



RESTITUTION WORKSHOP OF THE RESULTS OF THE OPERATIONAL STUDY ON  
COMMUNITY PBF CONDUCTED BY THE PUBLIC HEALTH DEPARTMENT OF THE FACULTY OF  
MEDICINE AND BIOMEDICAL SCIENCES, YAOUNDE I UNIVERSITY

REPORT

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## LIST OF ABBREVIATIONS

AEDES: European Agency for Health and Development  
CBO: Community-Based Organisation  
CHC: Catholic Health Centre  
CIG: Common Initiative Group  
CNEC: Cameroon National Ethics Committee  
CODAS-Caritas: Diocesan Committee for Social/Charitable Activities  
HC: Health Committee  
DHC: District Health Committee  
CRA: Community Relay Agent  
CRS: Catholic Relief Services  
DHC: Diocesan Health Coordination  
DHD: District Health Department  
DHMC: District Hospital Management Committee  
DMC: District Management Committee  
DREB/EAST: Regional Delegation of Basic Education for the East Region  
DRES/EAST: Regional Delegation of Secondary education for the East Region  
DRSP/EAST: Regional Delegation of Public Health for the East Region  
DS: Dialogue Structure  
EB: Executive Bureau  
FMBS: Faculty of Medicine and Biomedical Sciences  
GA: General Assembly  
HDHD: Head of District Health Department  
HF: Health Facility  
HSSIP: Health Sector Support Investment Project  
IMCI: Integrated Management of childhood illnesses  
IEC: Information, Education and Communication  
IHC: Integrated Health Centre  
LLIN: Long-lasting impregnated mosquito nets  
MC: Management Council  
MC: Management Committee  
MINATD: Ministry of Territorial Administration and Decentralisation  
MOPH: Ministry of Public Health  
PBF: Performance Based Financing  
PHD: Public Health Department  
PPA: Performance Purchasing Agency  
REDSSEC: Healthcare revitalisation for Eastern Cameroon  
SWAp: Sector- Wide Approach

## 1. / INTRODUCTION

On the 29<sup>th</sup> day of May 2012 a restitution workshop of the results of operational research on community PBF took place in the big Conference Hall of CHRISTIANA Hotel. Community PBF research is in line with the implementation of the Multi-Country PBF Network activities in Cameroon. The Multi-Country PBF Network Project aims at improving the functioning of the health sector through active sharing of different experiences in the areas of PBF and research.

Knowing that community participation is the weak link in our health system chain, community PBF seems to be a fitting solution to boost the latter. This explains the importance attached to operational research conducted by CODAS-Caritas and the Public Health Department of the Faculty of Medicine and Biomedical Sciences, Yaoundé I University. Organised by CODAS-Caritas-Batouri area in collaboration with the Regional Delegation of Public Health for the East Region, the above-mentioned workshop aimed at presenting to the general public and particularly main health and education stakeholders the results of this research to ensure the success of PBF Extension Project in the area of health and PBF Education Project in Batouri Diocese. This workshop was chaired by Dr BIDJANG Robert Mathurin, Regional Delegate for Public Health in the East Region in the presence of the following:

- The Right Reverend Faustin AMBASSA NDJODO, Batouri Bishop and Legal Sponsor of the Project;



- Mr. ENANDJOU BWANGA, HSSIP Coordinator, representing the Minister of Public Health ;
- The Regional Delegate of Secondary Education for the East Region ;
- The Regional Delegate of Basic Education for the East Region

## 2. / OBJECTIVES OF THE WORKSHOP

The restitution workshop of the results of the research on community PBF focused on the following:

1. Existence of HCs and DHCs and the level of their operability in the Health Districts of the East Region of Cameroon;
2. Existence and level of operability of Management Councils of Catholic Health Facilities under the performance contract with REDSSEC Project;
3. Causes of non-existence and/or non-operability of Health Committees and Management Councils;
4. Strategies for dialogue structures to be operational in order to enable them to efficiently participate in the implementation of the PBF Extension Project as community-based health service providers;
5. Discussions about strategies to enhance community participation in health care in general and PBF in particular.

## 3. / ORGANISATION

This workshop was organised by the Regional Delegation for Public Health in the East Region and the project implementation team made up of the following:

Right Reverend Faustin AMBASSA NDJODO, Batouri Bishop and legal sponsor;  
Mr. MANDENG, CODAS-Caritas and Project Deputy Coordinator;  
Dr. TSAFACK Jean Pierre, Project Coordinator;  
Mr. MOUSSOUME EKOANGUE, Contract Expert;  
Mr. MGBA Etienne, Community PBF Research Manager  
Mr. NIEPOUYI Dominique, Administrative and Finance Manager

#### 4. / PROGRAMME FOR THE WORKSHOP

Time	Themes	Person in charge
8 : 30	Arrival and seating of participants	EC
8 :45	Arrival of Regional Delegate of Public Health for the East Region and Right Reverend Faustin AMBASSA NDJODO	CODASC Coordinator
8 :50	National anthem	Project Coordinator
9 :00	Opening prayer	Reverend Faustin
9 :10	Official address to open the workshop	DRSP
9 :30	Current situation of PBF in Cameroon	PAISS Coordinator
9 :40	Presentation 1 : Introduction and objective of the study	Prof Kuaban/Dr Njournemi
	Coffee-break	Secretary/Accountant
10 :10	Presentation 2 : Methodology of the study	Prof Kuaban/Dr Njournemi
10 :40	Presentation 3 : Results of the study	Prof Kuaban/Dr Njournemi
11 :10	Presentation 4 : Conclusion and recommendation	Prof Kuaban/Dr Njournemi
12 :10	Discussions	DRSP
13 :10	Closing speech	DRSP
13 :20	Vote of thanks and closing prayer	Reverend Faustin
13 :30	Cocktail and end of the workshop	Secretary/Accountant

#### 5. / PARTICIPANTS

The workshop brought together 50 participants representing the Church, the Government and Civil Society Organisations.

