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Manyu Primary Health Program

Program Document

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Summary

Manyu Primary Health Program has been developed after two years of ground work by the MHO. The groundwork existed of building up the institution and gathering information on health in Manyu Division. The health information was collected through the Government (National, Provincial and District level) and through an extensive Health System Research in Mamfe Central and central Ejagham (Akwaya and Lower Ejagham still to be tackled).

The program consists of setting up Community Primary Health Centers based on the demand and health perception of the population. A participatory (bottom up) approach will be used to realize health care, which is “affordable, accessible, sustainable and indigenously owned, funded and managed”.

To overall goal is enable rural communities in Manyu Division to initiate, administer and sustain a health program in their own environment and culture. The MHO seeks to train trainers at all levels. Both should lead to an improved health standard of the Manyu population.

<u>**List of abbreviations**</u>

MPHP	:	Manyu Primary Health Program
NGO	:	Non-Governmental Organization
MRDP	:	Manyu Rural Development Project
SNV	:	Netherlands Development Organization
MHO	:	Manyu Health Organization
MOPH	:	Ministry of Public Health.
CBHC	:	Community Based Health Care
CDHC	:	Community Determined Health Care
GPC	:	General Program Manager
SOWEDA	:	South West Development Authority
VSO	:	Voluntary Services Overseas
MECA	:	Manyu Elements Cultural Association
EU	:	European Union
MC / CE	:	Mamfe Central and central Ejagham
UB	:	Upper Banyang
PHC	:	Primary Health Care
IHC	:	Integrated Health Center
BOD	:	Board Of Directors
TA	:	Technical Advisor
SOE	:	Supervisor Of Education
AFS	:	Area Field Supervisor
HSR	:	Health System Research
CPHC	:	Community Primary Health Centers
VHC	:	Village Health Committee
DMO	:	District Medical Officer
LAP	:	Life Abundance Program
MSF	:	Manyu Solidarity Fund
MPP	:	Mamfe Prison Project

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1.0 Background information

1.1 Introduction

The Manyu Health Organization has been registered at the 13th of September 1997 as an association (Non Governmental Organization (NGO)). The organization is located in Mamfe, South West Province, Cameroon. The MHO is a non profit making organization. The MHO would like to play a supplementary role to the Public Health Department and other NGO`s working within the health sector in Manyu Division with a focus on Primary Health Care.

From September '97 the MHO effectively started appealing to donors to support its activities. So far a baseline study on the existing health system is carried out in 83 out of 240 villages in Manyu Division. Based on the study results the MHO started training Village Health Committees (VHC) and will set up three Community Primary Health Centers. These activities took / take place in collaboration and with the support of the Netherlands Development Organization (SNV) and European Union (EU).

MHO believes that health care for the underprivileged population can only occur when they are actively involved in decision making and taking processes. This requires a participatory and community based approach. This means that MHO will focus on setting up and supervising Community Primary Health Centers.

This document gives an outline of objectives, activities, and organization of MPHP.

1.2 History

The MHO deemed it necessary to collect basic information from the health services as well the population before it could devise its strategy. A HSR was carried out in Mamfe Central and central Ejagham (MC/CE) and Upper Banyang (UB). The results from UB have been processed but not analyzed yet. From the first results no difference is expected in the outcome and conclusions which will influence the devised strategy.

So far the MHO has worked with 5 staff members on a temporally base. One accountant, three health specialists and a secretary. The BOD counts 10 members at the moment (see annex 1, organization chart MHO).

