REPUBLIC OF CAMEROON

MINISTRY OF PUBLIC HEALTH

REGIONAL DELEGATION OF PUBLIC HEALTH, NORTH WEST

North West Special Fund for Health, Bamenda

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PRIMARY HEALTH CARE

A GUIDE FOR DIALOGUE STRUCTURES

JUNE 2010 EDITION

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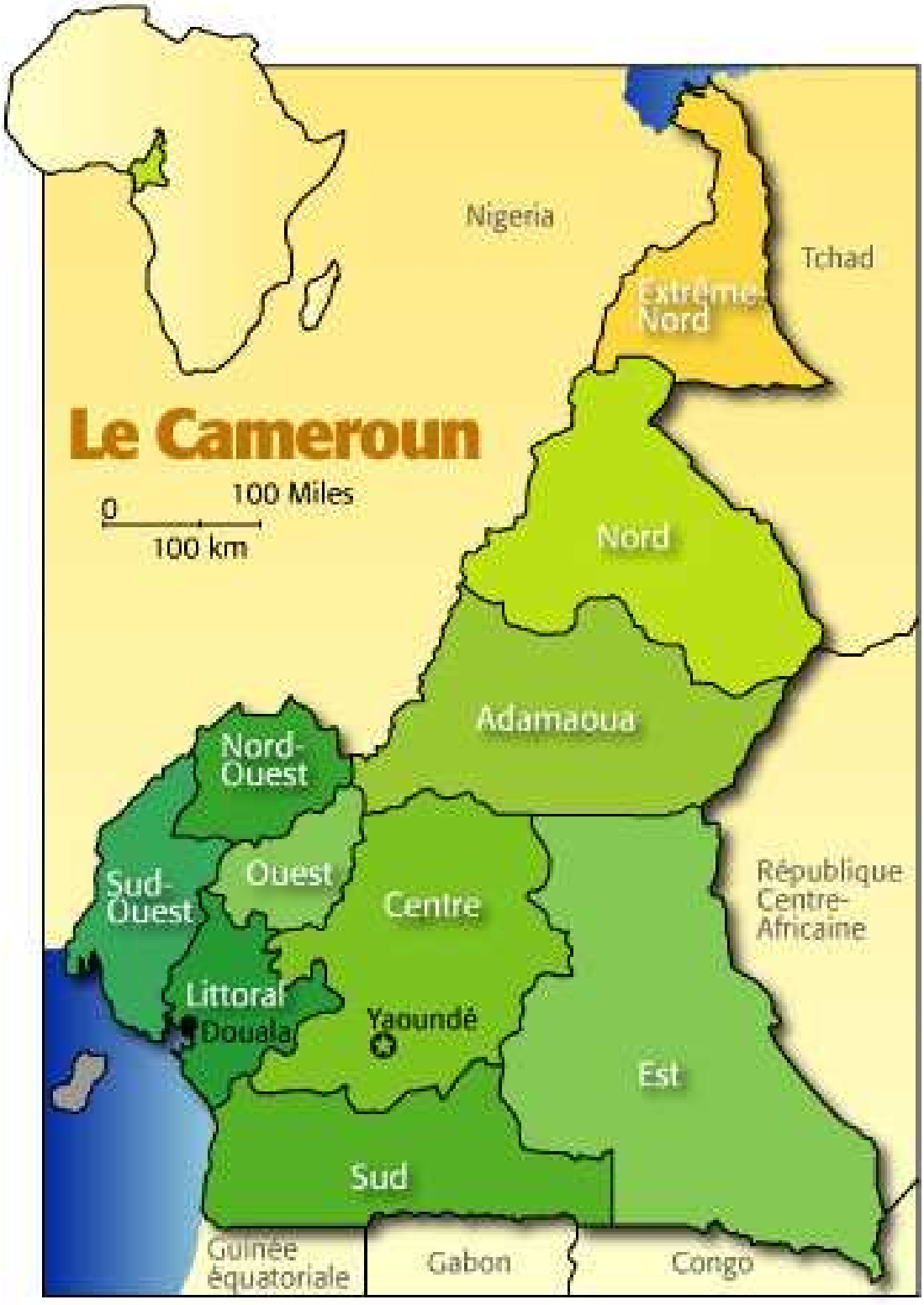
COVER PICTURE: Partial view of the ultra-modern NWPSFH building in Bamenda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Congo
République Centre-Africaine

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ABBREVIATIONS

AFP	Acute Flaccid Paralysis
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Clinic
ARV	Anti Retroviral Drugs
CBGA	Chief of Bureau General Affairs
CPA	Complementary Package of Activities
DCS	District Chief of Service
DFRP	Department of Financial Resources and Properties
DH	District Hospital
DHC	District Health Committee
DHMC	District Health Management Committee
DHS	District Health Service
DHT	District Health Team
DMC	District Management Committee
DO	Divisional Officer
Dr	Doctor
DTG	Diagnostic and Treatment Guide
EPI	Expended Programme for Immunization
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HAHC	Health Area Health Committee
HC	Health Centre
HIMS	Health Information Management System
HIV	Human Immunodeficiency Virus
HSS	Health Sector Strategy
ITN	Insecticide Treated Nets
IWC	Infant Welfare Clinic
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MHO	Mutual Health Organization
MINEFI	Ministry of Economy and Finance
MPA	Minimum Package of Activity
NGO	Non Governmental Organization
NHMIS	National Health Management Information System

NWSFH	North West Special Fund for Health
Oncho	Onchocerciasis
PHC	Primary Health Care
PIE	Planning, Implementation and Evaluation
PLWHA	People Living With HIV/AIDs
PMTCT	Prevention Mother to Child Transmission
PPSC	Provincial Pharmaceutical Supply Centre
RDPH	Regional Delegation of Public Health
SDO	Senior Divisional Officer
SIA	Supplementary Immunization activities
SQI	Systemic Quality Improvement
STIs	Sexually Transmissible Infections
SWAp	Sector Wide Approach
TB	Tuberculosis
UNICEF	United Nations Children's Fund
UNO	United Nations Organisation
WHO	World Health Organization

GENERAL INTRODUCTION

The National Health System in Cameroon or the Reorientation of Primary Health Care has as one of its objectives to rationalize the use of resources through the concept of community participation.

To ensure this, the strategy calls for the creation and functioning of dialogue structures for each service and structure at every level of the system. A dialogue structure, seen as a forum for communication and management brings together community members (users) and health workers (providers) to take decisions on the health of the population. Community members are democratically elected to serve for five years. The experience since 1991 is that like every true democracy, each election brings in new crop of members who are completely ignorant of the system, its principles and practices. Each generation of community members in the dialogue structures thus needs training and orientation to permit them work well.

The implementation of the reorientation of primary health care came at an era when the training of health workers and their recruitment into the public service had been frozen. Authorities and health workers charged with the implementation of the system are in need of additional “on-the-job training”.

The training and reorientation of the dialogue structures and members of the health team has often met with difficulties. Too many documents exist in monograph and sometimes have conflicting information. In other places such documents are not even available. To fill the gap, a first edition of the Guide for dialogue structures was published. Considering the innovations that occurred in the health sector since then, there was need to revise the document which briefly summarizes the basic principles and practices of the reorientation of primary health care and the 2001 – 2015 Health Sector Strategic Plan.

The authors are proposing here a document which summarizes the reflections and practices of the reorientation of primary health care in the North West Region in particular and Cameroon in general. It shall be used as a teaching guide and as a desk reference to be regularly consulted by those engaged in this strategy. It permits the harmonization of training at any level. This document is conceived and written for members of the dialogue structures; members of the health teams at the operational level (health professionals and pharmacy attendants), doctors and Nurses in training.

The present edition has been revised and new portions have been written or rewritten based on constructive criticisms received from users, trainers and reviewers. We are highly indebted to them for their fruitful contributions. Nevertheless, the authors and reviewers do not claim that this book is complete or perfect. Its presentation and content will be improved upon based on objective criticisms from readers and trainers.

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Chapter 1: THE HEALTH SYSTEM IN CAMEROON

1.1. INTRODUCTION

The present health system in Cameroon principally based on the Reorientation of Primary Health Care and centered on the Health District System is a result of a series of reforms from inherited colonial system. Based on the short comings of earlier strategies, the Reorientation of Primary Health Care was conceived in 1985. Its implementation was carefully developed and studied until 1989 when it was approved for field trial. In 1990 the promulgation of the laws bearing on freedom of association and on the waiver to sell drugs, reagents and small equipments in government health units on a cost recovery basis set the pace for its effective implementation nation wide.

1.2. HISTORICAL BACKGROUND

The Cameroonian Health Care System has undergone four major transformations:

A) From the colonial period to 1978, the Cameroonian health care system was characterized by:

- State monopoly with little or no private initiatives
- Health Care (services and drugs) were free as the state bore the entire costs.
- Irrational distribution of health structures and resources mainly concentrated in towns and major economic pools at the expense of the rural milieus.
- High priority to curative activities at the expense of cost effective preventive measures.
- A passive participation of the population (just recipients).
- Low priority given to traditional medicine by public authorities in spite of popular glamour.

Thus with growing economic crises, this strategy became too expensive and unaffordable. Drugs and equipment could not be replenished; training of staff was a problem. Remote areas were abandoned to themselves. The system failed.

B) In September 1978 Cameroon was one of the many countries and organisations that attended the WHO and UNICEF sponsored conference on Primary Health Care in the East European Kazakhstan State capital, Alma Ata. Against the above background, the conference resolved that in many third world countries like Cameroon access to health care for the rural population was either poor or insufficient. It proposed a strategy for the promotion of health for all, termed Primary Health Care. It recognized traditional medicine and attached a lot of importance to that practice. The effective implementation of this policy in Cameroon started in 1982. During its implementation, the area of emphasis shifted from the well known health professionals and classical health structures (hospitals and health centres) to community health workers (village health

workers and traditional birth attendants) and their village health posts. This vertical programme consisted of the mobilization of the community to:

1) Construct, allocate or rent a building to be used as a village health post.
2) Form village health committees for animation and communication.
3) Select a child of the soil as village health worker or traditional birth attendant.
4) Acquire a limited list of essential drugs.
5) Ensure the training of the village health workers and the birth attendants.

At Rica, Russia, in 1987 a global midterm evaluation showed that not the PHC concept but the so-called vertical PHC approach as outlined above had failed colossally:

- The approach was not sustainable
- It lacked field coordination and offered room for the duplication of interventions.
- It lacked supervision from the most peripheral health units with which it went into competition
- There was no real planning resulting in irrational use of scarce resources.
- It was difficult to retain village health workers who either deserted, or got entangled into embezzlement of the limited resources or into illegal professional activities beyond their skills and competences.
- Generally the population took the village health workers for health professionals whose performance was below expectation.

C) In 1990, Reorientation of Primary Health Care was introduced in Cameroon as a natural outcome of the failure of the vertical PHC programme. It is the result of two essentially African conferences seeking to redress the situation without necessarily changing the strategy or philosophy but simply reviewing the implementation of each concept involved. The two conferences are the 1985 Lusaka and 1987 Bamako conference of African Ministers of Health.

D) In spite of all these adjustments mentioned above, some shortcomings were observed notably

- Lack of a legal framework for community participation;
- Lack of a legal framework for the national supply of essential drugs, notably the Regional Pharmaceutical Supply Centre (RPSC);
- Lack of reforms in basic and continuous training;
- Lack of a framework of collaboration between stakeholders;
- Lack of regulation, supervision, monitoring and evaluation;
- Strong centralized management of the sector;
- Low use of public health care structures;
- Inadequate organization of PHC in urban areas;
- Low availability and accessibility of essential medicine;
- Poor development of the referral/counter referral system;
- Predominance of the direct payment for care.

This led to the adoption of the 2001 - 2015 Health Sector Strategy (HSS)

1.3. THE THREE PHASE HEALTH DEVELOPMENT SCENARIO

At the regional meeting of African Health Ministers and WHO in Lusaka in 1985 a strategy to accelerate health development was developed. This strategy called "three phase health development scenario" stresses:

a) The global and multi sectoral approach to health issues,

b) The interlinking of health and socio-economic development.

It further calls on the reorganization of the national health system into three (3) lavels viz: central, intermediate and peripheral. Each has specific functions to reinforce PHC activities. It clearly defines the functional relationship between the layers. It clearly identifies the peripheral layer otherwise called the DISTRICT as the operational unit for the execution of PHC activities. It brings the actors as near as possible to the site of execution.

1.3.1 The Bamako Initiative

In 1987, WHO, UNICEF and African Ministers of Health met in Bamako the capital of the West African state of Mali and formulated a series of measures styled "BAMAKO INITIATIVE" aimed at reviving their health services which were breaking apart for lack of funding from the community and funding agencies. The Bamako Initiative (BI) has five principal concerns.

- Improvement of the quality of Maternal and Child Health (MCH) services so as to pay greater attention to these groups carefully described as vulnerable.
- Reinforcement of peripheral health structures which are the Health Centres and first referral hospitals. They serve a majority of the population.
- Mobilization of community financing through cost recovery by sales of drugs and services
- Enforcement of Community Participation by putting in place a system to ensure the participation of individuals and communities in decentralized decision taking in health matters through their dialogue and management structures.
- Putting in place of an Essential Drugs Policy so that cheap quality drugs in their generic forms can be made available to the population. Essential drugs must be available and affordable.

1.3.2. The Reorientation of Primary Health Care

Using the result of the midterm evaluation of the Primary Health Care and the recommendations of both the 1985 Lusaka conference and the 1987 Bamako Initiative, the Government of Cameroon through the Ministry of Public Health began to reorganize its health system under the name Reorientation of Primary Health Care.

The Reorientation of PHC in Cameroon is not a programme as such but rather the reorganisation (readjustment or correction) of the national health system so as to meet with the social objective of health for all. It is therefore a strategy in the national health policy which counts on the active and effective community participation for the

management and functioning of health services. The Reorientation of PHC has two major components:

- The reorganization of the national health system
- The rationalization of the management of resources either provided to or generated by the sector, within the spirit of partnership between the state and the community. This is called co-management.

A) Reorganisation of the National Health System

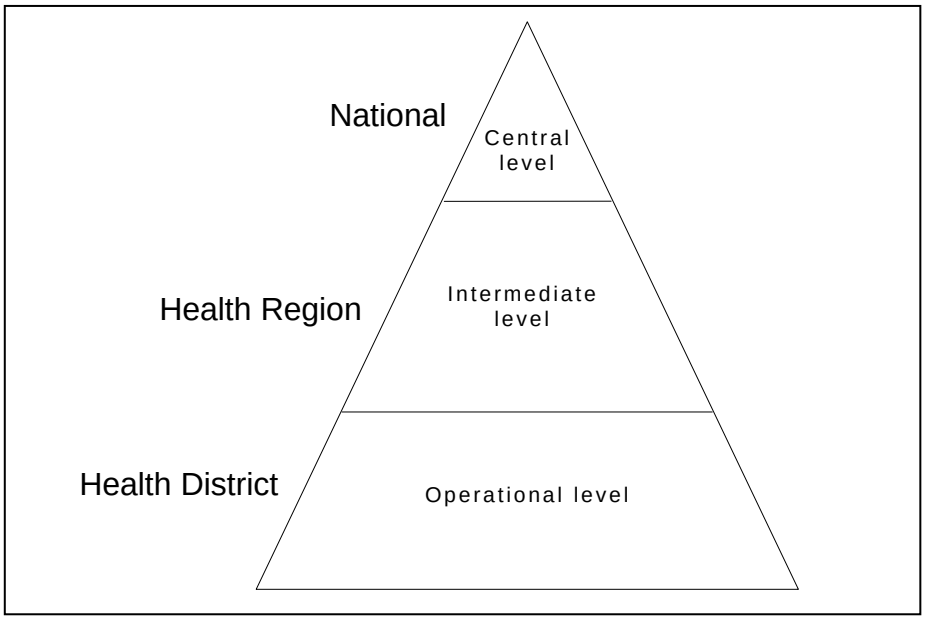
The reorganization of the health system has three objectives:

1) Improve the accessibility of health to the population (take the services to the people).
2) Increase the efficiency of health services in order to better take care of health problems.
3) Improve the quality of health care by paying attention to the vulnerable groups (women & children).

The reorganized health system in Cameroon has three levels viz:

1. the peripheral or operational level = Health District
2. the intermediate level = Health Region
3. the central level = National

Figure 1: National Health System pyramid in Cameroon



Just as the pyramid shows, the health district or the operational level takes care of more people than the intermediate and central level. It is there that community participation is practiced. It is there that the community can express its felt and real needs and the mobilization into action.

The two upper levels are more specialized and provide the technological know-how which may be too complicated for the operational level. They provide the necessary support which is strategic and technical. Each level has its corresponding Health Service and Health Care Structures. This is better illustrated in the following table.

Table 1: Health Levels and their corresponding health services

Level	Role	Health services for administration and technical supervision	Structures for health care provision
CENTRAL	Provides strategic support	Ministry of Public Health	General, Central and Teaching Hospitals
INTERMEDIATE or Regional	For technical support	Regional Delegation for Public health	Regional Hospital
OPERATIONAL or PERIPHERAL or DISTRICT	For operational support	1. District Service for Public Health 2. Integrated Health Centre Office	1. District Hospital 2. Integrated Health Centre

1) **Strategic Support**: This involves making laws and policies, allocating, resources (staff, money and material), defining new programmes, ensuring the training of high level human resources and supervision of the middle level.
2) **Technical Support:** Translate policies, laws and programmes into activities for which resources may be reallocated. Supervise the operational level.
3) **Operational Support:** Assist in the real execution of activities which may be patient care, prevention of disease or in promotion of activities to draw awareness and mobilize the community towards an anticipated action.

Geographically, the central level covers the entire national territory. The intermediate level covers an administrative region. The operational level covers a further breakdown of each Region into Health Districts and each district into Health Areas. The break down (demarcation) of the national territory into health districts and areas is not in keeping with the breakdown of the administrative regions into smaller administrative units. In short the Health District has no direct administrative equivalent.

Health Districts and Health Areas are carved out using predetermined population, geographic and socio-economic criteria to optimally use the health services and health care structures at each level.

Criteria for the demarcation of health districts

1. Population

A viable health area has a population of 5 000 to 12 000 in the rural setup and 10.000 to 20.000 in the urban areas. A health district covers a population of 70.000 to 120.000 inhabitants. A district may cover between five to ten health areas.

2. Geographical Accessibility

All physical obstacles (big forest, rivers, and mountains) and distances separating each population group from its health care structure are identified. These physical

obstacles should in no case obstruct the population from gaining access to the principal health care structure in the area or district. As much as possible these physical obstacles serve as limits between districts and between health areas.

3. Socio-economic consideration

Economic development of the area should be considered. As much as possible bring together in a district or in a health area communities who can live in peace and accept to share together their failures and successes.

A functional Health District is a geographical entity with:

1) A well defined population (70.000 - 120.000)
2) Many health areas
3) A reference hospital called District Hospital (health care structure)
4) A district health service for administration and management
5) A dialogue structure to ensure community participation in the spirit of true partnership.

In a functional health area at least 80% of health problems will be adequately handled at the Integrated Health Centre while only 20 % above its competence will need the attention of the District Hospital (first reference level). This level too should conveniently handle about 80% of the referred cases while the rest are referred for more appropriate management to the Regional Hospital (second reference level). Thus there is a functional relationship of referral and counter referral of patients between the health care structures in the three levels of the national health system.

To avoid unnecessary overlapping of activities between the levels, to rationally use the health structures per level and to ensure quality care, the present health system determines for each level the Minimum Package of Activity (MPA) that it can deliver. The MPA is defined as the number of activities put together at that level so as to solve the particular problems of the population at that level of the system. It will certainly vary per level and per locality but tied to the local disease distribution (epidemiology) and priority given to each problem (how big the problem and how easy it is to be solved).