N°	Full names	Structure and position
1	Dr. BIDJANG Robert Mathurin	Regional Delegate for Public Health /East Region
2	Right Reverend Faustin AMBASSA NDJODO	Bishop of Batouri Diocese
3	Mr. ENANDJOUR BWANGA	HSSIP Coordinator
4	Mr. MEYENG Félix	Regional Delegate for Basic Education /East Region
5	Mr. AMBANI NOMO	DREC/EAST (SDAG) Representative
6	Dr. NJOURMEMI Zakariaou	DSP/FMSBM/UYI
7	Dr. NGEUFACK TSAGUE	DSP/FMSBM/UYI
8	MABONGO Daniel	FMSBM/UYI
9	Dr. TSAFACK Jean Pierre	RPFMP
10	Dr. DONFACK MBASSO	CSSD Yokadouma
11	Dr. WASSEP TINDA	CSSD Nguélemendouka
12	Dr. DJEUGABENG Fabien	CSSD Messamena
13	Dr. SAAGOUYEM Bernard	CSSD Mbang
14	Dr. DZUDJO Pierre	CSSD Garou-Boulai
15	Dr. NGON A YOMBO	CSSD Lomié
16	Dr. MABOULI NKOMON Floribert	CSSD Kétté
17	Dr. MEBOUINZ Daniel	CSSD Batouri
18	Dr. NOUPOUE Joseph	CSSD Abong-Mbang
19	Dr. BAYIHA Christian	CSSD Doumé
20	Dr. TEDJOUKA Etienne	CSSD Bertoua
21	Dr. TCHEUMAGA Sylvain	CSSD Moloundou
22	Dr. ESSINDI MBIDA Jean Pierre	CSSD Bétaré-Oya
23	Mr. AYISSI NOUBOSSE Isidore	CSD Batouri
24	Mr. MBO'OH MBASSAGA Justin	CDS Yokadouma
25	Mr. BOYOGUENO Louis de Gonzague	PBF Focal Point /East Region
26	Mr. SANEMEGO	DRSP/PF R.R.SD
27	Reverend ELOMO Emmanuel	SEDUC/Batouri Diocese
28	KOUMA Charles	Accountant SEDUC Batouri/PBF Education
29	Mr. ESSONO NZOUE Jean	C.B.A.G Bétaré-Oya
30	Mr. TIOTSIA RENE	Bary School/PBF Education
31	Mr. EMO Mathieu	DDES Kadey/PBF Education
32	Mr. ONDOUA René	APD SEDUC Batouri/PBF Education
33	Mrs EBENDE Cécile	Bary School/PBF Education

34	Reverend Sister Jean Gabriel HOARAU	Bary School /PBF Education
35	Mr.ETOUNDI NKOU	DREB/IC-BL/PBF Education
36	AMANG Denis	CRTV/Journalist
37	Mrs LUM Presilia	CRTV/Journalist
38	MEKOK Martin	ACTION/Journalist
39	NTSAMA Martin Crépin	CANAL2/Journalist
40	AKORBONGO	CANAL2
41	TIGNANG M. Roméo	DIKALO/ Reporter
42	KOUMAI KISITO	ARIANE TV
43	NTI Bertrand	ARIANE TV
44	KENMOGNE	STV
45	Mrs MVOE Michèle	CFHMB
46	Mr. MOUSSOUME EKOUANGUE	RPFMP
47	Mr.NGONSI Benoit	Verifier/REDSSEC
48	Mr.NIEPOUYI DOMINIQUE	RPFMP
49	Mrs EKEMEYONG Epse ONANA	REDSSEC
50	Mr. MGBA Etienne	RPFMP

It should be pointed out that 13 out of 14 Heads of District Health Departments of the East Region were present.

## 6. / OPENING CEREMONY

The opening ceremony started with a prayer said by Reverend Faustin AMBASSA NDJODO, Batouri Diocese Bishop, and the short speech delivered by the Regional Delegate for Public Health in the East Region.

In his opening address, the DRSP/East Region, after welcoming all participants to the workshop, said that the latter was a concrete materialization of the collaboration among the Ministry of Public Health, Cordaid and CODAS-Caritas/Batouri area within the framework of the implementation of the Health Sector Strategy to achieve MDGs. He requested all participants to follow attentively and participate in discussions in order to go back with relevant recommendations. He reiterated that community participation was a priority for the Ministry of Health's road map.

## 7. / CURRENT SITUATION OF PBF IN CAMEROON

After having rightly expressed his satisfaction about the initiative by CODAS-Caritas/Batouri area in collaboration with the Public Health Department/ Faculty of Medicine and Biomedical Sciences of Yaoundé I University, Mr. ENANDJOURM BWANGA, HSSIP Coordinator (Health Sector Support Investment Project) representing the Minister of Health thoroughly presented the situation of PBF in Cameroon.

The historical reminder started from the definition of PBF as a health financing strategy aiming at increasing the quantity and quality of services provided to communities through a performance contract up to Batouri Diocese's pilot experience.

The political will, the availability of national expertise and financing constitute Cameroon's assets.

The current situation can be summarized in the four following points:

- IDA Credit Agreement : 25 millions USD over a five- year period
- Pilot Project in four (4) Regions: Northwest, Southwest, Coastal and East Regions)
- 4 Health Districts in 3 Regions (Northwest, Southwest, Coastal Regions)
- All 14 Health Districts of the East Region (REDSSEC Project Extension)

HSSIP *objective*:

- Improve the quantity and quality of health services provided to communities with a special emphasis on maternal and child health (MDGs 4 and 5) and the fight against malaria
- Structuring: two components, a) service provision at Health Districts level (80% of the funding), b) institutional support (20% of the funding)

- Implementation strategies:
  - o Project restructuring (it completed in 2011);
  - o Setting up of a performance purchasing agency within the Special Fund for Health Promotion -Coastal Region;
  - o Recruitment of international NGO's to play the role of performance purchasing agencies in the three other Regions

*Other initiatives*

PBF introduction in Catholic health facilities of the far-north region with Cordaid funding.  
 PBF introduction in the education sector in 16 public and private school institutions in Batouri Diocese with Cordaid funding.

*Coastal Region*

Starting up in February 2011: 55 contracts have been already signed with health facilities;  
 About 80 millions CFA francs of subsidies paid to health facilities;  
 The process is going smoothly;  
 Results are encouraging and a thirteen-minute film was produced in February 2012.

