor.
- Transform RHDS coordinators into health district or project supervisors.

ANNEXES

Annex A: LIST OF CONTACTS

Annex B: LIST OF DOCUMENTS CONSULTED

Annex C: DEVELOPMENT OF THE RHDS DRUG DISTRIBUTION

Annex D: SUMMARY FINDINGS: DRUG DISTRIBUTION/COST RECOVERY

Annex E: EVALUATION SCOPE OF WORK

ANNEX A

Annex A: LIST OF CONTACTS

MOPH FAR NORTH PROVINCE:

Dr. Moussa Djidda, Health Delegate

Dr. Dama Mana, Chef de Service Dept. Mayo-Sava

Dr. Fopa Amadou, Chef de Service Dept. Mayo-Tsanga

HEALTH CENTER STAFF OF:

Midjivin

Lara

Moutourwa

Damay

Mozogo

Djinglia

Kerawa

Mémé

Save the Children, USA:

Dr. Luke Nkinsi, RHDS project director

Mr. Aboubacar Ouattara, Country Representative

CARE:

Mme Elènore Suomo, Director of Health Programs

Ms. Marily Knieriemen, Mokolo representative

Dr. Jermias Inrombé, RHDS project director

USAID:

Richard Greene, Health Population Officer

KOSA ADVENTIST HOSPITAL:

Dr. Andre

Dr. Moldanado

ANNEX B

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Annex B: LIST OF DOCUMENTS CONSULTED

CARE Annual Report 1990-1991, CARE, 1991
CARE Annual Report 1991-1992, CARE, 1991
Care Subgrant Description, CARE, 1990
Elaboration des Grilles de Supervision, SAVE/CARE, Feb-24-93
Evaluation Interne CARE, CARE, Feb 93
Evolution des Indicateur de Couverture (Dec 92-Feb 93), SAVE/CARE, Feb 93
Implementation Plan- Year 1, SAVE/CARE, 1991
Implementation Plan- Years I, II, III, SAVE/CARE, Nov-1-91
Interventions de la CCE (SANTE), CCE, Feb 92
Manuel du Centre de Sante, SESA, Nov 92
OPG Agreement RHDS, USAID, Aug-1-90
Quarterly Report 1: Aug-Dec 90, SAVE/CARE, 1990
Quarterly Report 2: Jan-Jun 91, SAVE/CARE, 1991
Quarterly Report 3: Jul-Aug-Sep 91, SAVE/CARE, 1991
Quarterly Report 4: Oct-Nov-Dec 91, SAVE/CARE, 1991
Quarterly Report 5: Jan-Feb-Mar 92, SAVE/CARE, 1992
Quarterly Report 6: Apr-May-Jun 92, SAVE/CARE, 1992
Quarterly Report 7: Jul-Aug-Sep 92, SAVE/CARE, 1992
Quarterly Report 8: Oct-Nov-Dec 92, SAVE/CARE, 1992
Reform of the Health Management System:, SAVE/CARE, Jun-15-90
Reunion Bilan... CARE, CARE, Dec 92
RG's Trip Reports 1-8, USAID, Aug-1-91, Aug-19-91, Jan-31-92, Mar-24-92, Nov-12-92, Jan-8-93, Jan-29-93 and Mar-19-93.
SCF/CARE Annual Report (Oct 91-Sep 92), SAVE/CARE, 1992
U.S. Economic Assistance to Cameroon, USAID, Apr-1-93