At the District level, the content of the Minimum Package of Activities (MPA) must be determined individually and developed for:

a) The Health Centre and Health Area
b) The District Hospital
c) The District Health Service.

This is further developed elsewhere.

The reorganization of health activities into Minimum Packages of Activities is simply a more operational and rational way of presenting the eight components of Primary Health Care which are:

1) Health Education
2) Promotion of good food and nutrition
3) Provision of safe water and basic sanitation
4) Maternal and Child Health including Child Spacing

5) Immunization against infectious diseases
6) Treatment of common ailments
7) Prevention and control of local endemic diseases
8) Supply of Essential Drugs.

The MPA at the Health Centre or Health Area will be more promotion and health prevention oriented than that at the District Hospital. That at the District Hospital will be more care oriented than at the Health Service and Health Centre. Whereas the MPA at the Health Service will be more administrative, managerial and supportive with the aim not necessarily to carry out independent field activities but to adequately assist the Hospital and Health Centres to perform their functions well.

The reorganization of the system is equally concerned with the quality of health care. It prescribes clearly that quality health care must:

- Ensure continuity by providing care from the beginning to the end of the episode
- Ensure comprehensive care by not only treating the disease but equally considering the physical, social and economic environment of the patient.
- Provide integrated care by ensuring that staff and equipment at each structure are such that curative, preventive and promotional activities can be carried out in the same place and time. It seeks to destroy the traditional separation into preventive and curative medicine.

B) The rationalization of the Management of Health Resources

The rationalization of the Management of Health Resources has dual objectives:

- Ensure better utilization of resources allocated to or generated by the sector.
- Ensure that the community is closely involved in management so that it can conscientiously be responsible for seeking appropriate solutions for its health problems.

For better utilization of resources the present system emphasizes the use of modern management tools such as the National Health Management Information System, financial documents, plans of action with a comprehensive budget, diagnostic and treatment guide and essential drugs formulary to rationalize treatment. These tools and systems described in chapter three and four of this guide guarantees transparent management and accountability.

The present health system further stresses that health is the concern of each and every one and not the exclusive preserve of the Ministry of Public Health and health workers. It thus promotes effective and active community participation in health by way of co-financing and co-management in a true and democratic sense of partnership between the state and the community and between the users and providers. This sense of partnership is demonstrated through the implementation of the concept of collaboration within and between the sectors in a decentralized manner.

The sure means by which resources generated or allocated can be rationally utilized, and through it, community empowerment and sectoral collaboration installed and strengthened is through the institution of dialogue structures for deliberation and

management at each level of the system. Essentially these structures which are either organs of deliberation/decision or execution or management are composed at each level of users and providers, of technical and non technical staff, of members of the various health related sectors, of the public and private sector. Such a group creates the critical mass which is ever ready to listen to the health and socioeconomic complains of the population that seeks to identify health problems of the community. It also seeks solutions in the form of simple and feasible package of activities to solve these local problems. The group plans, budgets for, executes and evaluates the actions so undertaken.

Current dialogue structures and their management organs exist at the operational and intermediate levels for all the responsible health structures and services. At the central level only management structures do exist for equivalent health structures. This is summarized in the table below.

Table 2: Health Levels and their Dialogue Structures

LEVEL	HEALTH SERVICE AND STRUCTURE	DIALOGUE STRUCTURES
CENTRAL	– SERVICE: Ministry of Health – STRUCTURES: Reference, General, central and Teaching Hospitals	– NIL – Management Committees only
INTERMEDIATE	– SERVICE: RDPH – STRUCTURES: Regional Hospitals	– Provincial Special Fund and its Management Committee – Regional Hospital Management Committee
OPERATIONAL	SERVICE: District Health Service STRUCTURES a) District Hospital b) Integrated Health Centre and Medicalized Health centre	– District Health Committee & District Management Committee – District Hospital Management Committee – Health Area Committee – Health Area Management Committee

The composition, roles, and functioning of these dialogue structures are further developed in chapter 2 of this text.

There is a functional relationship between these dialogue structures. Community members who are the active members enter the dialogue structures from the bottom and contest with peers for entry into the higher structures and organs. The lower structures and organs report to the higher structures and organs while the higher structures and organs supervise and redirect the lower ones. At each horizontal level the general assembly of the dialogue structure is the supreme organ that supervises and enacts decisions of the management committees elected from its members.

1.3.3. The 2001 - 2010 Health Sector Strategy (HSS)

The consensual adoption in 2001 of the Health Sector Strategy (HSS) marked a turning point in the evolution of the health policy in Cameroon. It reflected the future

vision and proposed a set of reforms to be conducted to face up to health problems of the population. Its objectives were:

(i) To reduce global morbidity and mortality by one-third among the most vulnerable groups of the population,

(ii) To set up a health system delivering the Minimum Package of health activities (MPA), at one hour's walk for 90% of the population,

(iii) To practice effective and efficient resource management in 90% of the public and private health units and services at various levels of the pyramid. These objectives were set up in 17 strategic axes of which the implementation was done in 08 programs and 39 sub programs.

Within the framework of implementation of the Paris Declaration on the effectiveness of development assistance, the Government, Technical and Financial Partners and Civil Society Organizations in 2006 seized the favourable opportunities to commit to the establishment of the Sector Wide Approach (SWAp). This includes:

(i) Political will,
(ii) Mutual trust and shared interest,
(iii) Strong government commitment and leadership,
(iv) The ongoing decentralization process,
(v) The existence of a critical mass of human resources,
(vi) The increase in financial laws for health.

The mid - term evaluation of the implementation of the 2001 - 2010 HSS was done with the aim of updating or attuning the latter to 2015 in accordance with the MDGs. From this evaluation emerged a general trend with some salient points and recommendations for updating the strategy, its alignment to 2015 in line with the Millennium Development Goals (MDGs) as well as its implementation.

A) General trend for the 2001 – 2015 Health Sector Strategy

This concerns five main areas namely:

1) Improvement and alignment of the health policy
2) Development of health districts
3) Health of the mother, adolescent and Child
4) Disease control
5) Health promotion

The 2001 - 2015 HSS intends to strengthen the implementation of health sector reforms to translate into reality the "Health Sector Policy Statement of 1992". In concordance with this scenario, the health district system has been chosen by Cameroon as the level where operations for the implementation of national health strategies must be conducted. In addition, Cameroon like other UN member states, has subscribed to achieving the Millennium Development Goals (MDGs) by 2015.

The health sector is particularly committed to six MDGs which are:

- N°1: Reduce extreme poverty and hunger.
- N°4: Reduce under-five mortality.

- N°5: Improve maternal health.
- N°6: Combat HIV/AIDS, malaria and other diseases.
- N°7: Ensure environmental sustainability.
- N°8: Develop a global partnership for development .

To contribute in achieving the health related MDGs, the Cameroon Health Sector intends to work towards developing its 178 health districts through efforts to strengthen the entire health system. It also intends to ensure the evolution of the district health development process with the production and provision of health care and services likely to contribute to the achievement of heath related MDGs with a system to monitor the performance of the sector.

A) Nomenclature of the 2001 – 2015 HSS

It comprises:

I. 4 intervention areas (Domains) including 3 for health care delivery namely:

i. Health of the mother, adolescent and child,

ii. Disease control,

iii. Health promotion,

And one for health system strengthening

iv. Health district development.

II. 14 health care delivery intervention classes

III. 7 health service strengthening intervention classes

IV. 63 categories including 36 health care delivery and 27 health service strengthening interventions;

V. 259 types of intervention including, 138 health care delivery and 121 health service strengthening interventions.

1.4. CONCLUSION

Briefly presented above is the Health System in Cameroon otherwise called “Reorientation of Primary Health Care”. It has come about as a result of the failure of two earlier strategies and approaches which led to the determination of wrong priorities and irrational use of resources. The new system based strictly on the PHC ideology is therefore seeking to improve health care by reorganizing and rationalizing the National Health System. Emphasis has thus shifted from hospital based care and or development of health post to the Health District with its health service, hospital and network of integrated health centres as the operational unit. The 2001 - 2015 HSS intends to strengthen the implementation of health sector reforms to translate into reality the "Health Sector Policy Statement of 1992"

The definition given to PHC at Alma Ata is still as valid in the current health system as it was in 1978. The full understanding and implementation of every concept embodied in this definition are so important that this chapter cannot be ended without reference to them.

These concepts are essential health care based on practical methods and techniques:

- Socially acceptable
- Universally accessible
- With the participation of the community
- At the cost the community can afford

Chapter 2: DIALOGUE STRUCTURES

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Chapter 2: DIALOGUE STRUCTURES

2.1. DEFINITION

Dialogue structures (health committees) are organs and forums put in place to ensure and enhance:

a) Effective community participation in health care
b) Communication between health staff and the community.
c) Partnership between the state (health providers) and the community (users) in health care.

In short, a good dialogue structure for health, otherwise called health committee, should at all time be composed of at least four categories of persons:

a) Elected community representatives to validly represent the interest of the people
b) Providers of health care, that is, members of the technical health team, non governmental organizations, common initiative groups, or faith based organizations active in the area of health and present in the community.
c) Representatives of health related sectors present in the community.
d) Representatives of the supervisory authority. That is, the Ministry of Public Health and the local administration.

2.2. COMMUNITY PARTICIPATION

2.2.1. Basis for community participation

The technical health team exists for the community. The community has health needs and it is the duty of the health team to prompt/mobilize the community to respond to those needs. Through primary health care, essential health care is made universally available to individuals, families and communities. It includes those services that promote health such as keeping a clean environment, a good water supply, care of women during pregnancy and child birth, nutrition of children, immunization and early treatment of disease. Such services depend for success on the active participation or involvement of the communities and individuals concerned. The technical health team has an essential role on such services but cannot alone ensure their success.

To achieve its goal the technical health team must be able to encourage, stimulate and support community participation. That is, help people to rely as much as possible on their own efforts and resources to meet their health needs. The technical health team must work with the community.

It is in this perspective that the national declaration on the implementation of the reorientation of primary health care emphasizes on partnership between the state (health personnel) and the community based on co-management and co-financing of health care to the population.

2.2.2. Definition of community participation

Community participation is the involvement of the community in health care and health related activities with a view to promoting self-reliance vis-à-vis solutions to its health problems (national declaration on reorientation of primary health care). This means that the community determines its health priorities according to its health needs and seeks for solutions, in partnership with the technical health team and other related sectors.

Community participation therefore includes:

a) Decision making
b) Identification of health problems and needs
c) Planning and execution of health activities
d) Elaboration of measures and strategies to solve problems and needs
e) Mobilization of resources to carry out programs, projects and health activities
f) Monitoring and evaluation of the health situation in the community.
g) Acceptance and use of health services offered by approved health facilities.

For the community to effectively and actively take part in health activities, it must be organized into dialogue structures. Dialogue structures are therefore indispensable instruments to foster and ensure community participation.

2.2.3. Duties of community representatives in the dialogue structures

1) Sensitize and organize the community for health promotion and prevention of diseases
2) Mobilize the community to participate more actively and positively in the various health programs
3) Identify health problems and needs of the community and propose strategies to solve them.
4) Inform the health personnel on the outbreak of any disease in the community
5) Enhance and participate in outreach activities
6) Mobilize the community towards the better utilization of health services
7) Educate the population on the health policy, programs and activities
8) Promote the spirit of partnership (collaboration, team work, confidence, cordiality, togetherness in health care etc.) between the state (health services) and the community.
9) Participate in co-financing and co-management of health activities with the health personnel.
10) Mobilize resources for health care in the community.

In short, community representatives shall work hand in hand with technical staff at every level. They shall not fight each other but seek to ease the task of each group.

2.2.4. Types of dialogue structures

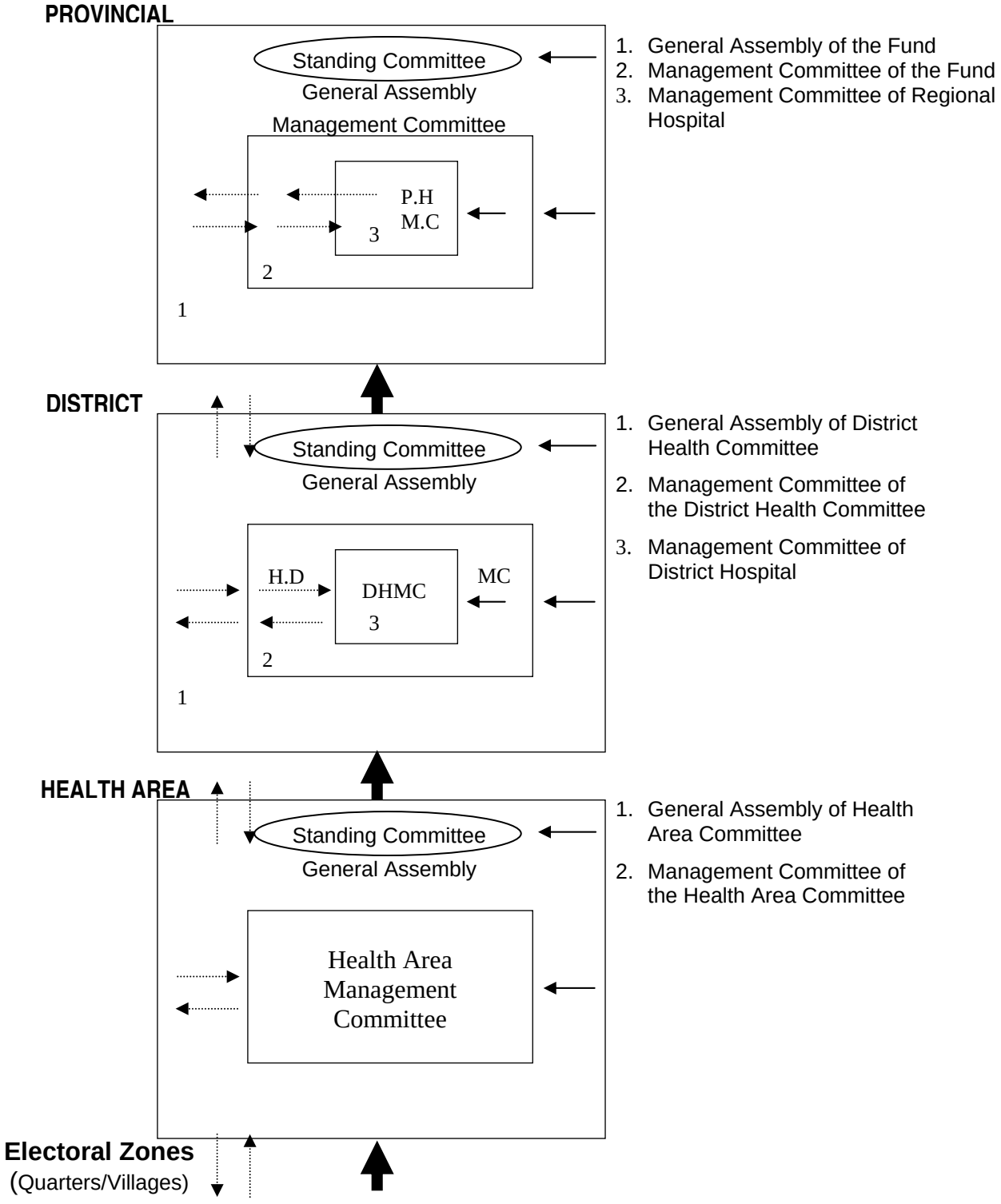
Dialogue Structures exist in 3 levels namely: the Region, the Health District, and the Health Area each with a number of organs. This is illustrated in table 3.

Table 3: Dialogue Structures and their organs

LEVEL	DIALOGUE STRUCTURES	ORGANS
REGION	The North West Provincial Special Fund for Health (FUND) (This is the Regional Health Committee)	- The General Assembly of the FUND - The Management Committee of the FUND - The Regional Hospital Management Committee
HEALTH DISTRICT	The District Health Committee (DHC)	- The District General Assembly - The District Management Committee - The District Hospital Management Committee
THE HEALTH AREA	The Health Area Health Committee (HAHC)	- The Health Area General Assembly - Health Area Management Committee

The health zones are created as electoral constituencies, and to facilitate contact between the health area committee and the members of the community.

Figure 2: The various dialogue structures from the health areas to the regional level



Note:

1) Vertical arrow (↑) indicates election of community members from one level to the other
2) Horizontal arrow (←) indicates election of community members into the various organs of a dialogue structure at each level.

3) Broken arrow (- - - ▸) indicates communication and action line between dialogue structures at various levels and between the different organs of the dialogue structure at each level.

2.2.5. Definition of Zone

It means quarters or villages in different places. Zones should be carved out in such a way that minority groups should constitute specific zones if need be.

2.2.6. Composition of district dialogue structures

The dialogue structures are constituted in the spirit of partnership between the technical health providers and the community at all levels.

2.2.6.1. The Health Area Health Committee (HAHC)

2.2.6.1.1. The General Assembly of HAHC

i. All elected community representatives from the zones. They are active members and have voting rights.

ii. Health staff are ex-officio members because they are not elected. They have voting rights. These are,

- Chief of the leading Health Centre of the Health Area
- One member of the health centre team
- District Chief of Service of Public Health, or his representative (supervisory authority).

iii. Honorary members (have a consultative function and no voting rights). They are:

- Heads of religious organisations active in the area
- One councillor elected by its peers from the area
- Two representatives of traditional authorities in the health area.
- One representative of the registered traditional practitioners.

iv. Co-opted members (have no voting rights but have a consultative function).

- One representative from each health related sector (agriculture, veterinary, education, etc) brought in as technical experts.

2.2.6.1.2. Standing Committee of the HAHC

a) President: elected from community representatives

b) Vice president: elected from community representatives

c) Secretary: Chief of the leading Health Centre

d) Two auditors: elected from community representatives

2.2.6.1.3. Management Committee

a) **Chairman:** elected from community representatives

b) **Secretary***:* Chief of the leading Health Centre

c) **Treasurer***:* elected from community representatives

d) **Financial secretary***:* elected from the community representatives.

e) **Members***:* two other elected community representatives who will automatically represent the health area at the district level.

f) District chief of service public health or his representative

2.2.6.2. The District Health Committee (DHC)

2.2.6.2.1. General Assembly of DHC

i. All the two community representatives from each health area. They are active members and have voting rights.

ii. Health staff (ex-officio members)
   a) District Chief of Service Public Health
   b) Director of the District Hospital
   c) The District Supervisor from the Regional level
   d) Two representatives of all chiefs of Integrated Health Centres in the district.
   e) Chief of Bureau Health (see new organisational structure)
   f) Chief of Administration and Finance with a voting right.

iii. Honorary members: They have consultative powers and no voting right.
   a) One representative of DO/SDO (Administration)
   b) All mayors
   c) One representative of private clinics
   d) One representative of private pharmacies
   e) One representative of the registered traditional practitioners.
   f) All parliamentarians
   g) One head of each religious organisation active in health activities in the district.

2.2.6.2.2. Co-opted members

One representative from each of the health related sectors (Social and Women affairs, Veterinary, Agriculture, Education, Youth and Sport, Environment, etc). Their role is consultative. They have no voting rights.

2.2.6.2.3. Standing Committee of the General Assembly of the DHC

1) **President:** elected from community representatives
2) **Vice president**: elected from community representatives

3) **Two auditors***:* One elected from community representatives (to audit both the DMC and the DHMC)
4) The chief of bureau Administration and Finance
5) **Secretary:** the District Chief of Service Public Health.