*Northwest*

Contract signed with AEDES on 15 December 2011;  
 The Performance purchasing agency has been set up;  
 The official launch of the process took place on 14 February 2011;  
 Training of trainers has been completed;  
 The signing of 50 contracts with health facilities is in the process;  
 The collection of information for basic studies has been completed.

*Southwest*

The contract was signed with AEDES on 15 December 2011;  
 The Performance purchasing agency has been set up;  
 The official launch of the process took place on 14 April 2011;  
 The training of trainers is ongoing;  
 The signing of contracts with health facilities is planned for end of June 2012;  
 The collection of information for basic studies is under way.

*East Region*

Agreement on the service provision contract with Cordaid.  
 The process for the signing of the contract is ongoing.  
 The official launch of the PBF process is planned for end of June 2012.  
 The performance purchasing agency will start operating in July 2012 throughout all the Health Districts of the Region.

CONCLUSION

It has been pointed out that the procedures for the recruitment of international non-governmental organisations (INGO's) are very long. However, HSSIP is in the process of meeting the needs of communities waiting with great hope.  
 The year 2012 is devoted to monitoring, contract implementation and the preparation of the assessment of the PBF impact with a view to scaling up.

8. / RESEARCH RESTITUTION

The restitution was done by the team led by Pr KUABAN, Head of the Public Health Department of the Faculty of Medicine and Biomedical Sciences, Yaoundé I University, and including the following members:

- Dr. DJOUMEMI, Health Economics expert, Co-investigator;
- Dr. NGUEFACK, Biostatistician, Co-investigator
- Mr. MABONGO, medical student, interviewer

## I. INTRODUCTION: BASIC INFORMATION AND OBJECTIVES OF THE STUDY

### Health system and dialogue structures

The Decree N° 95/013 of 7 February 1995 establishing the organisation of district basic health services stipulates that Health Committees (HC) and Management Committees (MC) are part of the district health organs, but does not specify their functions or legal status.

### Functioning of Health Committees and Management Committees:

HCs and MCs operate on basis of by-laws and internal rules and regulations adopted by the General Assembly meeting.

The regulatory standard is widely in force: each Health Committee meets twice a year, that is once a semester, with a possible extraordinary meeting to take place once a year. As for each Management Committee, it meets once a month, that is 12 times a year.

### PBF at community level

#### Definition of health financing:

Health financing: collection of funds from different sources (governments, households, companies, donors, etc.); they are pooled to share the financial risk among bigger groups within the population, and used to pay healthcare and services provided by public and private service providers.

PBF/FBR/P4P: The health service financing strategy, which aims at increasing the quantity and improving the quality of preventive and curative care/services provided to the population in accordance with standards through the purchasing of health care services. The purchasing of healthcare services is based on an agreement entered into one party doing the purchasing (purchaser) and another party selling health care services (seller means service provider).

Community PBF fits in the health system decentralisation (enactment of decrees on the enforcement of the law on the orientation of the 2004 decentralisation).

Order N° 2010/3702/A/MINSANTE/CAB of 9 September 2010 establishing the terms of reference specifying conditions and technical modalities to exercise powers transferred by the State to local decentralised collectivities or 'communes' as regards public health (infrastructure, equipments and health facility management).

Health system decentralisation: This is an essential link of the organisation of access to healthcare ensuring the population's active participation and the availability of services and primary healthcare at community level.

The legal and financial autonomy is ensured through regulation to guarantee autonomous management and civil society involvement in decision-making at decentralised level.

Civil society participation relies on dialogue structures, which should be reinforced within the framework of the community PBF programme.

The PBF scheme in healthcare revitalisation for Eastern Cameroon actually started in August 2006 with four catholic health centres in order to gradually replace traditional input-based financing.

Health Committee: It is the main stakeholder in the implementation of community PBF at the level of the health area.

The Health Committee seems not to operate in the health areas of health districts in the East Region of Cameroon.

The Community PBF implementation by REDSSEC Project made up for the Health Committee's absence by establishing Management Councils for Catholic health facilities.



The main purpose of Management Committees is to participate in the implementation of community PBF through the discussion and validation of the health structure business plan.

With this situation, this operational research aimed at making an in-depth analysis of the functioning of Health Committees and that of Management Councils in a bid to draw lessons from them and better prepare them for efficient interventions in the implementation of the community PBF Extension Project financed by the Ministry of Public Health and the World Bank as community-based health service providers in Cameroon.

## II. OBJECTIVES OF THE STUDY

### 1. OVERALL OBJECTIVE

The overall objective was, on the one hand, to assess the functioning of Health Committees and that of Management Councils and, on the other hand, to draw lessons to scale up the PBF Project with a view to providing community-based services financed by the Ministry of Public Health and the World Bank.

### 2. SPECIFIC OBJECTIVES OF THE STUDY

- Assess the existence and operationality of Health Committees in the health districts in the East Region of Cameroon;
- Assess the existence and operationality of Management Councils in catholic health facilities under the performance contract with REDSSEC Project;
- Determine causes for the non-existence and/ or non-operationality of Health Committees and Management Councils;
- Describe necessary adaptations to the current PBF programme in order to develop a genuine community PBF programme;
- Identify strategies to help Health Committees be operational to enable them to efficiently participate in the implementation of the PBF Extension Project as community-based health service providers;
- Popularise these strategies among regional authorities of the East Region of Cameroon to enhance community participation in healthcare;
- Prepare, in case of need, a scientific article on the study's database.

## II. 3. METHODOLOGY OF THE STUDY

### *II.3.1 Preparatory phase of the study*

Development of data collection instruments

List of individual questionnaire for Dialogue Structures, CR and Health Facilities.

Screening, recruitment and training of interviewers

30 potential interviewers recruited based on their qualification, experience in conducting interviews and their being residents of the geo-cultural area of the East Region of Cameroon.

A workshop on the training of all potential shortlisted interviewers took place on 5-6 September 2011 at Residence Hotel in Yaoundé. Details for this training are available in the relevant workshop report.

### II.3.2 PILOT SURVEY

A pilot survey for the pre-test of data collection instruments was conducted from 11 to 16 September 2011 in Mbang District.

Mbang District population is estimated at 49,332 inhabitants.

A research team made up of two main co-investigators and four data collection agents had conducted the mission.