ANNEX C

**ANNEX C: DEVELOPMENT OF THE RHDS DRUG DISTRIBUTION/
COST RECOVERY SYSTEM MILESTONES...PROBLEMS...PLANS**

- 5/89 MOPH releases RPHC strategy document.
- 1989 SESA/USAID conclude that standard CS project is ineffective because of health system constraints; PP amended to focus project activities on RPHC.
- 7/90 OPG awarded to S/C for standard CS project, including HCF.
- 8/91 RG Memo:
*In response to 1990 MOPH letter on RPHC, S/C agree to adopt RPHC & restructure OPG. MOPH considers revised joint agreement vague & requests resubmission.
*Plan 8/91 meeting of S/C, USAID, MOPH to develop detailed implementation plan.
- 10-12/91 S/C Quarterly Report:
*9/91 Rhumsiki meeting; OPG restructured to 9 objectives for RPHC (40 HC's).
*HIS in place.
*Detailed action plan in place for each sub-division.
*Intensified collaboration with MOPH.
*Drugs ordered from GTZ, but no depot set up.
*20 HC's to be operational by 3/92.
*MOPH personnel do not see RPHC as their work.
*MOPH transferring personnel already trained by project.
*Health committees want compensation and free care.
- 1/92 RG Memo:
*MOPH personnel consider RPHC a donor activity are reluctant to cooperate.
*Some community members do not understand/support new system.
*Unclear who supervises HC's
*Need to identify reference hospitals.
*Plan to launch first 20 of 40 health centers. Because of high cost, it may be necessary to reduce objective to 35 HC's.
*Plan to develop dx/rx protocols, renovate HC's
*Provincial drug supply system:
-Baseline survey completed.
-EM lists formulated for hospitals and HC's
-Agreement with GTZ re drug procurement
-Need 6 month initial drug stock.
-Need to carefully monitor drug consumption.
*Cost recovery/financial mgt. system:
-Need to set up bank/postal accounts.
-Need policy on indigent care.
-70% mark-up not enough; need to cost activities.

1-3/92 S/C Quarterly Report:

- *System set up for "tarification" and cost recovery.
- *Management system setup for DD/CR.
- *Revised HIS developed.
- *DD system not finalized, no depot.
- *Problems in procuring drugs; have been waiting 5 months.
- *Delay in opening HC's, community getting impatient.
- *budget problems; need to reprogram \$100K for drugs (6 month supply); propose to reduce HC objective from 40 to 30.

3-6/92 S/C Quarterly Report:

- *HC opening delayed because of drug procurement problems.
- *Drug order placed with IDA cancelled because of non-compliance with USAID procurement policies; order resubmitted to UNICEF.
- *Will use local procurement as stop-gap measure.
- *SCF mini-depot for 5 HC's to open in September.
- *HC's have been remodelled.
- *Community remains impatient.

7-9/92 S/C Quarterly Report:

- *8 HC's opened (5 SCF, 3 CARE); operating satisfactorily.
- *Problem of HC staff shortage and qualifications.
- *Still no LT solution to drug supply problem.
- *UNICEF drug order not yet received.
- *Need to improve supervision.
- *Need to train provincial supervision teams.
- *Need to design supervision checklists.

11/92 RG Memo:

- *Delegate position vacant for last 6 months; inadequate MOPH involvement/leadership in RPHC implementation.
- *Need to develop provincial DD system; should consider GTZ/SESA model with procurement through CIAME.
- *SCF mini-depot financed by project, not revenues.
 - Drugs purchased locally; cost too high.
 - Need RPHC system costs as basis for pricing.
 - Need baseline data on HC caseload.
- *SCF centers (Doumrou, Yagoua, Moutoura, Mindjivin)
 - Functioning well, good community participation.
 - High utilization.
 - MOPH reluctance to supervise?
- *CARE centers (Meme, Mogode)
 - Buy directly from local suppliers.
 - High cost+low margin=small surplus.
 - Using CIM protocols
 - No increase in utilization at Meme
 - No RMA or supervision protocols in use.

- *Need better coordination.
- *CARE should consider using SCF mini-depot.
- *Need to work with MOPH on HIS.
- *Need to update and use family registration system,.

10-12/92 S/C Quarterly Report:

- *4 additional CARE HC's opened.
- *Drugs:
 - Providing initial stocks and resupplying HC's opened remains a major problem.
 - Negotiations underway with CIM for drugs to be provided to the CAPP by the CE.
 - Local procurement has necessitated a price increase. Population objects.
 - Utilization has dropped considerably in all SCF sites
 - Parallel markets affecting drug sales in 2 SCF HC's.
 - Toulum has withdrawn from the project.
 - Need for MOPH to speed up establishment of the CAPP.

1/93RG Memo:

- *Need for MOPH to take lead in RPHC >
- *Need to establish Provincial DD system.
- *Mindjivin visit:
 - Need to expand role of women.
 - Need to improve prescriptive practices.
 - Need for policy on indigent care.
- *CARE should use SCF depot.
- *Need to finalize and use RMA's.
- *Need to finalize supervisory checklists.
- *Need to analyze key indicators.
- *Need to determine PHC system costs.
- *Need QA program

1/93RG Memo(2):

- *S/C have formulated a plan to implement recommendations and have made progress.