2.2.6.2.4. District Management Committee (DMC)

1) **Chairman**: elected from among community representatives
2) **Vice chairman***:* elected from the community representatives
3) **Secretary**: The district chief of service public health
4) **Financial secretary***:* A community representative
5) District supervisor from the regional level
6) Two other elected community representatives who will automatically represent the district at the general assembly of the Provincial Special Fund for Health.
7) The Chief Medical Officer of the District Hospital.
8) Treasurer*:* Service Manager of the District Hospital.
9) One Co-opted member

2.2.6.2.5. District Hospital Management Committee (DHMC)

1) Chairman*:* One mayor elected by his peers
2) Vice Chairman*:* elected from the community representatives
3) Secretary*:* Director of the District Hospital
4) Treasurer: the Service Manager of the District Hospital
5) District Chief of Service Public Health (member)
6) The four community representatives of the District Management Committee.
7) One staff representative elected by his peers.
8) One representative of the divisional/sub divisional treasury.

2.2.6.3. Frequency of meetings of the dialogue structures

The frequency of ordinary meetings for dialogue structures and their organs vary from level to level. This is illustrated in table 4.

Table 4: Frequency of Dialogue Structures meetings

Level	Ordinary meetings	Frequency of meetings
North West Provincial Special Fund for Health	General Assembly	Once a year
	Management Committee	Every 4 months
	Regional Hospital Management Committee	Every 3 months
District Health Committee	General Assembly	Twice a year (every 6 months)
	District Management Committee	Every 4 months
	District Hospital Management Committee	Every 3 months (at least)

Health Area Health Committee	General Assembly	Every 4 months
	Health Area Management Committee	Monthly

In the event where a General Assembly and its Management Committee have to meet within the same period, the management committees will meet first so as to produce reports to the General Assembly. Similarly, the hospital Management Committee meets first to make its reports available to the Regional or District Management Committee as the case may be.

2.2.6.4. Duties of members of dialogue structures

2.2.6.4.1. Standing Committee of General Assembly

1) **President:** Participates in the preparatory management committee meeting for each General Assembly meeting, convenes and presides at the General Assembly meeting.
2) **Vice president:** Acts in the place of the president in the absence of the President and undertakes activities as may be requested by the president.
3) **Secretary (health staff)**: Writes the minutes of the General Assembly meetings, distributes the minutes to participants, prepares invitations and agenda of meetings, guides the General Assembly meetings on the official health policy and technical issues, and co-signs minutes.
4) **Auditors:** Check the revenue, verify the execution of work plans and control the utilisation of corresponding budget, control the finances of the pharmacy. Their activities should be supervisory, advisory, and supportive, not conflicting.

2.2.6.4.2. General Assembly of dialogue structures

1) It is the supreme deliberation and decision making organ of the dialogue structure at all levels
2) Examines the report of activities of the Management Committees
3) Deliberates and adopts measures and strategies to implement health programs in the community.
4) Decides on the proposals of management committee on the use of surplus.
5) Examines and adopts the plan of activities and budget for the next financial period presented by the management committee.
6) Elects community representatives to management committees.
7) Decides on any other matters duly submitted to it by either the health personnel or community representatives.
8) Approves audit reports submitted to it to permit it judge the way the finances of the structure have been managed.
9) Identifies and approves community initiatives.

2.2.6.4.3. The management committee

The management committee is the management organ of each dialogue structure. As such it:

1) Ensures the execution of activities on the plan of action approved by the General Assembly.
2) Presents a report of activities to the general assembly.
3) Prepares and presents a costed plan of action (activity and budget) for each activity period.
4) Determines the health priorities of the community.
5) Mobilises resources (financial, material, human) for the execution of the approved plan of action.
6) Supervises the health facilities including the pharmacy.
7) Ensures the updating of inventory of material and equipment of health units.
8) Recruits (pharmacy attendants, and guards, etc) needed staff.

i. Chairman of Management Committee

- Represents the corresponding dialogue structure in all acts of civil life and liaises with public authorities.
- Convenes and presides over management committee meetings.
- Co-signs the financial documents of the dialogue structure including the bank accounts.
- Reports to the president of the standing committee on activities carried out by the management committee.

ii. Secretary of the Management Committee

- Takes minutes in all meetings of the management committee.
- Prepares and distributes minutes of Management Committee meetings to members.
- Prepares meetings of the Management Committee and the General Assembly.
- Co-signs all financial documents.
- Initiates the plan of action, work plan and budget for the scrutiny of the management committee.
- Educates and guides the management committee on health policy and programs.
- Keeps all management committee documents for safety and easy access to supervisors.

iii. Treasurer of the Management Committee

- He/she is the only person in the dialogue structure responsible for receiving and spending money according to instructions. In this capacity he/she:

- Co-signs all bank documents of the dialogue structure.
- Must make himself and all financial documents available to auditors, financial secretary and supervisors as need may arise.

iv. Financial Secretary

- Prepares and presents financial reports.
- Ensures that the financial documents kept in the pharmacy are regularly updated.
- Must make himself and all financial documents available to auditors and supervisors as need may arise.

2.2.7. Election of Community Representatives into the various Dialogue Structures

The modalities for elections are made on the basis of Decree No. 93/228/PM of 15/03/1993, and the Memorandum and Articles of association of the North West Provincial Special Fund for Health as well as its Internal Regulations and Resolutions.

The various dialogue structures for health care development in the North West Region are ancillary organs of the FUND and are governed by its constitution and bye-laws.

The FUND sets the period for the tenure of office for each set of officers and prescribes the date for new elections. Thus community representatives stay in office for five (5) years renewable once.

The management committee of the FUND is the validation committee for the elections. This session is usually in the months of March/April of each election year. The work of health committee members is benevolent and voluntary.

2.2.7.1 Election procedure

A) Electoral constituency: Each health area is broken into zones of 500 – 1000 inhabitants to elect two persons to represent the zone at the health area. A health zone with over 1000 inhabitants elects three persons into the health area committee.

B) Electoral Committee

i) Zonal level

- **Chairman:** President of the Standing Committee of the HAHC
- **Secretary:** Chief of the leading Health Centre
- **Members:** Traditional authority in the Health Area or his representative

Note: The Chairman of the Management Committee will replace the Chairman of the HAHC in his own zone if the latter is standing for election.

ii) Health Area level

- **President:** The District Chief of Service Public Health
- **Secretary:** Chief of leading health centre
- **Member:** President of the Standing Committee of the DHC
- Regional Supervisor
- Traditional authority in the Health Area.

iii) District level

- **Chairman:** Senior Divisional Officer and in very exceptional cases the Sub Divisional Officer. (When and where ever a health district covers just one sub division).
- **Secretary:** District Chief of Service Public Health
- Regional Supervisor
- **Member:** Divisional representative at the Management Committee of the FUND
- **Member:** Director of the District Hospital

C) Sequence of elections

Start with Zonal, Health Area, District and end with the Regional elections.

i) Zonal elections

Each zone with a population of 500 to 1000 inhabitants elects 2 community representatives to the Health Area Health Committee.

Each zone with a population above 1000 inhabitants elects 3 community representatives.

ii) Health area elections

Each Constituent General Assembly of the Health Area Health Committee, convened by the District Chief of Service of Public Health elects;

- 4 community representatives to the Standing Committee of the General Assembly of the Health Area.
  a) President
  b) Vice President
  c) 2 Internal Auditors
- 6 community representatives to the Health Area Management Committee:
  a) Management Committee Chairman
  b) Vice Chairman
  c) Treasurer
  d) Financial Secretary
  e) 2 Community Representatives who will automatically represent the Health Area at the District Health Committee.

iii) Health district elections

Each Constituent General Assembly of the District Health Committee is convened by the Chairman of the electoral committee.

- 3 community Representatives to the Standing Committee of the General Assembly of the District Health Committee:
  a) President
  b) Vice President
  c) 1 Internal Auditor
- 6 Community Representatives of the District Management Committee
  a) Chairman
  b) Vice Chairman
  c) Treasurer
  d) Financial Secretary
  e) Members: 2 Community Representatives who will automatically represent the District at the Fund's General Assembly
- 4 Community Representatives of the District Management Committee are elected to the District Hospital Management Committee as members. One of them will be Vice Chairman of the District Hospital Management Committee.

2.2.7.2. Basic rules

- No person holding an elected duty post at the Health Area level is eligible for election into the district health committee
- With the exception of the District Hospital Management Committee, no person holding an elected post at the District level is eligible for election into the NWPSFH General Assembly.
- Entry point for election for all Community Representatives is strictly at the Zonal level.

2.2.7.3. Criteria for eligibility

a) To be eligible for election into the Health Area Health Committee at the Zonal level, the person must:

1) Be resident in a Zone of the Health Area.
2) Know how to read and write.
3) Be respectful and respected in the community.
4) Must not be above 65 years old.
5) Be interested in and concerned about community health problems.
6) Be able to mobilise the community for their health care activities.

7) Be responsible and have an independent source of income (socially and economically viable).
8) Not be involved in parallel activities in the health domain (drug peddlers, patente medicine dealers, running illegal health unit etc).
9) Not be a civil servant or an employee likely to be transferred out of the health area at random.
10) Willingly and voluntarily sacrifice his time and resources for health promotion activities.
11) Not have been involved in dishonest and fraudulent activities which could have earned him imprisonment.
12) Not have a very close relation with someone gainfully employed by the FUND.
13) **Gender issue:** Encourage the entrance of more women and minority groups into the health dialogue structures. Where there is a tie for a post between a lady and a male the post should automatically go to the female contestant.
14) Any candidate who holds an elected Political Post, Traditional Rulers and affiliates is automatically disqualified.
15) All candidates vying for any elected post at all levels MUST be member of the Mutual Health Organisation.

b) To be eligible for election into the Health Area Management Committee the person must:

1) Reside within a walking distance of at most 5 kilometres.
2) Be readily available at all times at the Health Centre.
3) Be able to read and write good English.

c) To be eligible for election into the District Management Committee the person:

1) Must be able to read and write very good English.
2) Should reside in the Health Area nearest the District headquarters.
3) Should be readily available to the district technical health team at all times.

2.2.7.4. Election and handing over modalities

1) To be elected the person must be nominated (self nomination authorised) and seconded.
2) Election is by secret ballot
3) Election is carried by absolute majority, that is, above 50%.
4) Each candidate will choose his symbol and/or colour.
5) The elections in each District (from Zonal to District level) will be conducted under the supervision of the highest administrative authority in the Health District.

6) After the Zonal elections are completed in each Health Area, the new General Assembly is summoned into session by the District Chief of Service Public Health for the constitution of its organs (Constituent General Assembly) and election of its representatives to the DHC.

7) After Health Area elections are completed in each Health Area, the new General Assembly for the District Health Committee is summoned by the highest administrative authority on the initiative of the District Chief of Service Public Health to form its ancillary organs and to elect representatives to the Fund.

8) Handing over between the out going and the incoming dialogue structures at all levels must be effected as soon as the elections are over.

9) Each District Chief of Service for Public Health must submit to the Regional Delegation of Public Health a detailed election report including information (bio-data) on each elected representative immediately after the district elections.

Chapter 3: MANAGEMENT OF FINANCIAL RESOURCES

Chapter 3: MANAGEMENT OF FINANCIAL RESOURCES

3.1. SOURCES OF FINANCES PER LEVEL

The reorientation of Primary Health Care in Cameroon stresses on the principle of "co-financing". This means financing health activities and health development projects through the financial contributions of all the partners: the State, local councils, Community, local and International Non Governmental Organisations, bi-lateral and Multi-lateral Organisations. The various sources of financing health activities at the different levels of the dialogue structure are analysed per level in table 5.

Table 5: Sources of financing health activities at the different levels

No	Level	State sources	Community sources	Others
1	FUNCTIONAL HEALTH AREA	1. Government Credits for running and investment 2. Parliamentary grants 3. Local Council financing	1. Payment of fees for services 2. Mutual Health Organisation (MHO) financing 3. Surplus from the FUND from sales of drugs 4. Semester assistance from the FUND 5. Project levies	Donations, gifts and contributions from NGOs and Associations
2	NON FUNCTIONAL HEALTH AREA	1. Investment Credits when possible 2. Parliamentary grants 3. Local Council financing	1. Contributions especially in the form of project levies 2. Mutual Health financing (MHO) 3. Donations from elites and development associations	Assistance from NGOs, Associations and friendly Countries
3	DISTRICT HEALTH SERVICE	Government Credits for running and investment	1. 4% from Health Centres 2. 4% of 63% of revenue set aside of the District Hospital 3. District Health Committee Fund from NWPSFH 4. Supervision subsidy from the NWPSFH	Assistance from NGOs Support from International Organizations (WHO, UNICEF, GTZ, etc)
4	DISTRICT HOSPITAL	Government Credits for running and investment Local Council financing	1. Surplus from the FUND from drug sales 2. Payment of fees for services 3. Mutual Health financing (MHO) 4. Donations and gifts from the Community.	Donations and gifts from NGOs, Associations, Foreign partners.

3.1.1. Revenue from Charges on Services Delivered

As an economic entity, each health structure is a productive unit. It generates income from the services it provides. Services are no longer free. Whereas, in the private sector this is the principal source of income, in public sector there is subvention in addition to this scheme.

3.1.1.1. Health Centre

The following rates are currently implemented in the North West Region in Government Health Centres:

a) Consultation fees: 200 francs CFA for each consultation
b) ANC first visit (registration) 200 francs CFA.
c) Delivery fees: 1000 – 2000 francs CFA.
d) Laboratory fees: a price list from the NWPSFH fixes the price for each laboratory test.

These fees constitute the Community Fund of the Health Centre. As will be noted, collection of fees for essential programs like EPI has not been authorized except for payment of cards and injection materials (disposable needles and syringes) where and when necessary.

3.1.1.2. Government Hospitals

The following sources have been identified and some, though, not all have been implemented in all hospitals:

- Out patient consultations
- In-patient Care
- Deliveries
- Dental Care
- Rehabilitative Care
- Radiography Services
- Medical and Medico-Legal Certificates
- Occupational Medicine
- Pharmacy Services
- Mortuary Services
- Ambulance Services

The rates have been fixed by Decree No 63/DF/141 of 24th April 1963, in part and others have been determined by management on the other hand. This tarification is applicable to all Government Health Units functioning as a District Hospital or as a Medicalized Health Centre. It is worth mentioning that as far as laboratory activities are concerned, the NWPSFH has added a supplementary laboratory fee to the official value for every test in the North West to compensate for the cost of reagents and small laboratory materials purchased by the Health units. This supplementary fee is collected on Hospital Management Committee receipt booklet and paid into Hospital Cost Recovery Fund.

When and wherever the referral system is fully operational, a by pass fee will be established to penalize patients who by-pass their Health Centres to consult directly at the hospital. The proceeds are considered as community funds and not treasury fees and should be collected on the Hospital Management Committee Receipt Booklet.

On the other hand private hospitals are called upon to play the role of District Hospitals in places where the latter do not exist in accordance with Decree N°. 87/529 of 21st April 1987 bearing on the general ties of professional acts in the health sector.

3.1.2. Other Sources of Revenue

3.1.2.1. Running Credits

These are credits, which are allocated on an annual basis by the state to enable health unit's carry out their assigned tasks. They are usually delegated for the period of January 1st to December 31st and must be used during this period.

3.1.2.2. Investment Credits

They are credits voted and delegated for the acquisition of durable and non-consumable assets by the state (construction, renovation, purchase of capital goods, etc). These credits also follow the principle of annual budgeting.

This source of Government revenue is based on warranty, since the "money" is on paper. Sometimes it becomes difficult for managers to make use of government credits due to its long and cumbersome procedure and the liquidity syndrome in our treasuries. The state sometime waters down this rigour by making available money through an imprest account. This account is actually a percentage of either the running or investment credits which is available in liquid form so that managers can use as often as possible to do small purchases.

3.1.2.3. Parliamentary Grants

Where available this also forms part of the sources of revenue in our health units. They are disbursed to parliamentarians to meet certain political and other needs.

The above sources are available but insufficient to meet our ever increasing health needs. It is therefore time that we start looking at Risk sharing in our health units. We have cost recovery which is one aspect of cost sharing. This is found to exist between health providers and users.

Another factor is Insurance on health. The Health Committee at all the levels should get potential groups organized (Njangi groups) so that something be put aside to be used for registration into the Mutual Health Organisation.

3.1.3. Declaration of Government Hospital Revenue

The declaration of the revenue of Government Hospitals is guided by the following texts:

1. Arrete No. 003/MSP/MINFI of 12th July 1993, fixes the list of government hospitals authorized to conserve 35% of the hospital revenue for its development.
2. Decree No. 94/303/PM of 14th July 1994, states that the "quotes parts" (rebates or honoria) to hospital staff is 30% of total revenue collected except revenue from sales of drugs and mortuary fees.
3. Arrete No. 003/MSP/CAB of 16th November 1994, states that some staff of the hospital benefit from "quotes parts" following the criteria outlined in this law.
4. Decree No. 03/229/PM of 15th March 1993 states that:
    a) 50% of the remaining 70% (35% total revenue) is to be paid to the state treasury.
    b) 50% of the remaining 70% (35% of total revenue) is retained for the hospital development.

c) Solidarity fund is 10% of the amount for quotes parts (30% of total revenue); plus 10% of the amount for hospital development (35% of total revenue), and is paid into a special account opened by the Ministry of Public Health.

The finance law N^{o} 98/009 of 01/07/1998 prescribes that after the deduction of 30% revenue for honoraria to staff, the remaining 70% (not a fraction of it) all go into the revenue set aside. The 35% hitherto paid to the government treasury has been suppressed. With this consideration in mind, therefore the use of hospital revenue is thus:

1. 27% to staff,
2. 3% to National Solidarity Account for honoraria,
3. 7% to National Solidarity Account from Hospital Development Fund, and
4. 63% to the Hospital Development Fund (Revenue set aside budget).

The Hospital Development Fund (Revenue set aside budget) is a **Provisionary Budget** as opposed to the annual running credits which is a **Previsionary Budget.** It means that revenue collected in the course of one year is not used that year but saved into a Blocked Saving Account. It can only be used the following year year after the Management Committee has submitted the draft budget on its use to hierarchy (Regional Delegation of the Ministry of Public Health) and obtained an authorisation. Expenditures made are in the form of an imprest, the money is available and not anticipated.

The District Hospital bank account is run by the Director of the District Hospital, the Chairman of the District Hospital Management Committee and the Service Manager (Econome) who doubles as the Treasurer of that committee.

Order N^{o} 005/MSP of 15/07/1994 and completed by Order N^{o} 00301/MSP of 20/09/1999 prescribes the modalities for the use of revenue set-aside for hospital development. The conditions and procedure to follow in order to have the budget approved are equally outlined. The effective transfer of the National Solidarity (10%) to the appropriate account is an obligatory condition for the approval of the budget. Amongst others, the minutes of the Management Committee that studied and submitted the budget as well as a report on the execution of the budget of the previous year must be attached.

Revenue collectors must deposit their proceeds into the Savings Account every ten days. They must make monthly and quarterly revenue declaration through the District Health Offices of attachment to the Regional Delegation, using the appropriate tools.

After deducting 10% of the global revenue for National Solidarity, the Hospital Development Budget (Revenue set-aside) is presented in chapters as below extracted from article 2 of order N^{o} 0030/MSP of 20/09/1999.

1. Purchase/repairs of equipment	20%
2. Hygiene and Sanitation	15%
3. Depreciation	10%
4. Security (Guards)	15%
5. Staff Incentives/Bonus	30%
6. Miscellaneous	10%
(including District Supervision Fund, NID, etc)	

Thus,

1. The effective amount of money to be distributed to staff is 27% of the 30% total revenue.
2. The effective amount reserved for hospital development is 63% of the 70% of total revenue. This money is put into savings account in the name of the hospital with the following as signatories:
    - The Chairman of Management Committee of the Hospital
    - The Director of the District Hospital
    - The Treasurer (Service Manager of the Hospital).