The past activities and achievements are presented in a table;

Table 1.0 a **Activities and results MHO January 1998-September 1999.**

Activities	Results
MHO office formally established and staffed.	-MHO rents an office since January 1997. -The office was equipped with furniture thanks to the financial assistance of MECA Netherlands. -In September 1999 the office has expanded and housing facilities have been created for the expected PC from Europe. -An administrator, a secretary, a rural health worker and a technical advisor have been employed on temporally bases since September 1998. The present PC is working on a voluntary base.
Policy and intervention development.	-The Project Document "Rehabilitation of prisons in South-West, North-West and West Province" was realized half way 1998. -The analysis of the HSR in MC/CE was realized in February 1999. -The MPHP document was realized in September 1999.
Strengthening of health services.	-Three VHC's have been trained in May / June 1999. -Preparations have started to set up three CPHC's in MC/CE.
Rehabilitation of Mamfe Prison (MPP).	-The research on health and living condition inmates was carried out in March 1998. -The rehabilitation was carried out from March-June 1999. -The evaluation report was realized in June 1999.
Setting up network with GO's / NGO's.	-Close contacts with the international and national MECA's and MSF have been established. -From September 1998 (till March 2000) the MHO is working in collaboration with the SNV. -The VSO will recruit a PC / volunteer as from February 2000 (latest). -SOWEDA has supplied two motor cycles to the MHO. -SWPSFH has committed itself to supply drugs to three CPHC's in MC/CE and Mamfe Prison. -The BHC has financed the MPP. -The MHO has applied for a contract of collaboration with the MOPH-Yaoundé in January 1999 (no answer yet). -Regular visits were paid to the MOPH -Mamfe, MOPH-Buea, Japanese Embassy, German Embassy and Dutch Embassy to discuss the possibility of collaboration.
Capacity building of MHO personnel.	-Basic "training for trainers" course given to MHO and MRDP personnel in April 1999. -The administrator and rural health worker completed a computer course in September 1999.
Monitoring and evaluation.	-Three monthly reports and yearly reports and plans have been realized from the start (September 1997).

1.3 Context of the Program

1.3.1 Rationale

Manyu Division is situated in the Northern part of the South-West Province. The division borders the North-West Province in the North and Nigeria in the West. The divisional capital is Mamfe. Its surface is 8.500 square km. Total number of inhabitants is estimated at 160.000. The division is made up of four smaller administrative units (sub-divisions): Mamfe Central , Upper Banyang, Eyumojock and Akwaya. Through out the division pidgin English is the main language spoken by almost everybody. The main ethnic groups are; the Bayangi in Mamfe central and Upper Banyang, the Eyagham in Eyumojock, the Akwaya in Akwaya and the Awanchi in Kendem area. The division has only dirt roads. All roads are in deplorable state of disrepair. The main roads are Mamfe-Kumba (180 km.), Mamfe-Bamenda (150 km.) and Mamfe-Ekok (70 km.). In the months August, September and October these roads are often closed. In that same period, the dirt roads connecting Mamfe with the surrounding countryside are hardly if at all passable.

1.3.2 Health situation Manyu people

Manyu Division is divided into four Health Districts: Manyu, Akwaya, Nguti and Fontem Health District (see annex 2). Manyu Health District counts 10 Health Areas, Akwaya Health District 4 (Nguti Health District 5 and Fontem Health District 11). Each Health Area is supported and supervised by a Governmental Integrated Health Center (IHC) or hospital situated in that area. Exceptions are Akwa, Amassi and Bagundu health area (Akwaya, see annex 3) and Ogurang Health Area (Eyumojock, see annex 4) of which Akwa and Bagundu have ‘access’ to a non-Governmental health center.

In all districts a DMO is based. Manyu Division counts four hospitals of which the Mamfe Health District Hospital functions as a referral hospital. One hospital is based in Eyumojock and one hospital in Akwaya and a military hospital is existing in Mamfe. Manyu Division counts 16 health centers of which 11 are based in Mamfe Health District, 3 in Akwaya Health District, 1 in Nguti Health District and 1 in Fontem Health District. Out of 16 health centers 10 are run by the government, 4 are mission health centers and the community runs 2 health centers (see table 1.0 b, page 9).

Except the mentioned Governmental and non-Government health centers at least 10 Community Health Posts (CHP) were set up in MC/CE and UB before the health sector reform was implemented in Manyu in 1996 and are still functioning. The number of CHP’s in Upper Ejagham and Akwaya have not been verified.

Furthermore, many private health practitioners (508 were interviewed) are identified in MC/CE and Upper Banyang (UB) and are operating in the division. They are the main providers of “health care” to the rural population, although there quality of work is disputable and unknown due to a lack of control (non-existing) by the Government.