### II.3.3 ETHICAL CONSIDERATIONS

Before the collection phase, an ethical clearance form No 247/CNE/SE/2011 was obtained from Cameroon National Ethics Committee. Participation in this research was voluntary and free. Information provided was anonymous and confidential.

Free consent was required before the actual beginning of each interview.

An administrative information letter was sent to relevant authorities (Ministry of Health).

### II.3.4 PLACE, CHOICE OF SITES AND RESPONDENTS, TYPE AND DURATION OF THE STUDY

#### *Study place:*

The study was conducted in the East Region of Cameroon, specifically in four out of the eight health districts covered by REDSSEC Project.

Map of the East region of Cameroon

Districts, health areas, health facilities and communities from the zone covered by REDSSEC Project.

#### *Choice of the study sites*

The choice of the study sites is based on the stratified probabilistic method with three respective degrees of stratification: health districts, health areas and communities.

#### *Study respondents*

The study respondents were made up of members of Health Committees, Management Councils, Management Committees, District Health Committees, District Hospital Management Committees, health facilities managers, community relay agents, village/community chiefs, community leaders, community-based organisations members, and general population for Focus Group Discussions (FGDs).

The choice of study respondents was done at random on all study sites.

#### *Type of the study*

Descriptive crosscutting study using a combination of quantitative and qualitative survey.

#### *Duration of the study*

- ◆ 6 months: from September 2011 to February 2012.
- ◆ Preparatory phase: from September to mid-October 2011.
- ◆ Data collection: from 17 to 27 October 2011.
- ◆ Quantitative and qualitative data analysis as well as the drafting of the final report: from November 2011 to February 2012.

### II.3.5 STUDY PROCEDURES

The study procedures consisted in conducting three types of survey with different target groups interviewed through a questionnaire, a thorough interview guide and group discussion or Focus Group Discussion (FGD)

*Information on the existence of Health Committees and Management Councils at the health area level.*

*The Health Committee or Management Council was set up if one or some of the following criteria were met:*

- Availability of the proceedings of the constituent general assembly meetings of the Health Committee and the Management Council;
- Availability of the Health Committee and Management Council's by-laws and/or internal rules and regulations;
- Availability of an official receipt of the declaration of the association on behalf of the Health Committee or Management Council in accordance with the Law N<sup>o</sup> 90/053 of 19 December 1990 on freedom of association in Cameroon;

- Availability and physical presence of the members of the Health Committee or Management Council's Executive Bureau at the level of the health area;
- Existence of a Management Committee from a Health Committee of the Integrated Health Centre from the health area;
- Availability and physical presence of the members of the Management Committee's Bureau at the health area level.

*Description of the causes for the non- existence of the Health Committee and Management Council at the health area level*

- ◆ Lack of community association spirit ;
- ◆ Insufficient IEC/CCC on the Health Committee ;
- ◆ Ignorance of the Health Committee's importance at community level;
- ◆ Failing to convene the Health Committee's constituent general assembly meeting ;
- ◆ Lack of a standard guide for the establishment of a Health Committee;
- ◆ Population's lack of an association culture and mindset;
- ◆ Lack of the Health Committee's ownership by the population;
- ◆ Suspicion feelings among communities;
- ◆ Insufficient level of associative leadership;
- ◆ Legal existence authorisation by MINATD vs Ministry of Public Health;
- ◆ Others (to be specified), etc.

*Assessment of Health Committees and Management Councils' operationality at the health area level:*

- ◆ Availability of a Health Committee or Management Council's budgeted or non- budgeted action plan ;
- ◆ Availability of the annual progress reports for the Health Committee or Management Council;
- ◆ Holding of statutory Health Committee or Management Council General Assembly meetings;
- ◆ Proceedings of statutory Health Committee or Management Council General Assembly meetings;
- ◆ Holding of statutory meetings of the Health Committee or Management Council's Executive Bureau;
- ◆ Proceedings of statutory meetings of the Health Committee or Management Council's Executive Bureau;
- ◆ Proceedings of the deliberations and decisions of the Health Committee or Management Council's General Assembly meetings;
- ◆ Reports, budgets, accounts, balance sheets and other documents validated by the Health Committee or Management Council's General Assembly meetings;
- ◆ Proceedings of IEC/CCC community mobilisation activities (communities / Integrated Health Centre interface);
- ◆ Reports of community participation initiated by the Health Committee or the Management Council for health area activities.

*Description of the causes for the non-operationality of the Health Committee and Management Council at the health area level*

Causes linked to the system of the choice of Health Committee and Management Council members:

- ◆ Lack of or insufficient representation by Health Committee and Management Council's elected members representing quarters/blocks/villages of the health area community;
- ◆ Lack of or insufficient representation by rightful members of the Health Committee and Management Council;
- ◆ Overrepresentation of co-opted members of the Health Committee and Management Council;
- ◆ Lack of, insufficient representation and overrepresentation of honorary members;
- ◆ Co-optation of the Health Committee and Management Council's executive members, in particular the Chairperson ;
- ◆ Imposing friends, brothers and sisters and parents as the Health Committee and Management Council's executive members ;
- ◆ Non-respect of the period for the renewal of the Health Committee and Management Council's Executive Bureau and governing team;

- ◆ Predominance of the non-democratic choice of the members of the Health Committee and Management Council's Executive Bureau;
- ◆ Other causes (to be specified)

*Causes linked to the Health Committee and Management Council's governance*

- ◆ Ignorance of the Health Committee and Management Council's roles and functions within the community;
- ◆ Resignation of community members on account of the Health Committee and Management Council' confiscations by Health Facility representatives in decision-making;
- ◆ The Health Committee and Management Council's bad governance;
- ◆ Lack of responsibility and obligation to hold the Health Committee and Management Council members accountable before the community ;
- ◆ Failure to promote and popularise by-laws and internal rules and regulations governing the Health Committee and Management Council within the population ;
- ◆ Health Committee and Management Council leaders' ignorance of by-laws and internal rules and regulations.