The solidarity fund of 10% of the quotes parts is kept aside as indicated above. The hospital revenue is declared every ten days and put into the savings account of the health units.

3.2. TOOLS FOR REVENUE COLLECTION

To ensure accountability for the revenue collected at each level, a minimum number of revenue collection tools (instruments) has been instituted and must be used.

3.2.1. Health Centre

A) The Health Committee Cash Receipt Books

These are specially designed duplicate receipt books from which a receipt is issued to the user after payment of fees for services or whenever a donation is made. It bears the name of the Health Area Committee, well numbered and has provision for the filling of date, name of client, amount paid in figures and words, purpose and signatures of the receiver, pharmacy attendant (format attached).

B) Daily Cash Entry Register

This register is maintained by the Pharmacy Attendant (the Cashier of the Health Centre). At the end of each working day the Pharmacy Attendant makes a summary of the information on the duplicates of the receipts issued out that day and enters it in the Daily Cash Entry Register. This register has various columns with provision for date of operation, range of receipt numbers used for that day, sources of community income, total collection for that day and remarks. Whenever, the Treasurer of the Management Committee comes to collect money from the Pharmacy Attendant, he must write in **Red** the date of the operation, the total sum of money collected from all sources during the period, his name and that of the Chief of Health Centre. The Treasurer must each time carry out his operation of checking revenue and collecting money in the presence of the Chief of Centre and the Financial Secretary. As such both the Treasurer and the Chief of Centre must sign the Daily Cash Entry Register as witnesses for the transaction.

The amount of money thus collected must be entered into the Cash Movement Register (treated else where) and deposited in the savings account of the Health Area Health Committee.

3.2.2. Government Hospital

A) Community Fund

The same tools as at the Health Centre are used: Receipt Books and Daily Cash Entry Register for cost recovery fees at the hospitals.

B) Government revenue

1. Government Receipt Book (Quittance)

This numbered receipt book printed in duplicate by the Ministry of Economy and Finance to every public revenue collector is correctly filed and issued against any payment made to the Service Manager of the hospital or any other person acting as revenue collector (format attached). The receipt must bear the names of the user paying in the money, the amount of money in words and figures, the reasons for which the money is being paid; the signature of the receiver or collector and the date. The original is given to the user and the collector stays with the duplicate.

2. Hospital Revenue Declaration Form

This is the form which the revenue collector uses for the declaration of the hospital revenue after every ten days and a monthly synthesis (format attached). The number of cases for each activity is obtained from the registers of the respective units. The revenue declared for the period is obtained from the duplicate of receipts from receipt book (quittance) for each activity or act.

The distribution of revenue is effected as described in 2 above, and in the Hospital Revenue Declaration Form. The hospital declaration form is signed by the revenue collector, the Director of the District Hospital, and the Government Treasurer who (issues an official treasury receipt for the sum of money paid into the Government Treasury) certifies the correctness of the operations.

3.2.3. The Pharmacy

A) Drug Sales Receipt Book

Each community pharmacy has a serially numbered duplicate receipt book bearing the name of the institution to which the pharmacy is part. For every transaction between a user and the Pharmacy Attendant, a receipt must be issued and signed stating the amount received and the purpose for which the money has been paid. The user goes away with the original while the attendant keeps the duplicate.

B) Daily Financial Record Book

The pharmacy attendant at the end of each working day records the total revenue from sales of drugs for the day in the daily financial record book and updates the cash in hand.

Further, whenever the pharmacy attendant effects payment to the NWPSFH the amount is checked out of this book and duly signed by the officer of the NWPSFH to whom the money is paid. The Chief of Centre signs as witness.

In order to fight against fraud, the Management Committee of the Fund recommends a duplicate receipt book per pharmacy to be used in collecting money and money equivalent from the Pharmacy Attendant and transferring same to the central office.

The collector must present this booklet or any document presented as such from which a receipt will be issued on the spot for money collected.

Figure 3: Health Committee Cash Receipt Book

Date of operation	Receipt number (range)	Sources of income					Total	Remarks
		Consultation fees	Laboratory fees	Delivery fees	Donations	Bonus		

Figure 4: Daily cash entry register

HEALTH COMMITTEE CASH RECEIPT
NORTH WEST REGION

Date.....

Name of Health Centre Committee .....

Received from……Of.....

The sum of .....

Being payment for .....

.....

[ ] FCFA

RECEIVER **STAMP** **PAYER**

_____ _____

Figure 5: Government Receipt Book (Quittance)

QUITTANCE (RECEIPT)

Recu de .....
Received from
La somme de .....
The sum of
Pour .....
Being
À……Le .....
Issued at ***on the***

Le régisseur des recettes
Revenue collector

Table 6: Hospital Revenue Declaration Form

No	Activities	Number of cases	Revenue declared A	Quotes parts B = (30% of A)	Hospital Development C=(35% of A)	Government Treasury D=(35% of A)
1	New consultations					
2	Hospitalisation days					
3	Surgery					
4	Deliveries					
5	Medical certificates					
6	Medico legal certificates					
7	Laboratory					
8	X-ray					
9	Dental unit					
10	Ophthalmology Unit					
11	Occupational medicine					
12	Others					
	TOTAL					

National solidarity = 10% total B……..…and 10% total C……..Total ……..…….. FCFA

Staff honoraria (QP) = 90% total B……FCFA to be shared to staff.

Hospital development share = 90% total C……FCFA to hospital account.

Prepared on the
……..……..……..

By……..……..
(Name and signature)

Approved on the
……..……..

By……..……..
(Name and signature)

Paid to state treasury (in letters): ……..…….. FCFA

Quittance No……

At……..……On……..……

NAME AND SIGNATURE OF TREASURER

Chapter 4: STEPS AND PROCEDURES IN THE MANAGEMENT OF HEALTH ACTIVITIES AND RESOURCES

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Chapter 4: STEPS AND PROCEDURES IN THE MANAGEMENT OF HEALTH ACTIVITIES AND RESOURCES

4.1. INTRODUCTION

Management in simple terms means “Getting things done” using the available resources (human, material, financial, time resources, etc). The Management cycle includes planning, implementation and evaluation (PIE).

The planning phase includes identification of problems, a search for resources and clear budgeting.

Implementation phase is execution of the plan, monitoring of activities, control of level of realization and supervision.

Evaluation is not a terminal event. It is a continuous event. It simply measures what has been realized against what was planned.

The dialogue structures (health staff and community representatives) will be very much involved in the management of health activities and resources in the spirit of co-management: partnership between the State (represented by health staff) and the community.

In the context of health sector strategic plans and the National Health Development plans using SQI, all health units and health system levels (health area, health district and regional delegation) have to plan obligatorily for the MPA and CPA in the annual work plans and strategic development plans in view of achieving the MDG by the year 2015. This should be done to ensure a harmonious development of the health districts to complete viabilisation and attainment of the strategic development goals.

4.2. PLAN OF ACTION

The health plan is a course of action to be followed by the dialogue structures in order to achieve set objectives. It is based on identified priority and related needs of the community, taking into consideration the availability and efficient use of resources.

4.2.1. Identifying Priority Health Needs

Health needs in the community are so numerous that they cannot all be tackled at once. Some will be tackled first and others postponed to a later time. Those needs which the district team would like to tackle first are priority needs. For every health unit or health district, these priority needs or interventions will depend on their status on the scale of viability. However, there are some priority programmes whose activities must be carried out at all levels, and thus must be planned and executed especially in view of attaining the MDGs.

To select priority health needs, the district health team must use a set of standard criteria:

1. Their magnitude in terms of proportion of the general population or of specific sub groups of the population, such as women, pre-school children, school children affected.

2. Severity/danger to individuals and the community. Does the condition threaten life, cause major suffering, decrease the ability to lead a normal life, reduce productivity, and cause deaths?

3. Amenability to intervention (vulnerability). If a problem is not amenable to intervention because of technological requirements and other factors, it makes little sense to include it in the list of those targeted for action. It is not vulnerable.

4. Cost of intervention: If the cost of solving a problem is too high then it will not be a priority.

The plan of action is based on one budgetary or financial year, that is, January to December. The preparation of the plan of action involves planning, implementation (execution), monitoring, evaluation and reprogramming.

The plan of action must be feasible, concrete and realistic. The plan of action can be elaborated for the period of one year January to December or for several years. The plan of action includes the health needs according to priorities; objectives to achieve, and indicators to measure achievements, and also the global cost.

Table 7: Sample Plan of Action

Priority needs	Objectives	Activities	Cost	Indicator
1. Protect children less than one year against measles	1. 80% vaccination coverage at the end of the year	1. Vaccinate in all health centres 2. Effect outreach in non functional health areas	700,000	1. Number of health centres vaccinating 2. Number of children vaccinated/total number

At the level of the health area the plan of action is made by the Management Committee in November and presented to the General Assembly of the Health Area Committee for approval in December. A copy is forwarded to the District Chief of Service of Public Health. At the level of the Health Area the plan of action is initiated by the Health Centre Management team, presented to the Management Committee for study and modification by including other community felt needs. Then the latter submits to the General Assembly for deliberation and approval. A copy is forwarded to the District Chief of Service of Public Health.

At the Health District level the district plan of action is initiated by the District Management team finalised by the District Management Committee and submitted to the General Assembly of the District Health Committee for approval. A copy is forwarded to the Regional Delegation of Public Health.

4.3. WORK PLAN (BUSINESS PLAN)

The work plan consists of a list of activities or interventions and tasks that will be effected during a certain period to achieve the objectives of priority needs established in the plan of action. The work plan includes:

1. Date of execution of activities
2. List of activities

3. Place of execution of activities
4. Person responsible
5. Cost
6. Sources of finances

Table 8: Sample Work Plan

Month	Activities	Place	Person Responsible	Cost FCFA	Sources of finance
2/05/2010	Vaccinate children at outreach centre	Bamenda	Chief of Centre and 1 Nurse	20,000	Community Fund
6/05/2010	Buy kerosene for the fridge	Health Centre	Treasurer	15,000	Community Fund
7/05/2010	Buy stationeries for the health centre	Health Centre	Chief of Centre	50,000	Government credits
8/05/2010	Buy 20 bags of cement for Mbu health centre	Bamenda	Treasurer	70.000	External project
Total				**155.000**	

The activities can also be plotted on a Gantt Chart.

Table 9: Activities against time using the Gant Chart

Activities	January 2010			
	1st Week	2nd Week	3rd Week	4th Week
Planning				
Implement plan				
Evaluate				
Report				
Re-programme				

This is useful for monitoring and controlling the implementation of activities by eliminating non working days; duplication of efforts; determining the most appropriate dates for carrying out of activities.

The work plan is made up for a period of six months, at the beginning of each semester January to June, and July to December or a period of one year January to December. Activities not executed in the previous semester will be put in the following semester if they are still necessary.

The work plan is initiated at all levels by the technical staff and presented to the Management Committee for study and submission to the General Assemblies of the Health Area Committee and District Health Committee respectively for approval. The production of the district plans will take into consideration the plans of the Health Areas. The regional plans will be based on the District Health plans.

4.4. BUDGETING

The production of the plan of action and work plan is an obligatory prerequisite for budgeting. The total cost of the plan of action and work plan constitute the budget, financial support, needed to execute activities during the financial year January to December. Costing of activities implies determining:

- the number of persons involved
- transport to the place of execution
- fuel
- feeding

- night allowances
- other inputs, etc

Except for some standard rates defined by government or project texts the standardisation of rates is difficult and should depend on the financial resources of each level. The total cost of the plan should not exceed resources.

Budgeting should be done with the resources available because anticipated finances might not be at hand at the time of execution of activities. Several ambitious plans to construct Health Centres have ended at the foundation level.

4.4.1. Comprehensive (composite) budgeting

It must be practiced at all levels. This involves the utilisation of finances from all financial sources available to implement activities at each level. From the plan of action and work plan determine the total cost of activities and projects for the period considered. Using the sources of revenue in the work plan and for the projects, identify the amount of money to be spent from each source on activities. This expenditure is stated in tabular form (table 10).

Table 10: Sample Expenditure for a Health Unit

Source	Activities	Cost CFA	Total
1. Government Credits	- Supervision	30,000	
	- Vehicle maintenance	200,000	
	- Night allowances	150,000	
	- Purchase of TV set, etc	500,000	880,000
2. Community funds at health centre			
3. Surplus from drug sales			
4. Others			

The revenue or income, that is, the financial sources available at the corresponding level are stated as illustrated in the following table.

Source	Income	Amount FCFA
Government Running Credits		
Drug surplus		
Investment credits		
Fees for services		
Total		

Note: The expenditure should not exceed the income

Finances from the various sources might not be available at the same time so it is usually necessary to make a financial plan, using the most available source, then irregular source when ever it arrives.

Copies of the plan and budget of the health areas are sent to the district, and those of the district to the region.

4.5. EXECUTION OF PLAN AND BUDGET AT THE HEALTH AREA

4.5.1. Custody of the Community Fund

Each Health Area Committee must open a savings (Post office bank) account with the following signatories.

1. Chairman of Health Area Management Committee
2. Chief of Health Centre (Secretary)
3. The Treasurer

All money collected from the Pharmacy Attendant, who serves as the clerk of the Health Centre, by the Treasurer is deposited in the saving account. If there is no bank account, the money is left in the Pharmacy of the Health Centre. The treasurer does not take home money. The bank booklet and all financial records are kept by the Pharmacy Attendant in the Pharmacy.

4.5.2. Cash movement

1. Each Management Committee shall determine the maximum amount of money to be held in the safe at each time; the difference paid into the savings account.
2. Cash movement register: Money is collected by the treasurer from the pharmacy attendant In the presence of the chief of centre. This operation must be entered in the register dated and countersigned by both the Chief of centre and treasurer in the Cash Movement Register (see format). Money collected by the treasurer is entered under the heading –IN– as income. All expenditures incurred by the Management Committee must be recorded in the Cash Movement Register in the column –OUT– with full description of the corresponding operation. The Cash Movement Register is kept by the pharmacy attendant in the pharmacy. For any donation in cash, a receipt is issued by the pharmacy attendant and the transaction recorded in the cash entry and movement registers under –IN–.
3. Payment voucher: All payments made by the treasurer must be accompanied by a duly signed payment voucher (see format).

   It is prepared by the treasurer, checked and signed by the Chief of centre, approved and signed by the Chairperson of the Management Committee. The receiver signs it with complete identification.

Each payment voucher bears a serial number, numbered from January 1st to December 31st of each year. During supervision, health area supervisors must cross check and countersign all correctly filled payment vouchers.

Figure 6: Sample of a Payment Voucher

HEALTH DISTRICT_____

Health Area Committee .....

PAYMENT VOUCHER

P.V. Number.....

Date.....

Officer: .....

Pay to (Name & Address): .....

.....

The Sum of: .....

Being: .....

Prepared by the Treasurer:.....
Name/Signature

Checked by the Chief of Centre:.....
Name/Signature

Approved by Management Committee Chairman:.....
Name/Signature

Received the sum of: .....

On the:……Signature: .....

Name:……..ID Card No:……..Issued on.....

At: .....

Figure 7: Sample of a Cash Movement Register

Date	Payment Voucher No.	Description of operation	CASH			Sign. Treasurer	Sign. Chief of Centre	Sign. Chairman
			IN	OUT	BALANCE			

4.5.3. The Health Centre Fund

The following are the areas of expenditure and propositions of income generated from service fees at the Health Centre as practiced in the North West Region.

1) 35% for sundries – stationery, soap, kerosene, and working material needed for the running of the Health Centre. The list of needs is made by the Health Centre team and presented to the Management Committee for approval.

2) 36% for incentives – serves as motivation to enhance staff performance and also as assistance to community representatives. The incentive is shared as follows: 70% for all staff and 30% for community representatives of the Management Committee. Each group will set criteria for the distribution of incentives. Means of verification will be the payment voucher for distribution of incentives signed by all the beneficiaries.

3) 10% for supervision – outreach activities in the Health Area, participation at meetings by both Community Representatives and staff.

4) 10% for the payment of community employed staff.

5) 5% for referral subsidy – This is a revolving fund to be used on referred cases, and temporary and permanent paupers. Modalities are to be elaborated by the Management Committee of each Health Area.

6) 4% for contributions to the district supervision fund. The money shall be collected by Chief of Bureau for General Affairs (CBGA) and paid at the district health service into the District Management Committee account). It shall be used for fuel, transport, supervision material and sponsoring of meetings of District Health Committees. The budget will be elaborated by the District Chief of Service and presented to Management Committee for approval.

4.5.4. The use of surplus

The North West Provincial Special Fund for Health distributes surplus from the drug programme to the various health units with functioning pharmacies in the Region. The surplus serves to finance health unit activities and is directly managed by dialogue structures. The projects financed have to be health related. Justification for the use of money should be made and the utilisation should be in line with the plan of action and work plan hitherto presented before the money is released.

The justification should include: amount of surplus received, expenditures with all relevant documents, balance, comment by District Chief of Service of Public Health.

The supervision of the use of surplus is the responsibility of the District Chief of Service of Public Health and the Region.

A report is made through the District Chief of Service of Public Health to the Regional Delegate of Public Health and to the Fund.

Payment of new surplus will be made only to those health areas who have submitted:

- A copy of the financial report of the current year and budget for the following year presented to the General Assembly.
- A copy of minutes and attendance list of the General Assembly.
- A plan of use of the new surplus

4.5.5. Government credits

Government credits to Health Centres are managed according to the financial laws. They constitute a component of the comprehensive budgeting. (See Chapter 3)

4.6. EXECUTION OF PLAN AND BUDGET AT THE DISTRICT SERVICE

The activities of the district service are essentially sponsored by government credits which have defined management procedures.

Apart from the Government Credits the District Health Service receives in cash the following funds:

1. District Supervision Fund which is 4% of the revenue generated by all health units in the district, including the District Hospital.
2. Supervision subsidies from the Regional Delegation of Public Health.
3. District Health Committee Fund paid directly by the North West Provincial Special Fund for Health to the various committees to enable them function.
4. PHC supervision fund paid by the NWPSFH to the districts.
5. Other sources.

The district opens a savings account in which it deposits money coming from 1, 2, 3, 4 and 5. The account has as co-signatories the Chairman of the District Health Management Committee, the District Chief of Service and the Treasurer of the District Management Committee (Service Manager).

The management of these funds is the same as Health Centre Fund of the Health Area. All the finances of the district service are used in comprehensive budgeting (composite budgeting). All financial records are kept at the district service. A report on the utilisation of funds is forwarded to the Provincial Delegate of Public Health.

4.7. MATERIAL RESOURCES

The inventory of material resources in government institutions is made by the Stores Keeper. The Management Committee must:

1. Study the inventory lists and update them quarterly.
2. Ensure that any new material and equipment is recorded by the Store Keeper and that it also has independent ledgers for equipment room by room and updated every two months.
3. Ensure the judicious use of material resources by health staff and the community users of the health units.
4. Carry out some maintenance (preventive and curative) and purchase of simple materials with the available funds.

4.8. HUMAN RESOURCES

The technical staff of state health units are employed and paid by the state. Health units are only authorised to recruit three categories of staff namely pharmacy attendants, night watchmen and cleaners.

The environmental hygiene of the health unit is the responsibility of the community who can carry out human investment. Otherwise the environment could be kept clean by hiring labour internally. The internal sanitation of the health unit is the responsibility of the care taker of the patients and the staff.

Community representatives to the dialogue structures assist the technical staff in the field in mobilising the population and in the execution of activities as need arise.

4.9. EXTERNAL FUNDING OF PROJECTS

The external funding of projects is based on the needs expressed by the Management Committee. The needs should be expressed in terms of infrastructure and material resources adapted to the health units.