3/93RG Memo:

- *EC providing \$20000 in drugs to S/C.
- *Need to assure adequate drug stocks(8 month supply) before adding new HC's.
- *Current stock levels are too low.
- *Need to determine costs, revise prices.
- *Site visit to HC's:
 - Accounting records appear accurate.
 - HC use is low (11-16%).
 - Stock cards not updated, no reconciliation.
 - 3/3 HC's were out of 3-4 drugs.
 - Need to improve emergency drug use documentation.
 - Fees not posted.
 - Opposition to consult. fee blamed for low HC use.
 - Little progress on indigent care policy.
 - Health committees formalized.

- Outreach activities are effective.
- Cash handling procedures not always followed.

ANNEX D

**ANNEX D: EVALUATION SITE VISITS
SUMMARY OF FINDINGS: DRUG DISTRIBUTION AND COST RECOVERY**

HEALTH CENTER: MINDJIVIN, 4/21/93

Financial Management:

1. No policy and procedure manual.
2. No policy on indigent care.
3. Fee schedule not posted.
4. Community opposition to consultation fee.
5. Family register used to determine residency status.
6. Drug clerk and nurse reconcile cash on hand.
7. Daily collections co-mingled, not deposited intact.
8. Cash improperly safeguarded.
9. No bank/postal account.
10. Good treasurer and COGE involvement.
11. Concept of internal control not understood.

Inventory Control:

1. Drug storage clean and orderly.
2. Currently no stock outages.
3. Resupplied monthly from SCF depot.
4. IC cards updated weekly, including negative entries.
5. Drug consumption not recorded. Homemade form used to compile drug consumption.
6. Qmax, Qmin not used.
7. IC cards reconciled with stock on hand, but drugs issued not reconciled with sales.

HEALTH CENTER: MOUTOURWA, 4/22/93

Financial Management:

1. No policy and procedure manual.
2. No policy on indigent care.
3. Community opposition to consultation fee and prices.
4. Receipts not totalled, sometimes not given to patients.
5. Receipt numbers not used as cross-reference.
6. Drug clerk and nurse do not reconcile cash on hand.
7. Daily collections not deposited intact, commingled.
8. Cash improperly safeguarded .
9. Bank account.
10. Record **keeping** very poor, reconciliation difficult.
11. Concept of internal control not understood.

Inventory Control:

1. Drug storage adequate.
2. Periodic outages due to poor IC
3. Resupplied 1-2 times monthly from SCF depot
4. IC cards updated weekly, included negative entries.
5. Drug consumption not recorded in journal. Homemade form use to compile drug consumption, destroyed after use, thereby making reconciliation nearly impossible.
6. Qmax, Qmin not used.

7. IC cards not kept in order, making reconciliation difficult.
8. IC cards reconciled with stock on hand, but drugs issued not reconciled with sales.

HEALTH CENTER: MOZOGO, 4/23/93

Financial Management:

1. No policy and procedure manual.
2. No policy on indigent care.
3. Fee schedule posted; non-resident fee not used.
4. Community opposition to consultation fee.
5. Drug clerk and nurse reconcile cash on hand.
6. Daily collections co-mingled, not deposited intact.
7. Cash improperly safeguarded (Drug clerk takes cash home).
8. Postal account.
9. Concept of internal control not understood.

Inventory Control:

1. Drug storage too hot, poorly ventilated.
2. Currently 3 drugs out of stock.
3. Resupplied monthly from PHARMACAM AND LABOREX.
4. IC cards updated weekly, included negative entries.
5. Drug consumption not recorded. Homemade form used to compile drug consumption.
6. Qmax, Qmin not used.
7. IC cards reconciled with stock on hand, but drugs issued not reconciled with sales.

HEALTH CENTER: KERAWA, 4/26/93

Financial Management:

1. No policy and procedure manual.
2. COSA compiling list for indigent care.
3. Fee schedule posted; Consultation fee not used before Feb. Currently 100/150 rather than 150/250.
4. Community opposition to consultation fee.
5. Drug clerk and nurse do not reconcile cash on hand.
6. Daily collections co-mingled, not deposited intact.
7. Cash improperly safeguarded. Drug clerk holds excessive cash.
8. Postal account.
9. Drug clerk has access to stock of receipt books.
10. Record **keeping** is extremely poor.
11. Concept of internal control not understood.