*Causes linked to the Health Committee and Management Council's governance*

- ◆ Failure by the population and parent ministries to monitor and evaluate the Health Committees and Management Councils in the health area;
- ◆ Lack of the Health Committee and Management Council's physical visibility outside the premises of the health facility;
- ◆ Members' insufficient understanding of the Health Committee and Management Council's mission, role and duties;
- ◆ Lack of participation and the population's say through the Health Committee and Management Council in the health facility activities in the health area;
- ◆ Conflict of interest for Health Committee and Management Council members in the health area;
- ◆ Leadership conflict and refusal by Health Committees and Management Councils to comply with guidelines from the hierarchy;
- ◆ Other causes (to be specified).

*Causes linked to lack of incentives/motivations for Health Committee and Management Council members*

- ◆ Lack of sustainable financing for the Health Committee and Management Council to be operational ;
- ◆ Non-existence of and/or insufficient financial and non-financial incentives for Health Committee and Management Council members ;
- ◆ Other causes (to be specified)

*Causes linked to conflict management and resolution*

- ◆ Loss of control due to change in leadership ;
- ◆ Refusal to lose face following the change ;
- ◆ Other causes (to be specified).

*Crosscutting causes*

- ◆ Confusion and/or double administrative supervision between the Ministry of Territorial Administration and Decentralisation (MINATD) and the Ministry of Public Health;
- ◆ Other crosscutting causes (to be specified).

*Descriptions of necessary adaptations to PBF programme at community level*

- ◆ Types of community health activities already implemented in the health areas concerned with the study ;
- ◆ Experiences from Health Committees, Management Councils, community relay agents, health facilities regarding community health activities;

- ◆ Knowledge and experiences from Health Committees, Management Council, community relay agents and health facilities regarding PBF programme at community level;
- ◆ Comparison of community health performance in PBF and non-PBF zones on the study sites;
- ◆ Types of community health activities likely to be implemented in health areas within the framework of community PBF programme;
- ◆ Different community health indicators which can be assessed and purchased within the framework of the community PBF programme;
- ◆ Other necessary adaptations (to be specified).

*Identification of strategies that should help Health Committees to be operational and thereby implement the community PBF Programme Extension Project (1)*

- ◆ Identification of the strategies that could promote the establishment and existence of the Health Committee and Management Council;
- ◆ Identification of the strategies that could promote the operability of Health Committees and Management Councils;
- ◆ Revitalisation of Health Committees and Management Councils as regards community health activities within the framework of the community PBF programme;
- ◆ Redefining of the mission and re-organisation of dialogue structures tasks (Health Committee and Management Council) in conformity with community PBF principles;
- ◆ Redefining of the mission and re-organisation of the relay agents' tasks in accordance with community PBF principles;
- ◆ Redefining of the mission and re-organisation of the tasks of community-based organisations (CBO) in accordance with community PBF principles.

*Identification of the strategies that should help Health Committees be operational and thereby implement the community PBF Programme Extension Project*

- ◆ Redefining of the mission and re-organisation of beneficiary communities' tasks in accordance with community PBF principles;
- ◆ Redefining of the mission and re-organisation of the integrated health centre's tasks in accordance with community PBF principles;
- ◆ Redefining of the mission and re-organisation of the district hospital's tasks in accordance with community PBF principles;
- ◆ Redefining of the mission and re-organisation of District Health Department's tasks in accordance with community PBF principles ;
- ◆ Redefining of the mission and re-organisation of performance purchasing agency's tasks in accordance with community PBF principles;
- ◆ Other strategies (to be specified).

### *II.3.6 Study data management and analysis*

The collected data were managed and analysed by the rule book governing qualitative and quantitative research.

#### *Data analysis*

- ◆ Data analysis was made with the help of EPIDATA software whose advantage is its user-friendliness in data management;
- ◆ As this reference study was crosscutting, the data analysis was essentially descriptive, highlighting statistical parameters such as frequency, average, etc.
- ◆ EPI DATA data had often been exported to other SPSS and STATA software packages for more detailed analyses.

## III. STUDY RESULTS

### *Causes for the non-existence of Health Committee (1)*

- ◆ *Lack of spirit of association within the community: 28.2% of the dialogue structures members and 62.5% of community leaders;*
- ◆ *Insufficient sensitisation and information about the Health Committee within the population: 21% of dialogue structures members and 38.1% of community leaders.*
- ◆ *Population's ignorance of the community importance of the Health Committee: 27.6% of the dialogue structures members and 45.8% of leaders;*
- ◆ *Failure to convene the Health Committee's constituent general assembly meeting: 29.8% of the dialogue structures members and 56% of community leaders;*
- ◆ *Lack of standard guide for the establishment of the Health Committee at health district level :74% of the dialogue structures members and 58.3% of community leaders;*
- ◆ *The Health Committee's associative nature enables its legal existence to be authorised by MINATD instead of the Ministry of Public Health: 66.7% of community leaders;;*
- ◆ *The fictitious establishment of the Health Committee without the sitting of the general assembly meeting to elect or appoint the executive bureau members is considered as the reason for the non-existence in most FGDs (male and female FGDs) ;*
- ◆ *The population's lack of associative culture and mindset constitutes one reason for the non-existence of the Health Committee as expressed in FGDS (male and female FGDs) ;*
- ◆ *The population's lack of ownership of the dialogue structures, as it considers Health Committees as the extension of the health centres property at community level ; this was mentioned in almost all FGDs as the main reason for the non-existence of the Health Committee (male and female FGDs);*
- ◆ *Suspicion feelings towards leadership among different socio-ethnological groups having to make up Health Committees in the health area is considered as the reason for the non-existence in youth's FGDs (male and female youth) ;*
- ◆ *Insufficient leadership in general and female leadership in particular likely to initiate the establishment of the Health Committee in the health area is the reason widely expressed in women's and girls' FGDs );*
- ◆ *Lack of standard for the establishment of the Health Committee at health district level:74% of the dialogue structures members and 58.3% of community leaders;*
- ◆ *The Health Committee's associative nature enables its legal existence to be authorised by MINATD instead of the Ministry of Public Health: 66.7% of community leaders*