The external supply of drugs directly to state health units in the region is forbidden. If drugs are donated to any of these health units, the Management Committee must bring all the drugs to the Fund for quality control and modalities for utilisation.

The execution of the project should be based on a plan of action elaborated by all the partners involved.

The Management Committee plays a very important supervisory role. A quarterly report on the state of the project, including level of achievement and cost, must be made by Management Committee and forwarded to all the partners involved at the higher level.

4.10. COMMUNITY FINANCIAL SUPPORT

This is obtained from free will financial contributions from the community for community initiated projects. All communities should endeavour to perform community initiative projects to enhance the development of infrastructure and equipment of their health centre. It should include the external and internal population of the health areas.

Chapter 5: ORGANISATION OF DIALOGUE STRUCTURE MEETINGS AND WRITING OF MINUTES

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Chapter 5: ORGANISATION OF DIALOGUE STRUCTURE MEETINGS AND WRITING OF MINUTES

5.1. PURPOSE OF MEETINGS OF DIALOGUE STRUCTURES

i. To enhance communication and interaction between all partners involved in health care delivery (health care providers, the community; and other health related sectors)
ii. To coordinate health programmes and activities in the community
iii. To identify health problems presented as community needs.
iv. To develop appropriate measures to solve them
v. To assess or evaluate the state of affairs (activities, health etc.)
vi. To elaborate plan of action, Workshop and budget
vii. To develop strategies to implement health programmes and activities in the community.

Table 11: Dialogue Structure Meetings in the North West Region

Meetings	Convener	Purpose
1. Constituent General Assembly	The Governor of the North West Region	To elect community representatives to: – The Standing Committee, – The Management Committee, – Regional Hospital Management Committee and to Sub Committees
2. Ordinary General Assembly Meetings	The Governor North West Region President of the Standing Committee	– To deliberate and take major decisions affecting the life of the Fund, – Receive Management report of the past year – Examine and approve audit report – Vote new Budget – Vote plan for distribution of surplus
3. Extra ordinary General Assembly of the NWPSFH	The Governor of the North West Region	To solve urgent health related matters
4. Ordinary Management Committee of the NWPSFH	The Regional Delegate – Chairperson of the Management Committee	Planning, and assessment of planned activities of the Fund
5. Extra ordinary Management Committee	The Regional Delegate – Chairman of the Management Committee	To deliberate and solve urgent health related matters.

Table 12: General Assembly Meetings of Dialogue Structures of the Health District

Level	General Assembly Meetings	Convener	Participants	Purpose
District Health Committee (DHC)	Constituent General Assembly	The Senior Divisional Officer or Divisional Officer	Newly elected Community Representatives from Health Areas, Health Staff and other co-opted members	To elect community representatives to: Standing Committee, District Management Committee, Hospital Management Committee, NWPSFH
	Ordinary General Assembly	President of Standing Committee	Community Representatives from Health Areas, Health Personnel, Honorary Members, co-opted members.	Deliberate on health of the community, Supreme and binding decisions concerning health in the district.
	Extra Ordinary General Assembly	President of Standing Committee	Same as above	To solve urgent health related matters.
Health Area Health Committee (HAHC)	Constituent General Assembly	The District Chief of Service	Newly elected community representatives from zones, Health staff and the honorary members	To elect community representatives to: Standing Committee, Management Committee, DHC
	Ordinary General Assembly	President of Standing Committee	Community Representatives from zones: Health Staff, Honorary Members, Co-opted members	Deliberate on health of the community; take decisions on health in the health area.
	Extra Ordinary General Assembly	President of Standing Committee	Same as above	To solve urgent health related matters.

Table 13: Management Committee Meetings of the Health District

Level	Ordinary Meetings
District	District Management Committee District Hospital Management Committee
Health Area	Health Area management Committee

In Summary:

1. An extra-ordinary management committee meeting can be convened to solve urgent health related matters.
2. All management committee meetings are convened by the respective Chairpersons.

3. The participants to the meetings are the members of the respective management committees.

5.2. PREPARATION OF MEETINGS

This includes defining:

1. The purpose or objective of the meeting,
2. Type of the meeting,
3. Main subject matter or content,
4. participants,
5. Place (venue),
6. Time and duration,
7. Agenda,
8. Distributing any relevant documents to participants preferably three days before the meeting.
9. Acquisition of material and logistics for the meeting.

Every Management Committee makes preparations for its respective General Assembly Meetings and submits the draft agenda and invitations to the President of the Standing Committee for approval and signature.

5.3. CONVENING OF MEETINGS

1. By written invitation stating the type of meeting, purpose, place, date and time and bearing the signature of the President of the Standing Committee or the Chairperson of the Management Committee depending on the type of meeting.
2. Through announcements: Mass media (radio, television, press) or town criers; churches, etc. with the same information as in the written invitation.

5.4. DELIBERATIONS AT MEETINGS

5.4.1. How to conduct a meeting

a) The quorum: Check how many people are in attendance. Is the number sufficient to start the meeting and take decisions? Usually at least 50% of the invitees is a sufficient quorum to run a health committee meeting. If for the 3rd time, the quorum is not met, the deliberations can go ahead.

b) The Agenda: It is a list of items which shall be discussed. This list is presented, debated, modified and adopted for discussion.

c) The Opening remarks: Official statement made by the person presiding over the meeting. It is usually a word of welcome and a presentation of the purpose of the meeting.

d) The Minutes of the previous meeting: The minutes of the very last meeting are read, corrected and adopted.

e) **Matters arising from minutes:** It concerns brief discussions on decisions taken, activities and events discussed at last meeting for which a follow up was needed.

f) **Specific items:** This may be activity reports, financial report, audit report, fact finding report, supervision report, presentation of a programme of activities and the budget, etc.

g) **Discussion and decisions:** Each presentation is followed by a discussion on the topic for better understanding and decision. Such decisions are taken in the form of recommendations and resolutions. For each resolution, it is good to state who is charged with its execution, when and with what means. Sometimes a resolution may create a sub committee to examine the problem further before proposing a pragmatic solution.

h) **Other matters:** This permits the organizers to present and discuss matters which do not form the core purpose of the meeting. Discussion is done as in (g) above.

i) **Closing remarks:** The presiding officer officially closes the meeting.

j) **Minutes:** The minutes of the meeting must be developed and presented to the presiding officer by the secretary. The secretary and the president must co-sign the minutes after they have been read, corrected and adopted in the next meeting, before they are circulated.

k) **Conduct during meetings:** During meetings, one person speaks at a time after having taken permission from the President/Chairperson. The person addresses the Chair and the house. The speech must be brief and relevant to the topic under discussion.

5.4.2. Characteristics of a Chairperson

For any meeting to be successful, the person who presides over it must have the following characteristics.

a) He/she must compose himself/herself and prove to be a real democrat knowing fully well that his/her role is that of a moderator over the meeting.

b) Be prepared to listen to the opinion of other members and make corrections where applicable.

c) Must have a good insight of the matter or issue he/she is handling.

d) Knows that the will of the majority triumphs, not the Chairperson dictating.

5.5. CONTENTS OF MEETINGS

5.5.1. Health Area Management Committee

a) Assess the level of implementation of plan of action, work plan and budget approved by the General Assembly of the Health Area Health Committee.

b) Review the health coverage of the community, using the monthly reporting forms of the health centre: HMIS data collection forms, vaccination returns, etc.

To appreciate:

- Consultations at health centre,
- Infant Welfare Clinic (IWC)
- Pregnant women attending Antenatal Clinic
- AIDS control
- Family planning
- Revenue
- Etc.

c) Identify health needs and develop strategies to solve them,

d) Examine the internal audit report and adopt corrective measures,

e) Review the functioning of the pharmacy bringing out any problems especially that of shortages and ways of recuperating them.

f) Prepare the General Assembly Meeting and submit agenda and invitations to the President of the General Assembly of the Health Area Health Committee for approval.

g) Prepare plan of action, work plan and budget and submit to the General Assembly for approval.

5.5.2. Health Area Health Committee General Assembly

a) Examine the report of the Health Area Management Committee.

b) Receive and deliberate on brief written reports of zones from the representatives of each zone, which should include:

- Vaccination of children
- Hygiene and sanitation
- Health Education on AIDS/STIs control
- Deaths and their causes
- Food hygiene and protection
- Other health needs.

c) Assess the health coverage of the health area using the reports presented by the health centre staff:

The month's data collection form of the National Health Management Information System for the previous six months should be received to appreciate the evolution of activities and measures adopted to improve health coverage. Decisions taken should be based on the objective analysis of the health centre technical report.

d) Examine and adopt the plan of action, work plan and budget for the health area presented by the Management Committee.

e) Approve health area report for the district health committee presented by the community representatives to the district.

5.5.3. District Hospital Management Committee

Assess the execution of the hospital plan of action and the corresponding budget.

Assess the performance of the hospital using the month's report of activities presented by the Director of the DH concerning:

- Consultations
- Deliveries
- Surgical operations
- Hospitalization
- Deaths and causes
- Hospital sanitation
- Community participation in the hospital
- Revenue

Study the internal audit report of the hospital including the pharmacy and elaborate corrective measures for any identified problems.

- Identify problems of the hospital and determine realistic measures to solve them.
- Prepare a plan of action and budget for the hospital.
- Make a work plan for new activities or projects for the hospital.

5.5.4. District Management Committee

- Assess the level of execution of district work plan and the corresponding budget.
- Appreciate the health coverage of the district from technical monthly reports presented by the technical health team, especially concerning:
  - Consultations at health units
  - Vaccination of children and pregnant women
  - Attendance at child welfare clinics and at antenatal clinics
  - Deliveries
  - AIDS/STIs control
  - Other health programmes

From the analysis of reports identify health needs and develop strategies to solve them.

- Study the internal audit report and develop corrective measures for discrepancies identified.
- Make a review of situation of pharmacies in the district from supervision reports of the district health team bringing out problems especially shortages incurred and measures to recuperate the money.

- Prepare a plan of action, work plan and budget for the district.
- Prepare the General Assembly meeting and submit the agenda and the invitation to the President of the standing committee of the general assembly of the district health committee for approval and signature.
- Listen to and deliberate on the report of the North West Provincial Special Fund for Health Management Committee presented by the Divisional Representatives.
- Prepare the district report for the NWPSFH.

5.5.5. General Assembly Meeting of the District Health Committee

1) Examine the reports of the District Management Committee meetings.
2) Review written reports from each health area co-signed by at least one community representative and the chief of centre in case of a functional health area, which should include;
    - The population of health area
    - Number of new monthly consultations for the last six months at health centre
    - Monthly new attendance at child welfare clinic
    - Monthly deliveries at health centre
    - Revenue from fees by activity (consultation, deliveries, etc)
    - Number of General Assembly Meetings of the health area Health committee held
    - Number of meetings of the health area management committee.
    - Vaccination of children and pregnant women
    - Environmental hygiene
    - AIDS Control Activities
    - Family planning
    - Deaths and possible causes in the health area.
    - Other health activities carved out.
3) Appreciate the health coverage of the district from the technical report presented by the health team on:
    - Vaccination of children, especially less than one year, for all the vaccines.
    - Child Welfare Clinic
    - Antenatal Clinic
    - Deliveries at health centre
    - AIDS/STIs
    - Family Planning,
    - Hygiene and Sanitation

- Control of diseases, endemic and epidemics.

4) Adopt measures and strategies to improve health coverage of the district in areas and domains with low coverage.
5) Examine the internal audit report and adopt corrective measures.
6) Examine and approve the plan of action, work plan and corresponding budget for the health district presented by the district management committee.
7) Adopt plan of action and budget of the district hospital presented by the hospital management committee.

5.6. PRESENTATION OF REPORTS

For every meeting to be meaningful, reports must be presented. These reports will show the level of implementation of activities in the action plan. This enables you to know how you have executed your activities with the meagre resources at your disposal.

Apart from the fact that reports enable you to keep pace with your action plan, it is also a forum for knowledge sharing, learning from each other what is happening in the health area. These reports may be:

a) Zonal Reports
b) Technical Reports
c) Financial Reports

a) Zonal Reports

These are reports written by the health committee representatives of each health zone or quarter or village as the case may be with some health areas. The reports show the level of implementation of preventive and promotion activities carried out in the zones within the given period.

b) Technical Reports

The report is given by either the chief of centre in case of a health area or the District Chief of Service in the case of district meetings. The report should be on preventive, curative and promotion activities. It may be purely a technical report but it has to be highlighted for the Community Representatives to appreciate.

c) Financial Reports: Income/Expenditure

At the health area level, this report is given by the Financial Secretary supported by the Treasurer, while at the District level the report is given by the Financial Secretary, supported by the Service Manager and the District Auditors. This report is very necessary for efficient and transparent management.

There must be evaluation to see how effective the reports are on the health programme. Evaluation of the reports will also determine the level of new inputs in the health machinery.

5.7. WRITING OF MINUTES

The minutes of a meeting include:

1. Title of meeting
2. Date
3. Time
4. Place or venue
5. Purpose or objective of meeting
6. Bureau of meeting
    - President/Chairperson
    - Vice President
    - Secretary
7. List of participants
8. Topics discussed and decisions taken
9. For each topic state the problem at stake, how it was discussed and the decision taken. Avoid long stories and be as impersonal as possible.
10. Date of next meeting
11. Minutes are signed by President/Chairperson and Secretary
12. Minutes shall be circulated to participants and the higher level.

CHAPTER 6: HEALTH INFORMATION MANAGEMENT SYSTEM FOR DECISION MAKING BY DIALOGUE STRUCTURES

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CHAPTER 6: HEALTH INFORMATION MANAGEMENT SYSTEM FOR DECISION MAKING BY DIALOGUE STRUCTURES

6.1. DEFINITION OF HEALTH INFORMATION MANAGEMENT SYSTEM (HIMS)

HIMS is defined simply as a system used for the collection, analysis and interpretation of health statistics to produce relevant information that can be used in the achievement of determined or set of objectives at all levels of the health pyramid (health area, health district, Region). The NHIMS serves as follows:

- Serves as a data bank at all levels of the Health pyramid.
- Facilitates evidence-based decisions
- Permits rapid decisions to be taken when faced with a threat of an epidemic.
- For rational use of resources especially where these are scarce.
- For evaluation of indicators.

6.2. HEALTH INFORMATION MANAGEMENT AT ALL LEVELS

The HIMS is a continuous cyclical activity which consists of

1. Entering into specific registers data or statistics on health services provided to the population.
2. Collection or extraction of data (statistics by tallying).
3. Compilation of data by filling out return forms.
4. Analysing the data collected to obtain information.
5. Determination of the level of achievement of objectives by comparing present. coverage and past coverage to set objectives.
6. Taking decisions and setting new objectives.
7. Defining strategies and determining resources to achieve new objectives.
8. Making plans of action and work plans.
9. Implementing the work plans.
10. Monitoring and evaluating and re-planning in order to attain the best possible health coverage for each health programme or health activity.
11. Writing and publication of reports.
12. Giving feed back to the producers of the health information and also transmitting the information to the next higher level.

Figure 8: Health Management Information cycle

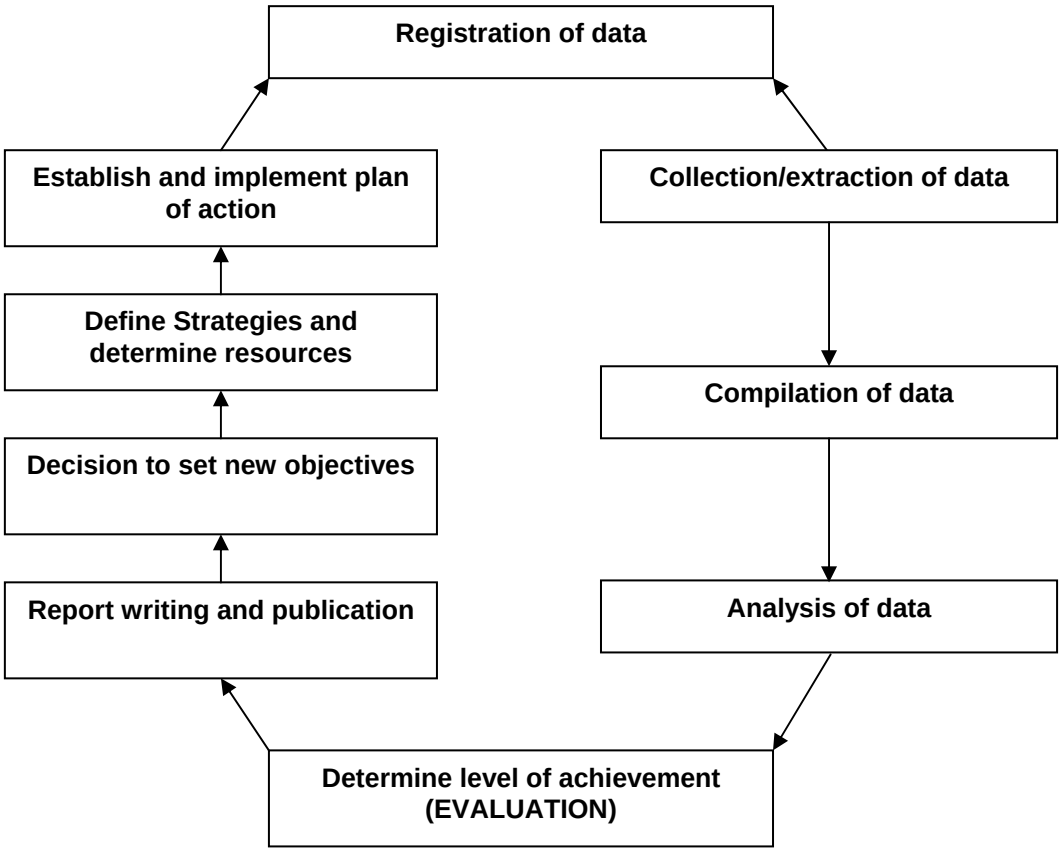
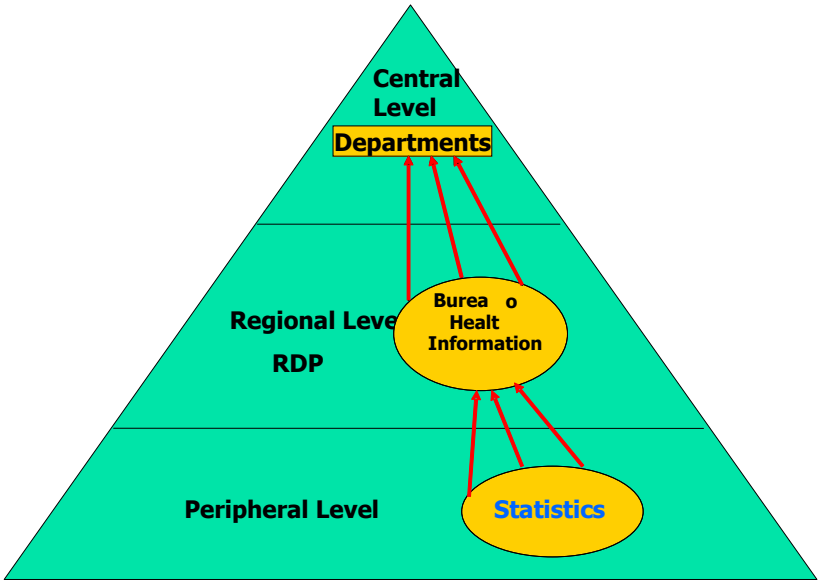


Figure 9: The Health Pyramid and NHIMS



6.3. WHO USES THE HEALTH INFORMATION MANAGEMENT SYSTEM?

1. The Managers and the management teams at all levels of the Health Pyramid

2. The decision making structures

By the Managers and management teams, we refer to:

1. Chief of Centre and his technical team
2. The District Chief of Service (DCS), the Director of DH and collaborators;
3. The Regional Delegation, the Director of the Regional Hospital and technical collaborators;
4. The Minister of Public Health, Directors of Central and General Hospitals and their collaborators.