Inventory Control:

1. Drug storage is clean and orderly.
2. Currently 5 drugs out of stock.
3. Donated Japanese drugs added to stock. Stock on hand excessive relative to consumption.
4. Resupplied monthly from PHARMACAM AND LABOREX.
4. IC cards updated weekly, included negative entries.
5. Drug consumption not recorded. Homemade form used to compile drug consumption.
6. Qmax, Qmin not used.
7. IC cards reconciled with stock on hand, but drugs issued not reconciled with sales.

HEALTH CENTER: MEME, 4/26/93

Financial Management:

1. No policy and procedure manual.
2. No policy on indigent care.
3. Fee schedule posted.
4. Community opposition to consultation fee.
5. Drug clerk and nurse do not reconcile cash on hand.
6. Receipts not issued for all transactions.
Daily collections co-mingled, not deposited intact.
7. Cash improperly safeguarded.
8. Postal account. Drug clerk has held up to 200K FCFA.
9. Drug clerk has access to stock of receipt books.
10. Concept of internal control not understood.
11. Drug clerk has embezzled 65K FCFA, but is still on staff.

Inventory Control:

1. Drug storage is clean and orderly.
2. Currently 6 drugs out of stock.
3. Resupplied monthly from PHARMACAM AND LABOREX.
4. IC cards updated weekly, included negative entries.
5. Drug consumption not recorded. Homemade form used to compile drug consumption.
6. Qmax, Qmin not used.
7. IC cards reconciled with stock on hand, but drugs issued not reconciled with sales.

ANNEX E

Annex E: EVALUATION SCOPE OF WORK

I. BACKGROUND

A. Initial Project Objectives and Strategy

In early 1990, Save the Children (STC) and CARE International (CARE) submitted a joint unsolicited proposal to USAID/Cameroon to strengthen community-based primary health care (PHC) services in Mayo Sava, Mayo Tsanaga, Mayo Kani, and Mayo Danay Divisions of the Far North Province. After a favorable review of the proposal, USAID approved the activity, named the Reform of the Health Delivery System (RHDS) Project, in August 1990 at a three year life-of-project funding of \$2.6 million.

The project's initial strategy for improving the health of women and children in Far North Province was based on the delivery of five key child survival interventions consisting of immunizations, diarrheal disease control, nutrition promotion/growth monitoring, malaria control, and child spacing. In addition, the project envisioned the creation of pilot cost recovery activities including the establishment of a system for resupplying health posts with a limited number of essential drugs. Finally, the project planned to design and implement a comprehensive health management information system involving family enrollment of target populations.

B. Reorientation of Primary Health Care in Cameroon

During 1990, as STC and CARE were developing their proposal for USAID funding, the MOPH (with donor assistance) was finalizing a new national primary health care (PHC) policy and designing the training and management instruments necessary to make it operational. This new policy, entitled the Reorientation of Primary Health Care (RPHC), follows closely both UNICEF's Bamako Initiative and the World Health Organization's strategy for delivering PHC in three phases. According to the new strategy, the national health system will be reorganized so that local communities will take greater responsibility for their health care. Each province will be organized into health districts which will supervise and support health areas. The health areas will encompass health centers and village health posts. Health areas and centers will be co-managed by community health committees. Each health center will have a drug store and cost recovery mechanism which will permit the funding of the important recurrent costs of the PHC program. Health services will be delivered in a fully integrated fashion with emphasis on continuity of care (i.e., links between primary and reference services) for each episode of illness.

C. Project Redesign

In 1991, USAID, the MOPH, STC, and CARE all reached the conclusion that the project needed to go beyond the implementation of a limited number of child survival interventions in order to have a significant and sustainable impact on the health status of the targeted population. The population's lack of confidence in the Health system and the resulting low utilization of MOPH health facilities severely undermined the successful implementation of the key child survival interventions planned under the project.

Specifically, the project's centralized, vertical approach needed to be replaced by a decentralized, integrated strategy focused on improvement of health systems (supervision, logistics, clinical practices, etc.) and community involvement in the management of health care. In addition, the lack of national budgetary funds available for rural health meant that the cost recovery component of the project needed to be significantly expanded beyond the resupply of drugs to include the funding of some of the variable recurrent costs associated with the delivery of PHC services. As a result, USAID and the MOPH decided that the project would be reformulated based on Cameroon's newly revised PHC service delivery strategy.