### *Causes for the non-operationality linked to the system of the choice of the Health Committee's members*

- ◆ *Co-optation of the Health Committee's executive members by some health facility managers: 26% of the dialogue structures members and 53.6% of community leaders;*
- ◆ *Imposition by some leaders of friends, brothers and sisters and parents as the Health Committee' s executive members: 22.6% of the dialogue structures members and 10.7% of community leaders;*
- ◆ *Non-renewal of the Health Committee's Executive Bureau and governing team since its establishment: 52.5% of dialogue structures members and 64.5% of community leaders ;*
- ◆ *Non-representation within the Health Committee of the representatives of all villages, chiefdoms, quarters or blocks constituting the health area: 57.1% of community leaders;*
- ◆ *Predominance of the non-democratic choice of the Health Committees' Executive Bureau members: 53% of community leaders;*
- ◆ *Non-respect of the period for the renewal of the Health Committee's Bureaus in the health area: 44% of dialogue structures members;*

### *Causes for the non-operationality linked to the Health Committee and the Management Council's governance*

- ◆ *Community's ignorance of the Health Committee's roles and functions: 56.3% of dialogue structures members and 77.4% of community leaders;*
- ◆ *Resignation of community members on account of the Health Committee' s confiscations by Health Facility representatives in decision-making: 46.4% of dialogue structures members and 19% of community leaders;*
- ◆ *The Health Committee's bad governance: 62.5% of community leaders;*

- ◆ Lack of responsibilities and obligation to hold the Health Committee's members accountable before the community: 78.6% of community leaders;
- ◆ Failure to promote and popularise within the population by-laws and internal rules and regulations governing the Health Committee: 27.1% of dialogue structures members;
- ◆ Ignorance of by-laws and internal rules and regulations by the Health Committee leaders: 44.2% of dialogue structures members and 60.1% of community leaders;
- ◆ *Failure by the population and parent ministries to monitor and evaluate the Health Committees in the health area: 47% of community leaders;*
- ◆ *The lack of the Health Committee's physical visibility outside the premises of the health facility is a cause mentioned several times in FGDs:*
- ◆ *Members' insufficient understanding of the Health Committee's mission, role and functions: 38.1% of community leaders ;*
- ◆ *Lack of population's participation and say through the Health Committee in the health facility activities in the health area :57.7% of community leaders;*
- ◆ *Conflict of interest for Health Committee members in the health area:72% of community leaders;*
- ◆ Leadership conflict and refusal by Management Council to comply with guidelines from the hierarchy are the main causes for the non-operationality of Management Councils: 32.1% of community leaders. FGDs indicate that the Management Councils' non-operationality is due to the conflict of leadership, positioning and the refusal to comply with the guidelines regarding the coordination of social/charity activities and particularly health activities in Bertoua Diocese (male and female FGDs);
- ◆ Involvement in parallel health activities: 12% of Health Committees members;
- ◆ Lack of interest in community health issues: 8% of Health Committee members and 1% of Management Council members;
- ◆ Civil servants/employees appointed elsewhere outside the health area: 6% of Health Committee members.

Non-operationality causes linked to lack of incentives/motivations for Health Committee and Management Council members (8)

- ◆ *Lack of Health Committee's sustainable financing to ensure the functioning and encourage members to work smoothly: 79% of Health Committee members and 71.4% of community leaders;*
- ◆ *Non-existence of and/or insufficient financial and non-financial incentives for Health Committee members: 70.2% of Health Committee members and 65.5 % of community leaders.*

*Non-operationality causes linked to conflict management and resolution within Health Committees and Management Councils*

- ◆ *Loss of control due to change in leadership : 51.4% of dialogue structures members and 32.1% of community leaders as a major cause for the non-operationality of Health Committees and especially Management Councils in Bertoua Diocese;*
- ◆ *Refusal to lose face: 28.5% of community leaders as the main cause for Management Councils' non-operationality, especially in Bertoua Diocese.*

Crosscutting causes for Health Committees and Management Councils' non-operationality

- ◆ The double administrative supervision by MINATD and the Ministry of Public Health is one cause for non-operationality: 13.8% of dialogue structures members and 24.4% of community leaders.

*Necessary adaptations for the PBF programme*

- ◆ *The study shows that some Health Committee members already participate in community health activities in their capacity as community relay agents, community-based organizations members, members of the dialogue structures executive bureau and community members.*

Community health activities remunerated in CR.

Quality of Health Committee and Management Council participating in community health activities.  
 Distribution of community relay agents according to the organisation of origin.  
 Types of current organisations as expressed by CR  
 System of CR's current remuneration.  
 Obstacles to Health Committees' participation in community health activities.  
*Knowledge and experiences on community PBF*  
*Existence of PBF contracts and sub-contracts*  
 Skills and practices of community PBF  
 Types of community health activities or services contracted or likely to be contracted through community PBF  
 Comparison of performance between PBF and NON-PBF Integrated Health Centre  
 Comparison of performance between PBF and NON-PBF CR  
 Comparison of performance among Health Committees, Management Councils and Community-Based Organisations  
 Comparison of the remuneration between PBF and NON-PBF CR  
 Average annual receipts from the recovery of costs and PBF and NON-PBF IHC performance subsidies  
 Average monthly receipts from the recovery of costs and PBF and NON-PBF IHC performance subsidies  
 Average monthly receipts from the recovery of costs and PBF and NON-PBF CR performance subsidies  
 Average monthly receipts from HC, MC and CBO performance subsidies  
 Average annual expenditure on performance bonus and payment of PBF and NON-PBF IHC performance sub-contract  
 Average monthly expenditure on remuneration and motivation incentives for PBF and NON-PBF CR  
 Average monthly expenditure on remuneration, performance bonus and motivation incentives for PBF and NON-PBF CR

Adaptations of malaria prevention and care indicators;  
 Adaptations of onchocercosis care indicators;  
 Adaptations of community IMCI indicators;  
 Adaptations of maternal health care indicators;  
 Adaptations of nutrition monitoring and vaccination indicators;  
 Adaptations of TB and HIV surveillance indicators;  
 Adaptations of IEC indicators /meetings/supervisions;  
 Adaptations of home mortality monitoring indicators;  
 Adaptations of population census/reporting indicators;  
 Adaptations of establishment and management of latrines indicators;  
 Adaptations of water points establishment and management indicators;  
 Factors determining the use of community health services;  
 Behavioural obstacles to the use of community health services;  
 Separation of PBF functions: WHO CONTRACTS?  
 Separation of PBF functions: WHO PAYS?  
 Separation of PBF functions: WHO VERIFIES?  
 Separation of PBF functions: WHO REGULATES?  
 Separation of PBF functions: WHO DECIDES THE INDICATORS?