By decision making structures, we refer to the various dialogue structures and their management committees which are:

- Health area health committee,
- Health area management committee,
- District health committee,
- District health management committee
- District hospital management committee
- Provincial Special Fund for Health Management Committee
- Regional hospital management committee.

Researchers in the health sector even the administration right from village level will need the HIMS findings to plan development program in the various areas. In short, the use of HIMS is not limited to the health sector alone.

In principle health information generated should be used first by the person who generated it for local action before forwarding it to the next level.

6.4. GEOGRAPHICAL INFORMATION

a) For each Health Area/Health District, the following have to be determined.
   - The geographical boundaries
   - Administrative boundaries
   - Its administrative attachment
   - The names of health areas, villages, quarters and zones
   - The different community groups present in the geographical demarcation
   - The further break down into smaller units (health areas for districts, health zones for health areas) to facilitate program operations in relation with the population of the catchment area.

b) Geographical map (Health District and Health Area).

Identify the physical features which can influence the level of accessibility to the geographical demarcation.

6.5. DEMOGRAPHIC INFORMATION

Health activities are people oriented. It is important to know how many people, male and female, adult and children are living in each health area and each health district. These are known as target populations. It is this population figure that shall be used as a measuring stick to know what fraction of the population of each district or area has been satisfactorily served. The population figure is called the denominator. The population of each district or area can be determined by two methods;

1. The population of a community in a given year or period can be calculated by projection. That is the total population from the national census is multiplied by the growth factor to obtain the present population.

2. Do a head count of members of the community by the health committee.
   - Maintain a census register according to household.
   - Update the census register quarterly by adding names of new comers and births and by removing names of out gone people and those who have died.

   This method is more difficult and costly but is more useful and reliable. You need to sensitize the people and prepare them for the exercise which can be twinned up with home visits to reduce cost.

   It is preferable to carry out a health census since each health centre will eventually be operating a dating file system.

Equally, the result of a health census permits the easy breakdown of the population into target groups corresponding to expected population for each specific program or activity. The following target groups are commonly used.

1. Children less than 1 year (00 – 11 months), 4% of the total population
2. Children less than 5 years (00 – 59 months), 18% of the total population
3. Children aged 5 – 14 years , 28.3%
4. Pregnant women, 5% of the total population
5. Women of child bearing age 14 – 49 year, 23% of the total population
6. Adolescent, 15– 24 years, 20.2%
7. People aged 65 and above, 3.8%
8. Population living within 5 km from the health centre. This is called immediate health centre population.

6.6. SOURCES OF HEALTH INFORMATION

6.6.1. Types of information

1) Census register for population

2) Health Registers from:
   - General Consultations (medical and surgical consultations)
   - Refocused Ante Natal Clinics
   - Infant Welfare Clinics (IWC)
   - Special clinics
   - Cash entry and cash movement
   - Clean deliveries

3) **Reports of Health activities such as:**
   - Supervision, monitoring and follow up
   - Training activities
   - Minutes of meetings
   - Seminars
4) **Personnel management**
5) **Inventory of material**
6) **Infrastructure**
7) **Drug management**
8) **Financial information**
9) **MHO information**

6.6.2. Treatment of health statistics

a) Registration of the statistics

The primary sources from which data for health information management are extracted have been enumerated above. These documents must be specially designed to facilitate collection of the right information and the extraction of data. The health care providers must be current with the reporting of their activities.

b) Extraction of data

There are specific data collection tools (forms) on which to enter the data for each activity or intervention carried out. At the end of each clinic, activity or day, the health care provider must answer the question: “How many people have been served by that activity, clinic or that day?” To do this, he uses a tally sheet to extract the raw data in figures from the primary source of information.

c) Determination of coverage rate

It is easier to compare ratios than absolute figures. The results are always presented in percentage per month, or per year. To do this you express the number of people who benefited from the service or activity as a percentage or fraction of the target population for whom the activity was intended e.g.

$$\frac{\textit{Number of children 00 – 11 months who had BCG in one year months}}{\textit{Number of children 00 – 11 months who were in that year}} = \textit{EPI Recruitment rate}$$

d) Determination of objectives in terms of coverage rate

Fix the objective to be attained. For example: the EPI objective for the Region is now 80% for completely vaccinated children.

e) Comparison of the actual coverage rate

The actual coverage rate per activity achieved shall be compared with the expected coverage rate to see to what extent the objective set has been attained. This is best done by plotting first the expected coverage rate and secondly the true coverage in the form of graph or histogram.

In the Region each health centre has a monitoring chart on which to plot its performance;

- Birth declaration
- Death declaration
- Morbidity per health area

From the chart it can be clearly seen how well or badly the centre is performing, by observing the difference between the expected and the actual coverage curves.

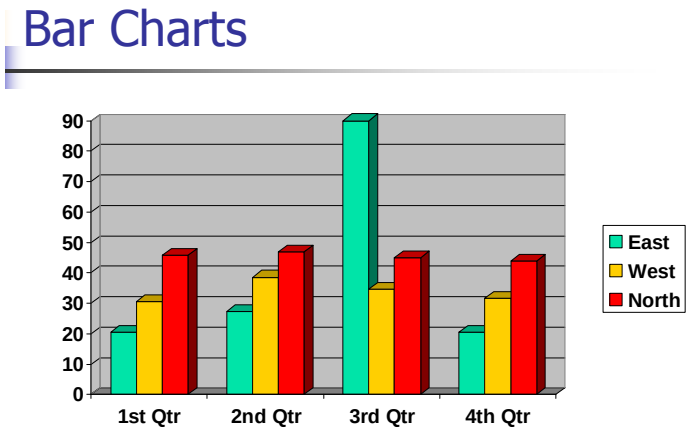
f) Using the coverage rates for management decision

1. The technical team (management) will judge the performance as to whether it is satisfactory or not.
2. Identify the causes for poor performance or excellence
3. Propose solutions to improve on performance
4. Discuss 1, 2 and 3 with all the production staff for their commitment to proposed solutions.
5. Present 1, 2 and 3 modified by 4 to the management committee for discussion, recommendations and resolutions.
6. When ever it meets, the general assembly will receive the report and deliberate on it.
7. Forward the filled forms to hierarchy and in the comments section write the measures taken at the first level.
8. The district level will also study the forms and comment, make feedback instructions to the health areas.

g) Presentation of Health Statistics within the framework of NHIMS

Table 14: Sample summary of absolute values

Male	Female	00-11 Months	12-59 Months
50	80	123	600
10	20	150	200
45	32		



6.7. CONCLUSION

The use of the Health Information Management System for decision making and management of health activities will help the dialogue structures in the following ways;

1. To identify health problems and needs of the community at all levels.
2. To identify appropriate solutions to the identified problems/needs.
3. To set realistic objectives towards the solutions of the problems
4. Monitor and appreciate the achievements of their set objectives for health programmes and projects in the community.
5. Evaluate the impact of their health programmes on the health status of the community.

Chapter 7: SUPERVISION OF HEALTH UNITS BY THE MANAGEMENT COMMITTEE

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Chapter 7: SUPERVISION OF HEALTH UNITS BY THE MANAGEMENT COMMITTEE

7.1. INTRODUCTION

In this chapter, we are going to treat the important subject of supervision of health units by members of the management committee both at the district and health area levels. We will start with some basic definitions.

7.1.1. What is supervision?

Supervision in the broad sense refers to the series of measures taken to check that plans, norms, instructions etc. are effectively applied and to verify for evidence (indicators), and oversee activities being carried out by staff in order to appraise the situation and help to improve. It is encouraging and supportive and not policing and laying of blame.

7.1.2. Types of supervision

We normally distinguish between two types of supervision: **Vertical supervision and Horizontal supervision**, depending on the level at which it is taking place:

a) **Vertical supervision** refers to the measures taken by the higher level in a system to ensure that staff effectively applies instructions, norms, rules and regulations that have been put at their disposal in order to help them improve their performance. This is supervision by a higher management organ. In this type of supervision there is a difference in the competence level of the person who supervises (supervisor) with respect to that of the person being supervised (supervisee); For example, the supervision of the District Chief of Service of Public Health by the Regional Delegate of Public Health.

b) **Horizontal supervision** is similar to vertical supervision except that the person supervising and the one being supervised are of the same level. All the persons involved in the exercise are working at the same horizontal level. A typical example is the supervision carried out by members of the Management Committee of the health unit or service which the committee has the responsibility to manage.

In both cases, the main aim of supervision should be to help to improve.

7.2. JUSTIFICATION

It is necessary and important for members of the management committee to fully participate in the supervision of health units for the following reasons:

- It facilitates the identification of problems within the health unit under the responsibility of the management committee and helps it to seek solutions for improvement.
- It permits each management committee to have a self-appraisal and know how well or how badly it is performing and decide on the measures to correct the situation.
- It also permits the management committee to have a “trial balance sheet” of its activities and from there, be able to identify its weaknesses and areas

needing further explanations and/or training from the higher supervision bodies.

- It enforces team spirit amongst members of each management committee and the staff of the health unit.
- Last but not the least; it permits the management committee to control the property of the health unit under its responsibility. In fact, over the years, supervision or controlling of a health unit by its management committee has either been inexistent or too weak. As a result of this, health units have been losing a lot of property, drugs, equipment, community funds, buildings etc. These properties are often lost through burglaries, embezzlements, shortages by staff, misappropriation and lack of maintenance.

7.3. WHO IS A SUPERVISOR?

Each Health District has three types of health structures:

1. The District Health Service
2. The District Hospital
3. The Integrated Health Centre

According to the texts in force, each of the three units or structures has its Management Committee. The District Health Service has as its management structure the District Management Committee (DMC), the District Hospital has as its management structure, the District Hospital Management Committee (DHMC) and the Integrated Health Centre has as structure the Health Area Management Committee (HAMC). This is better illustrated in table 15.

Table 15: Core members per dialogue structure

Position	DMC	DHMC	HAMC
Chairman	Community Representative	Community Representative	Community Representative
Treasurer	Service Manager	Service Manager	Community Representative
Secretary	District Chief of Service	Director of the DH	Chief of Health Centre
Members	Two community representatives	Two community representatives	Two community representatives

Supervision of health units implies the checking or overseeing of the activities carried out by the management committee members themselves and secondly the activities performed by the health care providers, be they government or community employed. Each management committee must supervise itself before supervising those regularly employed in the health unit.

As will be seen later, most of the aspects to be supervised are highly technical and will need a lot of technical inputs to interpret and understand. As such it is highly advised that community representatives should not carry out this exercise single-handedly. Each supervision team should be mixed, both for horizontal and vertical supervision, consisting of one technical staff, preferably the secretary of the management committee or his designee on the one hand and of a community representative, preferably the chairperson of the management committee or his designee from amongst the two other community representatives in the committee. In

short, the chairman and secretary of each management committee shall do supervision jointly. However, it should be stressed that the absence of any of the two should not be a reason for not carrying out supervision, as their designees are equally competent to carry out the exercise.

7.4. WHAT SHALL BE SUPERVISED

i. Plan of action

The supervisors must supervise the preparation of the plan of action and its realisation. Periodically, they determine the level of execution of the approved plan of action and find out, where applicable, the reasons for not fully executing it.

ii. Budget

As seen in the chapter dealing with financial resources, each level or better still each unit has to prepare a comprehensive budget, stating all the sources of income as well as all the areas of expenditure. The supervisors must oversee the preparation of this budget and ensure that all inputs are clearly stated and accounted for. Along with the supervision of the plan of action, each supervision team must monitor the level of realisation of the budget and highlight issues facilitating or blocking its realisation. It is the place of the supervisors to:

- Fight against over expenditure and deficits
- Ensure the regularity of each financial operation
- Enforce the correct use of financial documents
- Ensure that only the accepted fees and predetermined rates are being collected

Ensure that all money collected is duly banked or kept in a savings account and that withdrawals are carried out only by the three officials duly mandated to be co-signatories to the account, one of which must be a community representative (chairperson of the management committee, as stipulated in the chapter on finances).

iii. Equipment and logistics

- Participate in the reception of all newly-acquired equipment and logistics
- Ensure that the equipment list is regularly updated
- Ensure the correct use of equipment and logistics
- Identify broken down equipment for repairs or replacement
- Participate in the determining of equipment and logistics as well as prioritising them.

iv. Buildings and general surroundings

The buildings and premises housing the unit should be regularly checked to:

- Ensure that adequate security measures have been taken
- Ensure that the environment is clean
- Ensure the availability and cleanliness of toilet facilities
- Identify defects and leakages for early repairs

v. The Pharmacy

The District Hospital and Integrated Health Centre each has a Pharmacy section. It is run by a community-recruited and paid staff who forms an integral part of the health unit's staff strength. Each pharmacy receives drugs directly from the NWPSFH's central drug store in Bamenda. It is supervised every two months by a specialised drug supervision team from the central store. These supervisors collect money and where necessary, drugs from each pharmacy back to the central pharmacy. However, because the interval between such supervisions is too long and the effective time spent by the supervisors at each pharmacy is relatively short, many difficulties have been encountered which have resulted in the ever-increasing financial shortages incurred by staff in these pharmacies.

To remedy the situation, the Management Committee of each health unit must be responsible for regularly supervising the functioning of its pharmacy. The DMC also has the responsibility of verifying that the HAMC has been effectively supervising its pharmacy. How to carry out this important exercise is the object of a different document "Guidelines for controlling a pharmacy: A manual for the management committee". These two documents shall be used together.

vi. Functioning of the Management Committees at all levels

As earlier indicated, each management committee must supervise its proper functioning before going out to supervise others. It is also necessary that the District level, through the DMC supervises the functioning of the HAMC. This supervision is important in that it permits peer learning and provides an opportunity to collect information from the HAMC.

The main areas to be supervised should at least include the following:

- The regularity in the holding of management committee meetings
- The attendance of members at meetings
- Problems hindering the functioning of the management committee
- The number of supervisions carried out by the management committee at the health unit at a given period
- The frequency of supervision of the HAMC by the DMC

7.5. HOW OFTEN TO SUPERVISE (PERIODICITY)

There is no specific time periodicity for the supervision of each health unit. The more often these units are supervised, the better. It is suggested that because of its sensitive nature, each community pharmacy should be supervised at least once monthly. The other activities may be supervised every fortnight or monthly. Horizontal supervisions carried at intervals longer than one month are ineffective. In reality, horizontal supervisors should have supervised their various units at least twice before any external supervisor ever comes in. The vertical supervision of HAMC should be included in the work plan of the district and all supervisors duly informed.

7.6. HOW TO CARRY OUT SUPERVISION

We should distinguish between planned (announced) supervision and surprised (unannounced) checks. Surprised supervisions which are more properly termed "control visits" are carried out whenever rumours point to certain malpractices which

could not have been identified were the supervision announced. In a system that is functioning well, there will be less surprised supervisions than planned ones. In both cases, the execution of the supervision must pass through three main stages:

i. The preparatory stage

The supervisors must prepare for the supervision and know exactly why they are going to the unit and what they are going to look for. In announced supervision, they should make sure that the supervisees know exactly when they are coming. For controls the supervisors must define clearly the objective of the exercise and how they intend to proceed on the field.

ii. Actual supervision at the health unit

The supervisors must not enter the service like police officers or professors coming to levy blames on service providers but rather as comrades in arm coming to learn more on the functioning of the service. This includes as well the supervision of the HAMC by the DMC where the DMC should not go there with a spirit of superiority but with an open mind ready to learn from their colleagues. During the supervision, they must have a cool head, listen patiently, but critically, have a critical appreciation of all documents presented and make notes of any observations. Whenever necessary allow the local staff to give their reasons for why they do certain things in one-way and not the other. Provide appreciation where necessary.

iii. Exploitation of supervision results

Supervision results shall be written and co-signed by the supervisor and supervisee, in the supervision register or checklist and findings discussed at the management committee meeting, where appropriate solutions or actions will be carried out for identified problems. A supervision report must be made, distributed and filed.

7.7. CONCLUSIONS

Supervision at each unit and of lower units by the management committee is an indispensable tool for the management and smooth running of the health units. The management committee at each level should therefore take it seriously and not wait to complain after the services or units have gone into decay.

Chapter 8: THE MINIMUM PACKAGE OF HEALTH ACTIVITIES (MPA) AT THE HEALTH AREA AND DISTRICT LEVEL

Chapter 8: THE MINIMUM PACKAGE OF HEALTH ACTIVITIES (MPA) AT THE HEALTH AREA AND DISTRICT LEVEL

8.1. INTRODUCTION

The two structures directly involved with the provision of health care at the district level are:

- The Health Centre (HC) for the Health Area and
- The District Hospital (DH) for the whole district.

Each level offers specific health services defined by the government and for which it is best adapted, that is, has the appropriate staff and technology that can best deal with the health problems of the community. The activities at the HC are known as the Minimum Package of Activities. These activities involve a lot of interaction between the health service and the community (human relations) while those of the district hospital are more disease focused and thus are said to be complimentary.

The district system is organized in such a way that the Health Centre is the entry point and once in it, there should be no barriers in moving from one level to the other and information about the patient should accompany him/her to and from within the system. This is ensured by an effectively functioning referral and counter referral from the health centre to the district hospital and vice versa. It also ensures that good quality care i.e. care which is comprehensive, continuous and integrated is provided to the population.

8.2. THE MINIMUM PACKAGE OF ACTIVITIES FOR THE HEALTH CENTRE

These are mostly prevention oriented, promotional, and to a lesser extent curative care, which includes treatment of common diseases as well as chronic diseases such as tuberculosis, leprosy, hypertension, diabetes, HIV/AIDs etc; early detection and treatment of common diseases to avoid complications; the use of essential drugs to improve access to treatment and the referral of those cases above the technical competence of the health centre.

For chronic diseases needing long term treatment, the continuity of care component creates a good link with the more educative aspect of preventive care. Home visits provide an opportunity to support these patients take their treatment continuously and to reduce the dropout rate.

90 - 95% of the common diseases of the population can be effectively handled by the health centre. The use of Diagnostic and Treatment Guide (DTG) for curative consultation as well as development of good human relationship between the provider and the users increases the confidence of the population in their health centre which reduces the number of unjustified referrals as well as by-pass of the centre by patients to go directly to the district hospital.

8.2.1. Components of Maternal and Child Health

Maternal and Child Health consists of:

- Refocus Antenatal care

- infant and pre-school care
- vaccination
- control of diarrhoea diseases and
- family planning

8.2.1.1. Refocus Pre-natal consultation has the following objectives:

- To follow-up pregnancy and carry out clean deliveries
- To prevent mother to child transmission of HIV
- To treat illnesses associated with pregnancy
- To identify high risk deliveries early enough for prompt referral
- To train mothers on breast feeding, and essential nutrition
- To immunize against tetanus.

8.2.1.2. The infant and pre-school clinic or IWC carries out the following activities:

- weighing of children
- immunizations
- education of mothers on nutrition, breast feeding, family planning and oral re-hydration
- Growth monitoring and screening for factors that could impair normal development.
- De-worming

8.2.1.3. Health promotion and rehabilitation includes:

- environmental hygiene and sanitation
- school health
- provision of sufficient quantities of potable water
- information, education and communication adapted to the local health priorities e.g. AFP, Measles, Tetanus EPI, Onchocerciasis, Tuberculosis, HIV/AIDS, Malaria, Leprosy, Helminthiasis etc
- Social re-insertion of the handicapped.