After conducting the HSR in MC/CE (and UB) the following conclusions were set:

- Generally it can be said the existing health system is performing poorly with the exception of the mission health centers, due to a lack of proper management, a lack of basic and medical facilities or a lack of competence.
- The population underutilized the Governmental IHC and hospitals and CHP's in 1996 and 1997 and prefers to make use of the mission health centers and the informal private health sector (traditional healers and drugs peddlers mainly).
- The population of MC/CE has limited access to the formal Government and non-Governmental health services due to seasonal influences like the bad condition of the roads and increased prices of transport in the rainy season.
- The Government can not assure quality of care by the informal private health sector due to a lack of control.
- The VHC's is the only structure active on public health care issues (preventive health care) and reaches most of the villages in the area. Nevertheless, the impact on the health of the population can be doubted since only a few individuals involved have received training from the Government or NGO's.

It is believed that the majority of the population in Manyu Division has no access to the available health care structures due to distance (there are not enough health care structures) or limited infrastructure (roads and transport). Those who have access face the above mentioned difficulties.

Problem statement: the MRDP and MHO assume that the health status of the population of Manyu Division is declining due to these aforethought conclusions and statement.

Table 1.0 b Available health structures in Manyu Division (CHP's relate to MC/CE and UB only).

Health District	Hospital	Integrated Health Center	Mission Health Center	Community Health Center	Community Health Post
Mamfe	Mamfe	Ekok	Mamfe		Nchang
	Eyumojock	Afap	Besong Abang		Egbekaw
	Mamfe (mil.)	Kembong	Mbakang		Eshobi
		Mamfe			Bakwelle
		Kendem			Mbakem
		Bachuo Akagb.			Ajayukndip
		Tali			Sumbe
		Kajifu			Fumbe
					Ashum
					Nfaitock
Akwaya	Akwaya	-	Akwaya	Bagundu	-
				Tinta	
Lebialem	-	Takwai	-	-	-
Nguti	-	Eyang Atem A.	-	-	-
Total	**4**	**10**	**4**	**2**	**10**

1.3.3 Main actors in Manyu Division

The main actors in the division are MOPH, SOWEDA, SWPSFH and MHO. They are cooperating actively at provincial and district level.

MOPH
During the implementation of the health sector reform (1996) in Cameroon the South West Province has been divided into 14 Health Districts and 102 Health Areas. As mentioned before Manyu Division is covered by 4 different Health Districts and secondly, by 16 different Health Areas. The new policy of the Minister of Public Health implies that the Government wants to assure health care to the whole population within a distance of 5 kilometer by putting up new Government structures (IHC).

SWPSFH
The SWPSFH has a (essential) drug supply program in Manyu Division concerning all the Governmental IHC's and is also supplying to private organizations and enterprises.

SOWEDA
An extensive survey has been carried out on the development perspectives of the South West Province by SOWEDA. A budget for health care is available but not extensively used yet due to a lack of human capacity. SOWEDA does supply logistics (motorcycles and cars) to Governmental structures and NGO's working within different sectors.

MHO
MHO is intending to set up a PHC program in Manyu Division. They have carried out baseline studies on health in MC/CE and UB, trained three VHC's in MC/CE and worked with the underprivileged of Mamfe Prison. Preparations are going on to set up three CPHC in Bakwelle, Mbakem (CE) and Eshobi (MC).

1.3.4 Constraints and Opportunities

The described constraints and opportunities are relating to all the actors in Manyu Division. It gives an inside in the presently faced problems and future perspectives on development of the health sector and possibilities of collaboration between these same actors.

Constraints

The constraints faced by the actors (and population) in Manyu Division are several:

- A lack of proper management of the presently existing health structures (HSR MHO/SNV, 1999).
- Low motivation staff / limited willingness to work in rural and remote areas.
- Lack of finance: lack of motivated staff, basic and medical equipment and logistics (HSR MHO/SNV, 1999).
- The bad condition of the roads from June - November (rainy season).