D. Revised Project Strategy

In early 1991, the grantees, USAID, and the MOPH began revising the RHDS Project to reflect the service delivery strategy of the RPHC program. In late 1991, the change in project strategy was formally ratified in a project grant amendment. The revised RHDS Project is based on the following end-of-project status indicators which are to be achieved by 7/31/93:

- Thirty community co-financed and co-managed health centers in the four targeted divisions will be operational in accordance with the national RPHC strategy.
- A provincial drug supply depot and drug supply system will be in place for the four project-supported divisions.
- A model cost recovery system will be operating in the 30 community co-financed and co-managed health centers.
- A standardized health management information system will be operating in the project-assisted area.
- A coordinating consortium of public, private, and governmental providers of PHC will be functioning in the province.
- 60% of children 12 to 23 months of age will have been vaccinated with measles and DPT 3 vaccines in the project-supported area.
- Adequate prenatal and referral services will be provided in 80% of project-supported health centers.
- Adequate case management of diarrhea, growth monitoring services, and nutrition education will be provided in 70% of project-supported health centers.

E. Implementation to Date of the Revised Project Strategy

Since late 1991, the project has made the following progress in implementing the RPHC program in the four targeted divisions:

- The preparation of 20 health centers zones for the launching of community co-financed and co-managed PHC. This included the mapping, sensitization, and family registration of health center populations; the creation and training of community health and health management committees; the minor renovations of health centers; and the training of health workers.

- The launch of 12 community co-financed and co-managed health facilities.
- The design of a health management information system including a monthly health center activities report; a standard feedback letter for supervisors; and health center data collection instruments.
- The initiation of monthly supervisory visits to health centers, and the design of supervision checklists.
- The establishment of a drug depot to purchase essential medicines and resupply community co-financed and co-managed health centers, and the design of drug logistics procedures and forms.
- The design of financial management procedures and forms to manage cost recovery revenues at health centers.

Further progress under the project has been hampered by the following constraints:

- The lack of a MOPH delegate for the Far North Province for much of 1992. This has resulted in limited initial MOPH collaboration in the implementation of the RPHC program in the province; poor coordination of donor projects in the province; delayed plans for the development of a provincial medical supply system; and unresolved staffing shortages in some health centers.
- Changes in key project and country personnel for both STC and CARE.
- The delayed ordering and delivery of the initial supply of essential drugs.
- Initial poor coordination between CARE and STC.
- Poor motivation and performance of some health personnel implementing the RPHC in Far North province.
- Problems encountered by CARE in utilizing community development workers (from the the Ministry of Agriculture) as health educators in health centers.
- The lack of defined or functioning health districts in the province.

II. SCOPE OF WORK

ARTICLE I - NAME:

The evaluation of the Reform of the Health Delivery System Project.

Basic Data:

| | |
|-------------------------------------|--------------------------------------|
| Project: | Reform of the Health Delivery System |
| Authorization Number: | 631-0072 |
| Life of Project Cost: | \$2,600,000 |
| Date of Project Grant: | 8/1/90 |
| Project Activities Completion Date: | 7/31/93 |
| Grantees: | Save the Children, CARE |

ARTICLE II - PURPOSE:

The major objectives of the evaluation of the Reform of the Health Delivery System (RHDS) Project are as follows:

- To assess project progress in implementing the MOPH's RPHC program given the following constraints: the relatively short implementation period (March 1991 to present); the lack of a Far North Provincial Health Delegate for much of 1992; and the delayed arrival of the grantee's initial stock of essential drugs.
- To assess the strengths, areas for improvement, and overall capability of Save the Children (STC) and CARE in implementing and institutionalizing the RPHC program in the Far North Province.

ARTICLE III - SPECIFIC OBJECTIVES:

- A. Specific objectives related to assessing the project's progress to date in implementing the MOPH's RPHC program:
1. Verify whether the MOPH's RPHC program based on community co-financing and co-management of health care; full integration of services; and decentralization of health planning, management, and supervision activities to the health district level are appropriate for the Far North Province. In addressing this issue, the evaluation team should consider the following factors: the economic and social environment; the state of the private health sector; and the population densities and infrastructure of the targeted areas.
 2. Assess the overall effectiveness of the community co-financed and co-managed health facilities established under the project. This will include assessments of the following:

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- the quality and breadth of the preventive, promotive, and curative services provided by the facilities;
- the utilization of the facilities by the population;
- the impact of family registration on the quality of health services provided at health centers;
- the impact of outreach activities on the population's access to PHC services.