*Strategies that could promote the establishment and existence of the Health Committee*

- ◆ Transformation of Management Councils into Health Committees and their extension or establishment in health areas ;
- ◆ IEC/CCC community association and importance of the Health Committee ;
- ◆ Standard guide for best practices governing the Health Committee at the health area level.

*Strategies that could promote the operability of Health Committees*

- ◆ Improvement of Health Committees' governance according to the systems and principles of Management Councils experimented within the framework of community PBF;
- ◆ Use of democratic principles and rules governing the choice of Health Committees' members ;
- ◆ Determination of the term of office for Health Committees' Bureaus and respect of the period for their renewal;
- ◆ Taking into consideration the representation of different communities within Health Committees ;
- ◆ Reinforcement of the capacities of Health Committees' members;



- ◆ Responsibility and obligation for the Health Committee's members to be held accountable before the community ;
- ◆ Dissemination of Health Committees' by-laws and internal rules and regulations;
- ◆ Population's participation and say in Health Committees' management ;
- ◆ Integration of Health Committees as PBF partners and stakeholders at community level ;
- ◆ Training Health Committees' members on PBF principles.

#### IV. CONCLUSIONS AND RECOMMENADATIONS

##### IV.1 CONCLUSION

Community PBF in the East Region of Cameroon enabled to improve the use and quality of health services under some conditions: Existence of sub-contracts entered into with Health Committees, Community-Based Organisations, Common Initiative Groups, CR, significant reduction of prices, inclusion of quality indicators and services materialisation, regularity, swiftness and reliability of money transfer, prior approval of projected budgets for health centres under PBF sub-contracts, documentation of resulting fraud and sanctions.

Community PBF improves the performance of healthcare structures, the quality of services, and it enables to reduce the financial weight of the healthcare cost supported by patients at villages and quarters levels;

Community PBF constitutes an efficient instrument to better motivate relay agents by giving them an incentive based on their performances. This contributes to their retention in service provision and in community health activities.

##### IV.2 RECOMMENDATIONS

###### Recommendations for the Health Committee

- ◆ Identification in collaboration with other local stakeholders (CBO, CRA, IHC) of priority health problems and possible solutions ;
- ◆ Participation in annual planning by expressing the health needs felt by the community;
- ◆ Participation in the development of and decisions on the community health indicators to be financed;
- ◆ Mobilisation and sensitisation of the population about community health;
- ◆ Proceeding with the population census and updating it ;
- ◆ Assist community health service providers in the updating of family files : births, deaths, destitution, vaccination follow-up, chronic diseases ;
- ◆ Defining mechanisms to recover debts and outstanding payments and recovering them through its members;
- ◆ Signing and/or co-signing of the community health service provision contract with the Performance Purchasing Agency;

Ensure the balance between expenditure and receipts on community health activities and services;

- ◆ Development of internal modalities for the payment of performance bonuses to community relay agents (through the use of the indexes tool);
- ◆ Development of a form for community healthcare service provision ;

###### Recommendations for CR

- ◆ Implementation of community health services or activities in villages and town quarters ;
- ◆ Sensitisation of the population about positive behaviour vis-à-vis community health activities and services ;
- ◆ Promotion of community health within the population in general ;
- ◆ Giving the population health service information and urge them to resort to health facilities;
- ◆ Sign and/or co-sign the community health service provision sub-contract or contract with the dialogue structure, the health centre and the Performance Purchasing Agency ;
- ◆ Verification et authentication , at community level, of the data from community and public healthcare service providers;

- ◆ Ensure the balance between expenditure on and receipts from community health activities and services;
- ◆ Development of internal modalities for the payment of performance bonuses to community relay agents (through the use of the indexes tool);
- ◆ Development of a form for community healthcare service provision.

#### Recommendations for CBO

- ◆ Implementation of community health services or activities in villages and town quarters, in case of need;
- ◆ Verification et authentication , at community level, of the data from community and public healthcare service providers ;
- ◆ Assessment of the population's level of satisfaction using a questionnaire intended for communities and households resorting to community health services;
- ◆ Signing of a service provision contract with the Performance Purchasing Agency for community verification purposes;
- ◆ Verification of the existence of people registered as users by community service providers (dialogue structures, CRA, IHC);  
Checking the authenticity of services said to have been provided by community service providers (dialogue structures, CRA, IHC); within the framework of contract awarding;  
Assessment of average service provision costs, users' collection of costs and the population's satisfaction about the services provided by community service providers (dialogue structures, CRA, IHC);
- ◆ Collect suggestions from the population regarding service quality improvement and inform different stakeholders about them: community service providers (dialogue structures, CRA, IHC), dialogue structures and IHC officers, the Regulator and the Performance Purchasing Agency;
- ◆ CBO should not have any direct link with the community service provider based on the health area to be controlled to avoid conflicts of interest.

#### Recommendations for beneficiary communities

- ◆ Use of community health services;
- ◆ Expression of satisfaction during community surveys;
- ◆ Capacity to propose necessary changes in the community PBF system

#### Recommendations for IHC

- ◆ Provide a comprehensive MPA in the area reporting to it ;
- ◆ Manage reference and counter-reference system with community service providers ;
- ◆ Improve the quality of health service provision ;
- ◆ Encourage the performance by community relay agents and other community service providers (through sub-contracts);
- ◆ Develop the health area's quarterly budgeted management plan in collaboration with dialogue structures, subcontract structures under District Health Service supervision;
- ◆ Sign a quarterly performance contract with the Performance Purchasing Agency;
- ◆ Provide the population with quality healthcare services ;
- ◆ Ensure the balance between expenditure and receipts;
- ◆ Develop internal modalities for the payment of performance bonuses to integrated health centre staff (through the use of the indexes tool);
- ◆ Develop a service provision form ;
- ◆ Train and coach community service providers;
- ◆ Sign subcontracting contracts with community dialogue structures, community relay agents and other community service providers ;
- ◆ Purchase the services of community actors ;
- ◆ Purchase MPA services from secondary service providers.