- A lack of road infrastructure in Akwaya, Upper Ejagham and parts of UB.
- The informal private health sector (traditional healers and drugs peddlers mainly) are operating in the area without any Government control. They are easier accessible (and sometimes cheaper) to the population and control the majority of “the health care market” (HSR MHO/SNV, 1999).

Opportunities

- Active collaboration between the mentioned health care actors.
- Self Determined and Community Based Health Care. This to realize health care, which is “affordable, accessible, sustainable and indigenously owned, funded and managed” (MPHP, MHO).
- Access to more information on the functioning of the informal health sector, to devise a strategy to minimize their control of “the health care market”.
- Access to detailed information on the health status of the Manyu people (Baseline Health Surveys).
- Social economic development of Manyu Division as a result of the improved health standard of the population.

2.0 Strategy of the program

2.1 Vision

Convinced of the idea that PHC must be available for all, MHO wants to increase the availability of health care (number of PHC structures) in Manyu. MHO wants to concentrated on the underprivileged and the minority groups. Secondly, women in developing countries are the main providers and consumers of health care, therefore they will take an equal position to men in decision making \ taking procedures within MHO activities.

2.2 Mission statement

To provide PHC to those who are derived from it, departing from the participatory approach and the demand and health perception of the population and in agreement with the Government. This through technical assistance to the communities involved.

2.3 Community Determined Health Care (CDHC)

CDHC is a bottom-up (participatory) approach to health care, in which the community defines its own health beliefs and plans, sets its own priorities, implements its own strategies, and evaluates its progress toward meeting its own goals.

MPHP wants to obtain from the community members their definition of health and how they think they can attain health, and dialogue between the gaps of these beliefs and the reality occurring in the community. Both community and project staff may introduce new ideas into the dialogue in the search for solutions to the problems. Finally the communities set health goals and objectives for the coming year.

CDHC calls for a continuing cycle of action, reflection, new action, etc. This continuing praxis is based on the community definition of health and prescription for health. The process is dynamic, for as the community's views on health expand, their description of health and prescription will change. The MPHP field supervisor acts as a facilitator for the ongoing process.

2.4 Organization of the program

MPHP is a community health initiative. Each community makes an application to MPHP. MPHP does not target communities to impose health care. The received application will be considered by the management team. The community concerned will get a place on the priority list and different stages (see annex 5) will have to be followed before a CPHC can open.

The CPHC will belong to one of the Government determined Health Areas and falls formally under the supervision of the related IHC.
Health workers are chosen from among their communities and trained in basic PHC. Periodically they receive ongoing or continuing education and, on average every two years they will return to the MHO for a refresher course. The VHC's oversee the CPHC and administer its finances while they also help with the day to day management.

A cross-sectional community health survey is on new communities to establish baseline data on health. This include a census, adult literacy testing, physical assessment of the population, a disability survey and maternal and child survey, and general data on the local community.
The survey is planned and implemented by the MPHP project staff, with support involvement of the local community at the time of implementation.

2.5 Evaluation

Evaluation of goal achievement is done continuously and at the end of each year by the community. At year-end the community reviews their definition of health and prescription for health, and after reflection, may whish to make changes. The new goals are set by the community for the coming year.

Evaluation of the impact of the program on the health standard of the population is done by the MPHP project staff, who give a report to the community. The same baseline health survey may be implemented after a period of five or more years to measure the changes in health.

3.0 Goal, Specific Objectives, Activities and Outputs

3.1 Goal

To enable rural communities in Manyu Division to initiate, administer and sustain a health program in their own environment and culture. The MHO seeks to train trainers at all levels. Both should lead to an improved health standard of the Manyu Population.

3.2 Specific Objectives October 1999 - December 2001

1. External funding will continue to be sought for capital projects, educational developments and running costs.

2. Overseas students and researchers will start using MHO facilities.

3. Data processing and statistical analysis programs are in place.

4. The" first line in-service training will be completed by the field supervisors.

5. Two field supervisors will have improved their management and teaching skills and will began to follow up requests for CPHC's.