3. Assess public acceptance of the RPHC program. Assess the effectiveness of the community dialogue structures (community health and community management committees) established under the project in managing medical supply and cost recovery systems, in promoting health services, and in representing the population of large. Is the population actively participating in the community dialogue structures? Does the population accept the fees for services and drug charges? Does the population see the benefits to the new system?

4. Assess health worker acceptance of the PHC model. Are health workers accountable to the populations they serve? Are health workers effectively supervised by MOPH managers? Has health worker morale and performance improved since the introduction of the new system?

5. Assess the level at which the the project's medical supply system is functioning and whether it is sustainable. Does the system provide medical supplies to health facilities in a timely fashion? Are the ordering and stock management systems effective?

6. Assess the cost recovery system installed under the project. Given revenue generation to date, is it likely that the project's revenue targets can be achieved? (For example, can cost recovery revenues fund supervision, refresher training of health personnel, and other non-salaried recurrent costs in addition to the maintenance of the drug supply system?) Are drug prices appropriate or are they too high for the population to pay? Are the fees for services appropriate? Are there mechanisms being developed to assure medical care for indigents? Are revenue surpluses generated at health centers effectively utilized to improve health care? Are there sufficient financial and accounting controls in place to assure the proper collection and utilization of revenues?

7. Assess the quality of the supervision and health information systems established with the assistance of the project. Are supervision visits productive and taking place on a regular basis? Are health information reports completed accurately and in a timely fashion? Is health information analyzed and utilized by managers for decision making?

8. Assess the effectiveness of the project's child survival interventions of immunizations, control of diarrheal diseases, nutrition promotion, child spacing, and safe water supply. Are these interventions being effectively integrated into the daily activities of community co-financed and co-managed health centers? Are the information, supervision, and logistics requirements for these programs being effectively folded into the project's integrated drug supply, health information, and supervision systems? Are child survival services being effectively delivered to outlying areas through community-financed outreach efforts?
 9. 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 therapy, and growth monitoring coverage rates; and promote improved health practices?
 10. Assess the effectiveness of community-based primary health care activities implemented by the project. Assess the impact of community development workers (from the Ministry of Agriculture) in the CARE-supported project area.
 11. Assess the project's role in MOPH efforts to control the cholera and meningitis epidemics which affected the Far North Province in 1991 and 1992, respectively.
 12. Assess plans for developing viable health districts in the project-supported area.
- B. Specific Objectives related to assessing the strengths, areas for improvement, and overall capability of STC and CARE in implementing and institutionalizing the MOPH's RPHC program in the Far North Province.
1. Assess the quality and effectiveness of the technical assistance provided and the training programs implemented by STC and CARE under the project.
 2. Assess the degree to which STC and CARE have been able to effectively work with MOPH personnel in all aspects of the RPHC program.
 3. Assess how effectively STC and CARE coordinate with each other and with other PHC donors in the province. Are experiences shared in the areas of health information systems, drug logistics systems, training strategies and materials, supervision systems, etc?
 4. Assess the effectiveness of STC and CARE to work with the MOPH to mobilize communities in support of primary health care initiatives.

5. Assess the capability of STC and CARE to technically assist the MOPH to implement the following aspects of the RPHC program:

- drug supply logistics;
- cost recovery;
- development of health districts;
- provincial structures in support of the RPHC.

ARTICLE IV - TASKS:

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

- A. Review key project documents including the Project Grant Agreement, the Project Implementation Plan, training materials, progress reports, etc.
- B. Meet with USAID, MOPH, and other donor officials concerning the RPHC program.
- C. Develop an evaluation methodology and draft evaluation questionnaires for the field phase of the evaluation (2 days in Yaounde for items A, B, and C).
- D. Conduct a field trip to the Far North Province. Observe and assess the following:
 - project management structures established by CARE and STC;
 - provincial, divisional, and sub-divisional health teams;
 - drug logistics, supervision, health information, and cost recovery systems;
 - community health and health management committees;
 - community co-financed and co-managed health facilities;
 - health facilities which are not project assisted.

(Two weeks)

ARTICLE V - PERFORMANCE PERIOD

O/A April 15 to May 3, 1993

ARTICLE VI - LEVEL OF EFFORT:

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| A. Primary Health Care Specialist/Team Leader | 16 work days |
| B. Health Economist | 16 work days |

(Six-day work week is authorized).