#### Recommendations for HD

- ◆ Provide a comprehensive PCA in the area falling under its responsibility ;
- ◆ Manage references and counter-references with integrated health centres ;

- ◆ Improve the quality of health service provision ;
- ◆ Urge integrated health centres to achieve performance in their services ;
- ◆ Sign a quarterly performance contract with the Performance Purchasing Agency ;
- ◆ Develop a management plan in collaboration with DHMC members under DHC and DMC supervision ;
- ◆ Provide the population with quality healthcare services ;
- ◆ Ensure the balance between expenditure and receipts ;
- ◆ Develop internal modalities for the payment of performance bonuses to district hospital staff (through the indexes tool);
- ◆ Participate in the assessment of the quality of integrated health centres and community service providers;
- ◆ Participate in the training, coaching and supervision of integrated health centres;
- ◆ Purchase CPA services from integrated health centres and community service providers.

#### Recommendations for DHD

- ◆ Develop district quarterly management plans ;
- ◆ Sign a performance quarterly contract with the Performance Purchasing Agency;
- ◆ Countersign performance contracts among HD, integrated health centres, dialogue structures, community relay agents, CBOs and PPA ;
- ◆ Validate the quarterly management plans for integrated health centres and community service providers ;
- ◆ Organise monthly meetings on the monitoring and validation of HD, integrated health centres and community service providers ;
- ◆ Control the quality of the services by HD, integrated health centres and community service providers during integrated formative supervisions ; ;
- ◆ Participate in the external evaluation of the quality of HD, integrated health centres and community service providers with the Performance Purchasing Agency team
- ◆ Submit to DRSP a list indicating the services provided by the District Health Department ;
- ◆ Submit to DRSP the lists of services provided by HD, integrated health centres and community service providers ;
- ◆ Develop internal modalities for the payment of performance bonuses to District Health Department staff (through the indexes tool) ;
- ◆ Solve possible conflicts during PBF implementation at community level.

#### Recommendations for PPA

- ◆ Check and validate the quantitative data of the services provided by contracting structures ;
- ◆ Validate the qualitative data of the services provided by contracting structures ;
- ◆ Check and validate the quantitative and qualitative data from contracting CBOs ;
- ◆ Urge contracting structures to be performing ;
- ◆ Negotiate and sign performance contract with contracting structures ;
- ◆ Validate the community quarterly survey report, prepared by CBOs, on the services provided by contracting structures ;
- ◆ Validate within agreed time the quantitative and qualitative results from contracting structures;
- ◆ Transmit on a quarterly basis to DRSP with a copy to DHD the validated quantity and quality evaluation reports from contracting structures ;
- ◆ Calculate quality and equity bonuses granted to contracting structures ;
- ◆ Keep statistical data on MPA and CPA's community health activities or services regarding subsidized indicators for contracting structures;
- ◆ Pay PBF subsidies to community service providers;
- ◆ Participate in the settlement of possible conflicts related to community PBF implementation in collaboration with DHD and DRSP;
- ◆ Check within agreed time the accuracy of monthly quantitative services as declared by contracting structures in the presence of contracting structures managers;
- ◆ Monthly plan verification activities to be implemented in contracting structures;
- ◆ Compile the reports of verification conducted in contracting structures and prepare a relevant narrative report;
- ◆ Draw necessary samples to conduct community surveys in the presence of a dialogue structures representative;

- ◆ Participate in interviewers' training on indicators to be checked within the community;
- ◆ Analyse the evolution of services provided by contracted structures;
- ◆ Identify problems, discuss them with those concerned and propose possible solutions to contracted structures.

## 9. / DISCUSSION

Moderated by DRSP/EAST, discussions lasted a little bit more than one hour to enable participants to ask as many questions as possible.

At the end of the questions and answers phase, the research team said it has made scientific recommendations on PBF basic document as regards community PBF.

In the answers given to participants, it emerged that it was important for community relay agents to carry out integrated activities and that it was necessary to prepare a PBF standard guide. As a conclusion, the research team expressed its satisfaction about the work performed, which should be improved by other works.

## 10./ CLOSING CEREMONY

Address by Right Reverend Faustin AMBASSA NDJODO, Batouri Bishop

The legal sponsor of the Multi-Country PBF Network Project, Right Reverend Faustin AMBASSA NDJODO, thanked the National HSSIP Coordinator, Mr. ANANDJOURM BWANGA, for the interest he takes in all PBF activities organized by Batouri CODAS-Caritas and for having made arrangements for senior officials of the Ministry of Public Health, in particular the Honourable Minister, to attend the event. Then, he thanked Dr BIDJANG Robert Mathurin, Regional Public Health Delegate for the East Region for his availability, collaboration and the tact with which he organised discussions. Right Reverend AMBASSA NDJODO pointed out that PBF experience started in Batouri Diocese and extended over time, adding that it was relayed by the World Bank and the Ministry of Public Health. He expressed his satisfaction for having undertaken this initiative, adding that Batouri Diocese was the first beneficiary of this experiment. He specified that MCPBFN Project conducted the study and organised the restitution workshop. He congratulated Dr DJOUMEMI and requested him to convey his thanks to Pr KUABAN. He said that he was proud of having people who devote themselves to further research. He congratulated each participant and promised to send the electronic version of presentations. Among the information and training instruments that PBFN Project used to conduct advocacy and increase the critical mass on PBF, Right Reverend AMBASSA NDJODO mentioned PBF international course, the regional forum and the international forum. He expressed his hope that PBF education would be more successful. He announced a project in the pipeline, namely the project for the construction, at Batouri, of a PBF training centre for trainees with different educational backgrounds. He urged all participants to think more deeply about what they learned and make use of them.

Address by DRSP/EAST

In his closing address, Dr BIDJANG Robert Mathurin, Regional Public Health Delegate for the East Region thanked all participants, HSSIP Coordinator, DREB/EAST, DRES/EAST, PHD/FMBS of Yaoundé I University and Right Reverend Faustin AMBASSA, Batouri Bishop.

He underscored the importance of co-management and co-financing. He noticed that Health Committees are almost non-existent even non-operational. He said that community PBF was an opportunity that should be taken advantage of. He made a recommendation at DRSP/EAST level, consisting of speeding up the revitalisation of dialogue structures. He wished all participants a safe journey back to their different regions. The works ended with the prayer said by Batouri Bishop.