6. There will be a minimum of 4 CPHC's in place in Manyu Division.

7. The CPHC's will have a better understanding of their roles and functions.

3.3 Activities and Outputs

The activities and outputs are presented in a table and refer to the above mentioned specific objectives;

Table 3.0 a **Activities and expected results MPHP 2000-2001**

1.2 ▸ Apply for assistance to MECA's, Embassies and national and international NGO's in and outside Cameroon. ▸ Apply for assistance to individuals and enterprises in the Netherlands. ▸ Follow up approved assistance MECA USA to supply one computer (set).	1.1 ▸ MHO/MPHP has access to two computers. ▸ MHO/MPHP has access to two motorcycles. ▸ MHO/MPHP has access to one Toyota Hilux. ▸ A library is installed. ▸ Running costs are assured till the end of 2004.
2.2 ▸ Initiate contact with "Hogeschool Leiden" and "Hogeschool Ede" and identify other Polytechnics and Universities for student exchange in the Netherlands. ▸ Arrange student and researcher visits to the MPHP.	2.1 ▸ The Polytechnics and Universities show interest in the program through written applications to visit the project. ▸ The first student or researcher is coming to visit the MPHP by the end of 2000.
3.2 ▸ Visit Ministry of Public Health Buea to negotiate on training program by their responsible Information Technologist (IT). ▸ The administrator follows a stage/training in data processing with the IT. ▸ Consult private individual contacts in the Netherlands. ▸ Setting up of information system MPHP by the development director.	3.1 ▸ The administrator is trained and is able to process data of the MPHP. ▸ Assistance is given to the development director in setting up the information system ▸ All the collected information in 1999, 2000 and 2001 is processed and analyzed.
4.2 ▸ Consult LAP for the setting up and the syllabus of the in-service training of field supervisors. ▸ Identify and select participants for the training program. ▸ Prepare in-service training. ▸ Carry out in-service training.	4.1 ▸ LAP hands over their syllabus (copy) and gives advise on the methodology of the training. ▸ 3 Field supervisors are selected for the training. ▸ Facilitators are recruited and an adapted syllabus exists. ▸ 3 Field supervisors are trained and are prepared to supervise and train health promoters.
5.2 ▸ Consult LAP for the setting up and the syllabus of the follow up training of field supervisors. ▸ Identify and select participants for the training program. ▸ Prepare follow up training. ▸ Carry out follow up training.	5.1 ▸ LAP hands over their syllabus (copy) and gives advise on the methodology of the training. ▸ 2 Field supervisors are selected for the training. ▸ Facilitators are recruited and an adapted syllabus exists. ▸ 2 Field supervisors are trained and are prepared to follow up requests for a CPHC.
6.2 ▸ Sensitization of the communities / villages in Manyu Division on the MPHP. ▸ Carry out baseline health survey (quantitative data) in selected villages. ▸ Selection and training of health promoters / community health workers. ▸ Setting up and training of the VHC's. ▸ Setting up the health posts.	6.1 ▸ 241 Villages in Manyu are informed about and introduced to the MPHP. ▸ Basic information on health is available from 4 villages in Manyu. ▸ At least 8 members of the communities are trained as health promoters / community health workers. ▸ 4 VHC's are trained in the management of their CPHC. ▸ 4 CPHC are have been opened and are operating in Manyu Division.
7.2 ▸ Continuing education programs will be developed in the villages.	7. 1 ▸ LAP hands over their syllabus (copy) and gives advise on the methodology on training Health Promoters and VHC's.