Health promotional activities are carried out in the community and require active community involvement. However, the health services in providing technical guidelines as well as health education to the community on what attitudes and behaviours to adopt to live healthy lives as well as maintain a healthy environment, must be a model to be imitated. It therefore makes no sense for the health services to talk about a clean environment, use of latrines, provision of potable water etc. when the health centre and hospital are always in the bush, have no functional latrine, no water, nor provision for proper disposal of waste, the buildings are never renovated,

etc. which is what currently exists in most public health facilities in our region. This situation makes the population not to take the health team (composed of technical staff and community representatives) who go for inspection of compounds, schools, markets and special premises serious.

8.3. COMPLIMENTARY PACKAGE OF ACTIVITIES FOR THE DISTRICT HOSPITAL

This is dominated by patient care. The scope of these activities is expanded to take care of those problems which the health centre cannot handle. These include:

- Management of referred cases from the health centres and counter referrals as well as referral to the regional level,
- Management of medical as well as surgical emergencies,
- Surgical interventions,
- Dental as well as ophthalmologic care,
- Laboratory investigations not done at health centre level,
- Radiology and ultra-sound examinations etc.

The hospital, therefore, has personnel who are more skilled and specialized in curative care and utilize more sophisticated technology for diagnosis and treatment than the health centre.

Though preventive and health promotional activities are provided at the hospital, this is not a priority. The rationale for carrying out some of these activities is to reduce the incidence of missed opportunities. That is to say a child or pregnant woman, who has not been vaccinated by the health centre, should be vaccinated when she attends the hospital, because this might be the only opportunity to be vaccinated to avoid contracting the disease.

Considering the highly technical nature of the services offered at the District Hospital, it can be seen that Community Representatives have few areas in which they can directly assist. Their role is therefore mostly limited to the attributions of members of the Hospital Management Committee.

The above activities which are the basic minimum required to guarantee that the health needs of the population are met cannot be effectively carried out by the health staff alone. This is because the staff is insufficient in number and also they do not possess all the skills and means needed for the effective and efficient implementation of the package.

They have to work hand in hand with members of the dialogue structures to achieve their goal of making quality health care accessible to a majority of the population, and also give meaning to the concept of community participation in health care.

The need for community participation is clearly felt at the health centre and health area level where human relations play an important role than at the level of the district hospital.

8.4. THE DISTRICT HEALTH SERVICE (DHS)

The main function of the DHS is to put in place the basic structures of the health district and ensure that they develop in accordance with the national health policy taking into consideration the local realities with the ultimate aim of having a viable or autonomous district.

It does so by:

- Elaborating a multi annual district health development plan.
- Elaborating and implementing district annual operational plans.

The plan should take into consideration the problems of the health areas with their health centres, those of the district hospital and any other problems that are relevant for the development and functioning of these structures and the district as a whole.

Plans should be developed using a bottom-up and not top-down approach with the Systemic Quality Improvement (SQI) approach.

- Monitoring, supervising and evaluating of health services and programmes in the district.
- Promoting and strengthening community involvement in the health sector.
- Organizing public health activities in the district e.g. Supplementary Immunization activities (SIA) or mass vaccination campaigns, control of epidemic and endemic diseases etc.
- Promoting inter-sectoral collaboration.
- Mobilizing and rationalizing the use of available resources for the development of the District.
- Putting in place a health information system adapted to needs.
- To attain these objectives, the District Health Team (DHT) which is a technical team must work in collaboration with members of the District Health Committee (DHC).
- The DHC through the DMC participates in the elaboration and implementation as well as evaluation of the district operational plans.
- Mobilizes the resources for health promotion and development of services.
- Advocates on behalf of the district at the district development committee and other organizations.

Table 16: Areas of intervention by members of the Dialogue Structure in the implementation of the MPA

PACKAGE	ACTIVITIES OF DIALOGUE STRUCTURE
1. Curative Care	Mobilize population to: - utilize the service - pay for services - register with MHO - report early to health centre when ill - buy drugs from health centre pharmacy and not from hawkers - facilitate movement of referred cases to district hospital - Do contact tracing.
2. Maternal, Child and adolescent Health	- mobilize parents to allow pregnant women and children attend these clinics - Encourage parents to get children vaccinated - participate at out reach activities - help in dispelling rumors and false beliefs - promote the acceptance of family planning especially among the male folk - promote adolescent life skill education
3. TB, Oncho, Malaria, HIV/AIDS	- **TB**: encourage community members to consult if coughing for more than 2 weeks, encourage those affected to take drugs and do their control tests. Psycho social support for patients on treatment which is free. - **ONCHO**: undertake Mectizan distribution, encourage community members to take the drug and detect reactions and refer. - **MALARIA:** carry out home based management of simple malaria and promote the use of Insecticide Treated Nets (ITN) by the household - **HIV/AIDS:** encourage voluntary counseling and testing, assisting those on Anti Retroviral Therapy (ARV) to take their treatment regularly. Treatment is free - Encourage pregnant women and their spouses to go for PMTCT - To encourage the PLWHA to join support groups. - **Leprosy/ Buruli Ulcer/Guinea Worm:** be vigilant to encourage community members having patches that are suggestive of leprosy, direct members of the community who have ulcers that do not heal to the HC.
4. Health Promotion	- organize and participate in clean up campaigns - inspect public places and private compounds - protect water sources - Identify and report out-breaks of diseases and disasters to health staff

	- sensitize on the risk of disasters and of certain behaviours e.g. promiscuity, drug consumption - report on births and deaths in the health area - mobilize population to generate resources for health development - pass on health information to the population - Advocate on behalf of the health service at the village development committee and other organizations.

In order to effectively carry out the above tasks, the members of the dialogue structures need to be trained so as to improve and update their skills, provide them with the relevant technical knowledge and also familiarize them with the tools which they need for their tasks. By so doing, they will be motivated to work with enthusiasm and confidence, and will gain the respect of both their communities and health staff.

Chapter 9: PROCEDURES FOR INTERNAL AUDITING

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A) Community Fund

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B) Government Credits

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C) Surplus

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D) Donations

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Chapter 9: PROCEDURES FOR INTERNAL AUDITING

9.1. DEFINITION

Auditing is a control measure with the main objective of ensuring the judicious and accountable management of activities and resources in order to attain a set of objectives in any given institution. Emphasis will be placed in this context on the activities and financial resources.

9.2. TYPES OF AUDITORS

9.2.1. External Auditors

They are accounting experts who each year are awarded a contract on a competitive basis to control the accounts of the North West Provincial Special Fund for Health at the head quarters and outstations.

This process involves all money generated by the Fund and partners and used at all levels in the health system. At the level of the district, auditors are specifically concerned with sales of drugs in the Community Pharmacies, District Health Committee Funds, PHC Supervision Funds, surpluses and any grant in aid awarded to a health unit.

It is only after the external audit that surplus or loss can be declared. In the case of a surplus the management of the Fund distributes the surplus and presents to the Management Committee for scrutiny and presentation to the General Assembly for approval. It is very important for the district and health area health committees to cooperate with external auditors by accounting for any finances received and by fully participating in the inventory/auditing process so that the auditors' reports can be a true and fair picture of the financial transactions of the pharmacies in the health units for the year.

9.2.1.1. Regional Supervisors.

They are supervisors from the Fund, technical supervisors from the health district and the Regional Delegation of Public Health.

9.2.1.2. Auditors from the Ministry of Public Health.

From time to time, the Ministry of Public Health sends out officials from the Department of Financial Resources and Properties (DFRP) to control the health units. They may be reinforced by other officials from Ministry of Economy and Finance (MINEFI).

9.2.2. Internal Auditors

At the Health Area, there are two elected community representatives in the Standing Committee of the General Assembly of the Health Area Health Committee.

At the health district level the internal auditors are elected Community Representatives in the Standing Committee of the General Assembly of the District Health Committee and the Chief of Bureau General Affairs in the District Health Service.

Auditing can be done at any time especially when there are rumours of suspicion or misappropriation. Under normal circumstances, an audit is conducted before every management committee and General Assembly meetings. This is simply a verification exercise whose report is presented and discussed at the meetings.

Since auditing is conducted on financial documents, available cash and commodities in stock, the person to be audited must be informed ahead of time to prepare and put together all the necessary documents.

9.3. INTERNAL AUDITING AT THE HEALTH AREA

9.3.1. Revenue

A) Community Fund

This constitutes all the sources of income earned from the services rendered in the health units; namely consultation, delivery, ANC, circumcision, laboratory fees etc. It can also be called cost recovery fund.

From registers of the Health Centre, determine for the period considered, the number of cases of:

- new consultations
- deliveries
- new ANC
- laboratory tests, and
- other revenue generating activities

The following procedures must be followed when carrying out internal auditing:

I. State the fees per activity

II. Verify in the Receipt Booklet if receipts issued correspond to all cases from the registers. Obtain the declared monthly revenue.

III. Cross check the Daily Cash Entry Register to ensure that all revenue collected are recorded and correspond to that obtained from the receipts.

IV. The auditors then report their findings as follows.

Table 17: Monthly Revenue Report

ACTIVITIES	**Number of Cases**	**Declared Revenue**	**Expected Revenue**
New Consultation			
Deliveries			
Laboratory Tests			
New ANC			
Others (Specify)			
TOTAL			

To get the expected revenue, the authors multiply the number of cases by the fees per activity. If there are any discrepancies between the declared and expected revenue the possible reasons for them are identified.

V. Examine the Health Area Health Committee Bank Account Book.

a) State the bank account number
b) Verify if for each operation the Chairperson of the Management Committee, the Treasurer, and the Chief of Centre did sign.
c) Verify too from the pass book whether the bank situation in the book agrees with the movements and balance in the Cash Movement Register.

B) Government Credits

State the amount of credits per line per semester for that year and indicate as to whether or not the credit cards have all been received.

C) Surplus

State the amount of surplus and any other subsidy received from the NWPSFH for the period.

D) Donations

State the amount and sources of donations especially national for the period considered.

9.3.2. Expenditure

a) Auditors verify whether the Health Area has a work plan with the corresponding budget for the period considered.

b) Is the budget comprehensive (composite)? State the various amounts:

Source of funding	**Amount**
Community Fund	---------- Francs CFA
Government Credits	---------- Francs CFA
Surplus	---------- Francs CFA
Others	---------- Francs CFA

c) Payment Vouchers

- Verify if expenditures made were planned.
- Verify if payment vouchers are duly prepared and signed by the treasurer, Chief of Centre, Chairperson of the Management Committee and the customer.
- Verify if prices are realistic.
- State the monthly total expenditure using the payment vouchers for the period considered.

Table 18: Monthly Revenue Report

Payment Voucher		**Amount**
Number	**Date**	
Total		

d) Cash Register

- Check if revenue taken out of the Daily cash entry register is effectively entered as income in the Cash Movement Register.
- Verify if the payment vouchers identified above correspond to those in cash Movement Register under expenditures.

e) Examine the Bank Account Book

The balance in the bank Account book and cash in hand with the treasurer should correspond to the balance in the cash book. In the case of the pharmacy, the total sales on the last day of recording must agree with the physical cash in the safe of that pharmacy.

f) Daily Use Register

In checking the Daily Use Register the auditor must be able to determine whether the total number of drug item sold in a day agrees with the amount recorded in the stock card and whether the total cash sales in a particular day is the same amount transferred to the financial record book.

g) Financial Record Book

If all the daily sales totals have been transferred to the Financial Record Book, then the auditor must confirm whether the running total is correct as shown by the pharmacy attendant.

h) Examine the Materials and equipment acquired within the period of audit.

i) Surplus and Subsidies from the NWPSFH: verify the utilization as above examining:

- plan of action for its use
- payment vouchers
- cash movement register
- material acquired or work done
- bank account book
- Justification for the use of surplus and subsidies forwarded to the Regional Delegation of Public Health and the NWPSFH.

j) For specific projects verify the progress of work and the corresponding financial records stating the sources and amount of funding.

k) If there are discrepancies at any level, identify the reasons and contributing factors; then make recommendations.

l) Make an audit report following the steps outlined and present it to the Health Area Management Committee for appreciation and stating corrective measures before the report is presented to the General Assembly of the Health Area Health Committee.

9.4. INTERNAL AUDITING AT DISTRICT SERVICE

The two Auditors in the Standing Committee of the District General Assembly will carry out this work. The two persons are a Health Staff who is Chief of Bureau for General Affairs at the District Service and one elected Community Representative.

The audit exercise in this service will consist of:

1. Verification of a budgeted plan of action
2. Verification of the budget to ensure that in-puts from all partners are included (Comprehensive/composite budget)
3. Stating amount for each component of the budget
   a) Community Fund
      - PHC Supervision Fund
      - Subsidies form NWPSFH
      - Contribution for Supervision from Health Areas
   b) Government Credits
   c) Other Sources
4. An assessment of the level of execution of work plan and budget
5. Checking the payment vouchers
6. Verifying the cash movement registers to ensure that expenditures are recorded and that the balance corresponds to cash in hand or non-committed credit situation.
7. Examining the Bank Account Book to determine balance and movement of cash.
8. Stating the level of utilization of Government Credits, précising the amount used in the execution of work plan compared to amount budgeted.
9. Examining the utilization of other financial resources available.
10. Writing and presenting a final report to the District Management Committee for appreciation and corrective measures.

9.5. INTERNAL AUDITING AT DISTRICT HOSPITAL

The internal auditors are the same persons as for the District Health Service (see 4 above). The procedure is the same.

9.5.1. Revenue

I. Calculate the total monthly revenue declared on the Monthly Revenue Declaration Form.

II. Verify from the Receipt Booklet that the monetary value of all the receipts issued corresponds to the revenue declared for the period considered.

III. Make a report of the monthly declared revenue as follows.

Table 19: Monthly Declared Revenue

	ACTIVITIES	DECLARED REVENUE
1.	New Consultations (Dr.)	
2.	Hospitalization	
3.	Deliveries	
4.	Major Surgery	
5.	X-Ray	
6.	Laboratory	
7.	Dental Unit	
8.	Ophthalmology	
9.	Etc	
	TOTAL	

IV. Determine the Number of the activities from the Registers in the various units, including the Doctor's Consultations

Table 20: Monthly Activities

ACTIVITIES		NUMBER OF CASES
1.	New Consultations (Dr.)	
2.	Hospitalization days	
3.	Deliveries	
4.	Major Surgery	
5.	X-Ray	
6.	Laboratory	
7.	Dental Unit	
8.	Ophthalmology	
9.	Etc	
	TOTAL	

V. State the official fees per activity.

VI. Calculate the expected monthly revenue per activity and compare with the declared revenue.

Table 21: Monthly Activities

	Activities	Number of cases	Declared revenue	Expected revenue
1.	New Consultations (Dr.)			
2.	Hospitalization days			
3.	Deliveries			
4.	Major Surgery			
5.	X-Ray			
6.	Laboratory			
7.	Dental Unit			

8.	Ophthalmology			
9.	Etc			
	TOTAL			

If there are discrepancies between declared and expected revenue identify the possible reasons.

9.5.2. Expenditure

I. From the monthly revenue declaration form, bring out
   a) The total solidarity fund = 10% Quotes parts (30% of total monthly revenue).
   b) Plus 10% Revenue reserved for Hospital Development (70% of total monthly revenue)
   c) Quote parts = 30% Total Monthly Revenue minus Solidarity Fund i.e. 30% - (10% of 30%) = 27% of total revenue
   d) Hospital Development Fund = 70% Total Revenue minus National Solidarity Fund i.e. 70% - 10% of 70% = 63% of total revenue

II. Verify from reports if the “quotes parts” is distributed to hospital staff, stating dates and total amount distributed; and postal or bank receipts by means of which the Solidarity Fund is regularly sent to the Delegation of Public Health. Kindly state dates and amounts.

III. Use of the Hospital Development Fund
   a) Does the Hospital have a savings bank account? If yes, state Bank Account Number.

      Cosignatories of this account are:

      - Chairperson of Hospital Management Committee
      - Director of the Hospital
      - Service manager of the Hospital

   b) State the monthly revenue deposited in the account for the period considered.

Month/Date	**Amount**
M1	
M2	

   c) Is there a plan of action and corresponding budget for the utilization of the Hospital Development Fund according to the directives of the Minister of Public Health by Arrete N005/MSP of 15th, July 1994 and Arrete N^0 0030/MSP of 20/09/99.
   d) Have the draft budget been forwarded to the Minister of Public Health for approval? This must be done by end of October every year for the budget of the year beginning next January.

e) Have the budget been approved by the competent authority? If not why? What action is being taken to correct the situation?

f) What is the level of execution of the approved hospital development budget at the time of auditing?

g) In so doing, compare the execution of budget to the execution of plan of action, and verify:

- payment vouchers
- cash movement register
- material and equipment acquired; and work done
- money saved for the depreciation of equipment
- Bank account for balance and other savings

IV. Use of Surplus, verify

a) plan of action for the surplus
b) payment vouchers
c) cash movement register
d) material and equipment acquired and work done
e) bank account
f) Justification for the use of surplus to the Regional Delegation of Public Health and NWPSFH.

V. Finances of Special Projects
Examine the monthly project reports and financial reports.

VI. State Amount of Government Credits used for the realization of activities and projects in the Hospital.

VII. Write a detailed audit report using the headings and steps outlined above. State reasons for any financial discrepancies, use of funds without justification and other observations. Make recommendations.

Present the audit report to the Hospital Management Committee for appreciation and corrective measures. The audit report is thereafter presented to the General Assembly of the District Health Committee for adoption.

VIII. The Audit Report is signed by the two Internal Auditors, the Director of the Hospital, and the Service Manager.

* In case there is discrepancy and the Director + Service Manager hesitate to sign, let them make their comments and sign.

9.6. INTERNAL AUDITING OF THE PHARMACY

1) The Chief of Health Unit or his designated representative joins the two internal auditors at each level to audit the pharmacy, because of the technical nature of pharmaceutical products.

2) Sales of drugs are suspended for a few hours on the auditing day.

3) Start auditing from the annual inventory or the most recent audit of the year considered.

4) Determine the current capital situation of the pharmacy:

I. State in cash the quantity of drugs in stock after the annual inventory or last audit.

II. From the current capital situation card record all the supplies from the NWPSFH since the annual inventory or last audit, stating date, quantity of drugs in cash, and the cumulative total.

Table 22: Current Capital of Pharmacy

Date	Operation	Capital	Cumulative Capital
20 January 2009	Annual Inventory	1.000.000	1.000.000
25 December 2009	Supplies (since the last inventory)	2.000.000	3.000.000

5) Assess sales of Drugs since annual inventory or last audit.

I. Verify from RECEIPT BOOK
- If prices of drugs correspond to those on price list.
- If there are bulk sales and why?

II. Calculate the monthly sales using the DAILY FINANCIAL RECORD BOOK, and then the cumulative sales since the annual inventory or last audit.

Table 23: Sales

DATE/MONTH	AMOUNT	CUMULATIVE SALES

III. For period being considered, verify receipts of cash forwarded to NWPSFH and state clearly.
1. The receipt number
2. The amount collected
3. The date of issue
4. The name of the receiver

Your report should be presented in this form.

No.	Receipt No.	Date	Amount to NWPSFH	Name of Receiver

IV. Determine the cash in hand.
a) Count the cash available
b) Note the amount of money in the form of postal money order (mandate). The sum of the two constitutes the cash in hand on the day of audit.
c) Check if cash in hand corresponds to the amount in the Daily Financial Record Book.

6) Assess the quantity of drugs in stock to obtain its cash value on the auditing day.

I. Make sure that the pharmacy attendant fills the STOCK CARD for each drug to the date of auditing.

II. Using the stock card for each drug, calculate the total value of drugs in stock on the day of the auditing; this constitutes the first capital for the following period.