4.0 Planning of Activities

4.1 Activity chart MPHP 1999 / 2000

Activities	Year	1999			2000											
	Month	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
Activities Specific objective 1																
‣ Apply for assistance to MECA's, Embassies and national and international NGO's in and outside Cameroon.		x	x	x						x	x	x				
‣ Apply for assistance to individuals and enterprises in the Netherlands.					x	x	x	x								
‣ Follow up approved assistance MECA USA to supply one computer (set).		x														
Activities Specific objective 2																
‣ Initiate contact with "Hogeschool Leiden" and "Hogeschool Ede" and identify other Polytechnics and Universities for student exchange in the Netherlands.						x	x									
‣ Arrange student and researcher visits to the MPHP.															x	
Activities Specific objective 3																
‣ Visit Ministry of Public Health Buea to negotiate on training program by their responsible Information Technologist (IT).		x														
‣ The administrator follows a stage/training in data processing with the IT.			x													
‣ Consult private individual contacts in the Netherlands.						x										
‣ Setting up of information system MPHP by the development director.								x								
Activities Specific objective 4																
‣ Consult LAP for the setting up and the syllabus of the in-service training of field supervisors.		x														
‣ Identify and select participants for the training program.		x														
‣ Prepare in-service training.			x													
‣ Carry out in-service training.				x												
Activities Specific objective 5																
‣ Consult LAP for the setting up and the syllabus of the follow up training of field supervisors.		x														
‣ Identify and select participants for the training program.												x				
‣ Prepare follow up training.												x				
‣ Carry out follow up training.													x			
Activities Specific objective 6																
‣ Sensitization of the communities / villages in MC/CE and UB on the MPHP.					x	x	x									
‣ Carry out baseline health survey (quantitative data) in selected villages.								x	x							
‣ Selection and training of health promoters / community health workers.					x	x	x									
‣ Setting up and training of the VHC's.							x									
‣ Setting up / opening of the health posts.										x	x					
Activities Specific objective 7																
‣ Continuing education programs will be developed in the villages.														x	x	x

4.2 Activity chart MPHP 2001

Activities Year	2001											
Month	J	F	M	A	M	J	J	A	S	O	N	D
Activities Specific objective 1												
‣ Apply for assistance to MECA's, Embassies and national and international NGO's in and outside Cameroon.	x	x	x									
‣ Apply for assistance to individuals and enterprises in the Netherlands.												
‣ Follow up approved assistance MECA USA to supply one computer (set).												
Activities Specific objective 2												
‣ Initiate contact with "Hogeschool Leiden" and "Hogeschool Ede" and identify other Polytechnics and Universities for student exchange in the Netherlands.												
‣ Arrange student and researcher visits to the MPHP.	x											
Activities Specific objective 3												
‣ Visit Ministry of Public Health Buea to negotiate on training program by their responsible Information Technologist (IT).												
‣ The administrator follows a stage/training in data processing with the IT.												
‣ Consult private individual contacts in the Netherlands.												
‣ Setting up of information system MPHP by the development director.												
Activities Specific objective 4												
‣ Consult LAP for the setting up and the syllabus of the in-service training of field supervisors.												
‣ Identify and select participants for the training program.	x											
‣ Prepare in-service training.	x											
‣ Carry out in-service training.		x										
Activities Specific objective 5												
‣ Consult LAP for the setting up and the syllabus of the follow up training of field supervisors.												
‣ Identify and select participants for the training program.							x					
‣ Prepare follow up training.							x					
‣ Carry out follow up training.								x				
Activities Specific objective 6												
‣ Sensitization of the communities / villages in MC/CE and UB on the MPHP.	x ?	x	x									
‣ Carry out baseline health survey (quantitative data) in selected villages.	?											
‣ Selection and training of health promoters / community health workers.	?											
‣ Setting up and training of the VHC's.	?											
‣ Setting up the health posts.												
Activities Specific objective 7												
‣ Continuing education programs will be developed in the villages.										x	x	x