9.4. SUMMARY

The total cumulative current capital in cash from the annual inventory of the year considered or the last audit equals the total cumulative sales plus the value of drugs in stock on the date of auditing.

Date of Auditing _____

Total cumulative current capital	**Total cumulative sales**	**Cash value of drugs in stock on date of auditing**

I. Verify the containers of drugs to ensure that the unopened tins and cartoons are full by shaking those that cannot be opened, and counting them.

II. Note the dates of supervision of the pharmacy by the
- Management Committee
- District Health Team
- The NWPSFH
- The Regional Supervisor

III. Write up the audit report using the steps described above. State all discrepancies, possible reasons, measures to correct and your recommendations.

The audit report is signed by the
- Two Internal Auditors
- The Pharmacy Attendant
- And the Chief of Health Unit

The audit report is presented to the corresponding Management Committee for appreciation and corrective measures; before presenting it to the General Assembly of the respective Health Committees for adoption. A copy is forwarded to the higher level – District/Region.

Chapter 10: HEALTH AND DEVELOPMENT

Chapter 10: HEALTH AND DEVELOPMENT

10.1. HEALTH

The real measure of health is the ability of the individual to function in a manner acceptable to himself and to the group of which he is part. The World Health Organization (WHO) defines health as a "state of complete physical, mental and social well being and not merely the absence of disease or infirmity". Health and well-being are determined by factors such as good water, enough food, good roads, employment, habitat etc.

It is the economic growth of a society together with its social improvement such as health, education, housing, water supply, good roads etc. The relationship between development and health is a two-way interaction. The socio-economic status (income, occupation, education, living conditions etc.) has an influence on the level of health e.g. malnutrition is often due to poverty and ignorance. The improvement of health resulting from health education, good roads, good nutrition, environmental sanitation, etc can exert great influence on the economic level of individuals, families, groups and the nation.

A healthy population in a healthy environment has a healthy labour force, reduces absenteeism from various activities and healthy school population free of all predicaments to foster its development.

10.2. COMMUNITY INITIATIVES

Community initiatives are development projects or activities or programmes initiated and managed (planned, executed and evaluated) by the community to achieve goals.

Community initiated activities and projects are either community imposed or community oriented or community based.

10.2.1. Community imposed and oriented projects

Community imposed programmes, activities, and projects are planned and decisions made at the higher levels by professionals and imposed on the community (Top-Down Approach).

Community oriented programmes, activities and projects are those in which the professionals (health care providers) initiate to improve with the consent of the community on its economic status.

Community imposed and oriented projects are very often not long lasting because;

1) The population concerned usually fails to identify itself with and own the project (rejection phenomenon).
2) The mobilization of local resources is usually little or inexistent.
3) The project will continue on external funding sources. It is not sustainable as the project dies when external funding ends.

10.2.2. Community based projects

Community based programmes, activities and projects are those initiated in the community with the community members actively involved in all the aspects of its realization. Community based projects use a bottom – up approach with lots of support and initiatives from the bottom (the community itself).

They have the following characteristics:

1) They are people from the concerned community.
2) The project is naturally and socially an appropriate solution to identified community problems.
3) The community appropriates the project and ensures its sustainability through the mobilization of local resources.
4) Adequate utilization of services is assured.
5) Successful community based projects easily gain support from government and other external agencies.
6) Lessons and experiences learned from community based projects can be harnessed usefully to improve competence (knowledge and skills) of said community in further handling of more complex integrated socio-economic projects.

10.3. IDENTIFYING COMMUNITY NEEDS AND PROBLEMS

Through brainstorming, the dialogue structures (the development team and the health committee) come out with a list of the community needs and problems. Some will be real needs and some will be felt needs.

a) Felt needs: These are needs that a community recognizes that it needs e.g. telephone in a less developed community is a felt need.
b) Real needs: These are needs that a community recognizes as its needs as a result of technical knowledge, information and advice e.g. water supply in a community without good and enough water is a real need for that community.

A felt need in one community can be a real need in another community depending on the level of development reached by that community.

10.4. CRITERIA FOR SELECTING REAL NEEDS AND PROBLEMS

Community supportive programmes, activities and needs are:

a) Those which when realized will have meaningful impact upon the lives of the majority of the population especially the disadvantaged.
b) Those which favourably influence the long-range welfare of the community
c) Those which help the community stand on its feet.
d) Those which genuinely encourage responsibility, initiative, decision making, and self-reliance at the community level.
e) Those which build upon human dignity.

10.5. CRITERIA FOR SELECTING REAL NEEDS AND PROBLEMS

Due to the fact that resources are often limited and considering the complex nature of some projects, it is not advisable to plan to execute more than one project at a time. There is therefore need to prioritize and set targets for the selected projects. The criteria for setting priorities can include:

a) Which of the needs/projects is more pressing? Is there a threat to health or life?

b) The ease to have resources for the realization of the project

c) Is there a plausible or likely explanation for the programme, activity or need? Can lessons be drawn from it?

d) Are there conflicts of interest?

e) The ability of the community to sustain the project when realized?

10.6. THE ROLE OF THE DEVELOPMENT TEAM AND THE COMMUNITY

The management of resources generated by the state and the community in partnership is carried out by the Management Committee of the dialogue structure. The state is represented at each level by the technical team and the community by the community representatives at that level. The management committee is responsible for all management duties including planning. Its role in project execution includes:

a) Selects the priority project
b) Sets target for execution
c) Draws general plan of action
d) Regularly draws a work (by project committee) plan
e) Draws the budget for execution
f) Plans how to mobilize resources for execution
g) Forms a project committee
h) Presents the plan for adoption by the General Assembly of the dialogue structure.

10.7 CONCRETE EXAMPLES OF COMMUNITY INITIATIVES

- ❖ Promotion of health activities
- ❖ Construction, renovation and rehabilitation of health units
- ❖ Purchase and maintenance of medical equipment
- ❖ Environmental hygiene and sanitation
- ❖ Agricultural/food production and transformation
- ❖ Construction and maintenance of improved physical accessibility structures
- ❖ Training and education of other community members**.**

NB: The health committee with its management organ (the MC) constitutes a subcommittee of the integrated development committee of each community, be it at the village (health area) level, the sub divisional (district) level, or the divisional level. The above examples of community initiatives are often carried out within the framework of the integrated development committee initiatives.

10.8. SUSTAINABILITY

Sustainability is the ability to maintain a project functioning after the initial investment funds for its realization have been exhausted. A sustainable project is therefore a project, which after it has been realized could become financially self-sufficient after the initial investment of funds. Health care is sustainable when there is a long term ability to mobilize and allocate sufficient resources for producing the desired services. There goes the local saying that “oil from a raffia palm beetle can be used for frying the same beetle”. Finances generated through cost recovery from a well managed health establishment can effectively sustain that establishment. Some health programmes are part of larger integrated development projects, which provide productive activities to finance those which are not self supporting e.g. the dialogue structure of MHC Nkwen Health Area used to rent out part of its land for vehicle washing point, sale of wood and food sheds. These activities generated about 17.000 francs monthly for the health area. This amount increased the income of the health area realized from cost recovery.

In 1983 the health committee of the Kedjem Ketingoh health Area planted a fuel plantation and also managed a sweet potatoes farm. The sweet potatoes farm yielded enough money for the post. One year wood from that plantation was used to repair the health centre (the health post was transformed to a health centre).

Many health and health related projects often collapse because they are not sustainable and lack effective management. The incomes generated from cost recovery and subsidy from the state cannot effectively sustain many health units. Therefore, it is necessary to generate income from other sources.

10.9. PROJECT COMMITTEE

It is a sub committee of the health committee, in charge of a project. Membership is reinforced with competent staff from other sectors, and competent members of the community.

10.9.1. Terms of reference

It is responsible to the management committee, the general assembly and the community.

a) It ensures that a plan is drawn and approved for the project
b) It recruits workers (skilled and unskilled)
c) It mobilizes resources for the project
d) It draws a work plan from the plan of action
e) It purchases the necessary materials
f) It monitors the project regularly
g) It maintains proper records for the project
h) It reports about the project each time the management committee is meeting
i) It writes a detailed report about the project when it is realized.

10.9.2. Composition

It is an ad hoc committee whose members depend more on competence, honesty and trust in the community than on membership of the dialogue and management structures. Once the project is realized and its report presented and adopted, it ceases to exist.

10.9.2.1. Health Area

a) Chairman: Community representative (a retired technician if available)

b) Secretary: the staff representative in the dialogue structure

c) Treasurer: Community representative who is eligible.

Members:

d) The District Chief of Service Public Health or his representative

e) One member of the traditional authority (representative of all the traditional rulers)

f) Two community representatives from the general assembly.

10.9.2.2. The District Service

a) Chairperson: A community representative from the District Service Management Committee

b) Secretary: The Chief of Bureau Health

c) Treasurer: A community representative who is eligible

d) The District Chief of Service Public Health

e) The Director of the District Hospital

f) The District Supervisor from the regional level

g) The Representative of the Divisional Officer(s)

h) The Representatives of the Mayor(s)

i) One Community Representative.

Note:

i. Retired/unemployed technicians could be co-opted for particular projects. Their term of office would be when the project is completed.

ii. The project committee is the life wire of projects, hence only dynamic and hard working people should be chosen as members.

10.10. EXAMPLES OF COMMUNITY REALIZED PROJECTS

Two successful community based projects realized in two different districts are thus presented as case studies.

10.10.1. The Batibo District Hospital surgical complex

10.10.1.1. The Batibo Health District

Presentation

The Batibo Health District with a population of 71,000 inhabitants covers two administrative units: Batibo and Widikum Subdivisions. The district is carved out into health areas, some of which are functional and some are non functional. There are mission health centres and private nursing units.

The dialogue structures are composed of:

a) The health committee and management committee

b) The district dialogue structure with:

- The district health committee
- The district management committee
- The district hospital management committee

The Provincial Supervisor of that district is a member of the standing and district management committee.

10.10.1.2. The surgical complex

The Batibo District Hospital Surgical Complex is the 12th development project realized, was initiated among other 18 projects in 1992. The projects identified in order of priority include:

1. install electricity in the hospital
2. extend pipe borne water to the wards
3. create an improved surgical theatre
4. open a hospital pharmacy
5. improve relationships between health services and community, and the coordination of health centres
6. convert the incomplete building into a Pediatric Ward
7. construct roofed corridors to link the hospital buildings
8. increase the number of beds and beddings
9. construct modern pit toilet with shower facilities
10. create an improved physiotherapy unit
11. plant flowers and trees to demarcate the hospital boundaries
12. construct a real surgical theatre and surgical wards
13. build a nutrition centre
14. construct a water storage tank
15. build and equip an x-ray department

16. construct a mortuary
17. build a real paediatric ward
18. fence the hospital

The execution of the complex project started in January 1995 when the General Assembly of the dialogue structure adopted the plan (see page 14) to construct the surgical complex so as to solve problems from the improvised theatre, and to achieve objectives.

When the plan drawn by the Provincial Delegation of Public Health was adopted, strategies for the construction were put in place as follows:

10.10.1.3. Creation of two fund raising committees

a) a committee for the local population
b) a committee for elites out of Batibo and donor organizations

Hospital Development Fees

The institution of hospital development fees of 500 francs CFA.

This amount was paid once as consultation fees. Children, students, apprentices and desperate patients were exempted.

The Creation of a Project Committee

Composition

1. Chairman: District Chief of Service Public Health
2. Secretary: Chief of Bureau Health
3. Treasurer: President of the Standing Committee of the District Health Committee.

Members

1. Chairman of the District Management Committee
2. Chairman of the District Hospital Management Committee
3. Service Manager of the District Hospital
4. Two Community Representatives of the District Management Committee.

Terms of reference

The committee was charged with the following responsibilities:

a) Choosing the site for the building
b) Recruitment of workers
c) Purchasing of building materials
d) Organizing community human investment
e) Establishing appropriate records to ensure accountability and transparency
f) Drawing quarterly work plan of action

g) Writing quarterly update of the evolution of the project.

The sensitization and the mobilization of the administration, Chiefs of Health Centres, Dialogue Structures, Elites, Fons and Chiefs, the entire community was quite positive. The appeal for aid from philanthropic groups, NGO's, prominent personalities, Embassies, High Commissions and the funding agencies were also very positive. Fund raising rallies were organized and the appeal for equipment, German International Corporation (GIZ) and Clinic Care International donated equipment worth CFA 8.500.000 francs and 6.000.000 francs respectively.

10.10.1.4. Monitoring and evaluation of finances

The following methodologies were used to monitor and evaluate the money received.

a) Receipts: The duplicates of receipts issued for money received were regularly checked

b) Register: A register was opened for those who donated CFA 1.000 francs and above.

c) Thermometer drawing. Large thermometer drawing placed on the notice board was used to show the public the level of its mercury according to the monthly cumulative total finances received.

Feedback to the community donors

Letters of appreciation were always sent to all those who contributed to the realization of the project. The letters indicated the list of donors, amount received, the expenditure, further needs and appeal for more financial support.

10.10.1.6. Update report

An update of the evaluation of the project was made quarterly. It consisted of:

- Total finances received
- Sources of finances
- Level of achievement of the project
- Expenditure
- Financial support necessary to complete the project
- Lists of donors
- Appeal for more support.

The updates were displayed on the hospital notice board and sent to individuals, Embassies and Associations.

Finances raised as of March 1998

The total amount of money realized for the project through donations and the various fund raising activities amounted to CFA 51.332.567 francs.

Bankers during the operation were:

i. CCEI, Bamenda
ii. SCB Credit Lyonnais, Bamenda
iii. Credit Union, Batibo
iv. Post Office, Batibo

Plan of action and budget:

- The plan was drawn by the project committee and adopted by the General Assembly of the Dialogue Structure in March 1995
- 22nd of April 1995 – launching of fund raising
- May – June 1995 – Making of cement blocks and acquisition of stones
- 1st July 1995 – Initiation of the project foundation
- 30th september1995 – completion of foundation
- 14th October 1995 – laying of foundation stone
- November – December 1995 – Raising of walls
- January – February 1996 – Roofing
- March – April 1996 – Ceiling/metal works
- 13th April 1996 – fund raising rally
- May – June 1996 – Plastering and flooring
- July – September 1996 Glass works
- October – December 1996 – Equipment
- January – March 1997 – Finishing touches
- April 1997 – Inauguration

It was estimated to cost CFA 57.000.000 francs.

Evaluation of Project:

The project was evaluated as follows:

The execution of the plan of action

- The project was started on 1st July 1995 and realized in March 1998 instead of March 1997 as it was envisaged.

The balance sheet of income and expenditure

- The income of 51.332.567 francs balanced with the expenditure of 51,332,567 francs. This was due to the fact that the project was evaluated at different phases and the demand for more funds depended on the estimate of the work left.

a) Community participation

It was quite possible. The community contributed 34% of the total cost. The community was actively involved in all aspects of the project. The 34% does not

include labour. It should be noted that the community contributed 71% of the total cash of the 11 projects realized.

b) Funding organizations

Out of the applications made to 12 organizations, 4 responded with CFA 31.700.000 francs and GIZ adding to its own cash donation equipment worth CFA 8.500.000 francs.

c) Partnership between the state (represented by the health team-development team) **and the community** (represented by the district health committee). It was cordial and quite active in all the kinds of participation.

d) Inter-sectoral collaboration

The related services ranging from administration to school and churches whole – heartedly supported the execution of the project.

e) The District Technical Health Team

Their dynamism coupled with generosity (time was sacrificed and vehicles used) motivated all to contribute in their own way.

f) Supervision

It was both vertical (the Provincial Delegation of Public Health, the British High Commission and Embassies) and horizontal (the Project Committee).

g) Total Cost

The total costs including equipment from GIZ stood at CFA 59.832.576 francs.

h) Problems

Three major problems:

i. The absence of a service vehicle for the District Health Service and an ambulance for the District Hospital
ii. Lack of second doctor
iii. Lack of investment credits from government.

10.10.1.5. Sustainability

The report does not indicate how the effective running costs of the hospital would be maintained.

An appraisal

"This project has revealed that developing existing government institutions is cheaper and more effective through a community initiated project managed by the same community, and supervised by the donors, than channelling resources through non governmental organizations whose impact is most of the time felt and short lived at the level of the community. Similarly it exposes contracts given to contractors who often do only 50% of the expected work. The Batibo experience could work in most decaying state health institutions provided the community is trained to be as respectful, transparent and dynamic" as the authors of the project report see it.

10.10.2. MHC Nkwen Ward Extension: Health Area Project *(no written report available)*

The project was initiated by the Health Area Health Committee among other projects of the health area. The projects, which were identified and prioritized, were as follows:

1. Extension of the out patient department

2. Construction of Pit latrine
3. Road construction
4. Ward extension
5. Extension of maternity; it is on going
6. Purchase of equipment (part realized)
7. Construction of fence
8. Construction of theatre.

* The first three have been realized.

10.10.2.1. Objectives

a) Reduce congestion
b) Reduce the rate of infections
c) Create more space for patients
d) Provide quality care

10.10.2.2. Strategies put in place

Drawing of the plan

a) It was drawn by the Provincial Delegation of Public Health
b) Formation of Development Committee.

Composition

- Chairman: He was elected from the General Assembly of the Dialogue structure
- Three Technical Staff and some Community Representatives.

c) Mobilization of resources:

Funding

- Nkwen Urban and Rural Communities
- Elites
- Foreign donors
- Politicians and NGO's

Contributions

- Community 35%
- Donors 65% from foundation level.

Bankers

The money was kept in Amity Bank in a special account.

The signatories were:

1. Chairman of Development Committee
2. The Medical Officer in Charge of Nkwen MHC
3. The Treasurer of the Development Committee
4. The Donor

The chairman and the treasurer are members of the dialogue structures (community representatives).

10.10.2.3. Target and realization

The project was planned for five years from 1996 and was realized in two years period – 1998.

Equipment

Some equipment was supplied by:

- Soroptimists (NGO)
- Hon Clement Zamcho, Parliamentarian.

Evaluation

It was done by the community and the donor. The higher echelon of the health system was not actively involved. Apart from the plan drawn by the Delegation of Public Health, only moral supportive role was played.

10.10.2.4. Sustainability

The local running costs of MHC was generated from

- ✓ Cost recovery ; consultation fees, laboratory fees, birth attestation forms
- ✓ Rent of part of MHC land for wood sale which yielded 2500 francs monthly, food shed which yielded 5000francs monthly.

Note: This information was given by Dr Mrs. Mayer – Medical Officer in Charge of the MHC and Mr Wanzie J.C. Chairman of the Management Committee.

10.11. CONCLUSION AND RECOMMENDATIONS

Factors which can stimulate active community participation include among others:

i. Dynamic leaders
ii. Community initiated (based) projects
iii. Accountability/transparency.

These ingredients were present in the projects, thus stimulated the communities and others concerned to actively participate in the projects. The dynamism of the leaders, transparency and the successful realization of the previous projects accounted for the huge participation and success of the studied projects. In partnership, the active involvement of all the partners is essential. Self-reliance is not shifting government responsibility to the community.

In community participation, unrealized projects or those which collapsed after they have been realized greatly hinder community from participation in other projects. Community imposed projects are carried out in such a way that they effectively encourage greater dependency, unquestioning acceptance of outside regulations and decisions, and in the long run are crippling to the dynamics of the community. When a project is conceived, planning should not only consider resources for effective execution but also those for maintaining the project after realization. Land for the District Services, District hospitals and Health Centres are wasting. The example of MHC Nkwen can be emulated. Building houses for rental, renting out land for farming etc. can generate a lot of income for health establishments. When doing this it should not be forgotten that recruitment of health personnel and putting up of structures are other examples for the communities to emulate. Environmental hygiene especially should be considered when doing all this.

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