5.0 Expenditure

5.1 Budget MPHP October 1999 – December 2001

Description	Per month	1999	2000	2001
1. Exploitation costs				
1.1 Office rent	40.000	120.000	480.000	480.000
1.2 Office maintanance	10.000	30.000	120.000	120.000
1.3 Water, electricity, gaz	10.000	30.000	120.000	120.000
1.4 Depreciation office equipment	25.000	-	300.000	300.000
1.5 Maintanance office equipment	5.000	-	60.000	120.000
1.6 Fax, telephone, E-mail	25.000	-	300.000	300.000
1.7 Mailing costs	5.000	15.000	60.000	60.000
1.8 Office supplies	30.000	-	360.000	360.000
1.9 Depreciation inventory	5.000	15.000	60.000	60.000
1.10 Sundry goods	10.000	-	120.000	120.000
1.11 Representation costs	5.000	15.000	60.000	60.000
1.12 Bank fees	5.000	15.000	60.000	60.000
1.13 Other office expense	10.000	30.000	120.000	120.000
Component total	**185.000**	**270.000**	**2.220.000**	**2.280.000**
2. Vehicles				
2.1 Depriciation Hilux	100.000	-	-	1.200.000
2.2 Depreciation motor cycles (2x)	50.000	-	600.000	600.000
2.3 Maintanance Hilux	100.000	-	-	1.200.000
2.4 Maintanance motor cycles (2x)	20.000	60.000	240.000	240.000
2.5 Fuel Hilux	40.000	-	-	480.000
2.6 Fuel motor cycles (2x)	20.000	60.000	240.000	240.000
2.7 Insurance, vignettes	12.000	-	-	144.000
2.8 Insurance motor cyles (2x)	10.000	30.000	120.000	120.000
2.9 Toll	1.000	-	-	12.000
Component total	**353.000**	**150.000**	**1.200.000**	**4.236.000**
3. Personnel				
3.1 Salaries				
3.1.1 Program Manager	120.000	-	1.440.000	1.440.000
3.1.2 Development Director	120.000	-	1.440.000	1.440.000
3.1.3 Administrator	100.000	300.000	1.200.000	1.200.000
3.1.4 Supervisor of Education	100.000	300.000	1.200.000	1.200.000
3.1.5 Technical Advisor	60.000	180.000	720.000	720.000
3.1.7 Night Watch	60.000	-	720.000	720.000
3.1.8 Field Supevisor	80.000	-	960.000	960.000
3.2 CNPS (16% salaries)	102.400	124.800	1.228.800	1.228.800
3.3 Travel and lodging	20.000	-	240.000	240.000
3.4 Training	10.000	-	120.000	120.000
3.5 Meeting cost	10.000	-	120.000	120.000
3.6 Other personnel costs	10.000	-	120.000	120.000
Component total	**792.400**	**904.800**	**9.508.800**	**9.508.800**

Description	1999	2000	2001
4. Investments			
4.1 Hilux	-	-	12.000.000
4.2 Motor cycles (2)	-	2.400.000	-
4.3 Computers (2)	-	1.500.000	1.500.000
4.4 Telephone/fax	-	150.000	-
4.5 Furniture	-	300.000	-
Component total	**0**	**4.350.000**	**13.500.000**

Description total budget	Per month	1999	2000	2001
Total exploitation	185.000	270.000	2.220.000	2.280.000
Total vehicles	353.000	150.000	1.200.000	4.236.000
Total personnel	792.400	904.800	9.508.800	9.508.800
Total program costs	**1.330.400**	**1.324.800**	**12.928.800**	**16.024.800**
Total investments	**-**	**0**	**4.350.000**	**13.500.000**
Overall total	**1.330.400**	**1.324.800**	**17.278.800**	**29.524.800**

The overall budget needed for the period October 1999-December 2001 is 48,128,400 C CFA. When you deduct the investments costs (to be done once) 30,278,400 C CFA is needed to run the program (1999-2001).

5.2 Estimate input population

The input of the population is estimated at approximately 5-8 million C CFA per village / CPHC. The money is needed to build the health center, to equip the health center and to train the health promoters. The estimate is based on the budget of the setting up of Bakwelle, Mbakem and Eshobi CPHC's.

Between 35 % of this budget is estimated as the expenditure of new applicants who want to set up a CPHC, because the activities will take place on local level (community participation) and less money will be spend on training and equipment. It means that, when for example four CPHC's are set up before the end of 2001 theoretically the communities will contribute between 20-32 million C CFA which is roughly between 40-50% when you add the amount to the total program cost.

Annex 5

Stages in the opening of a Community Primary Health Center

Stage One – Initial formalities

- Village representative either writes to or visits, MHO office.
- Appropriate Co-ordinator is informed of the application.
- Pro forma letter, guidelines etc. are sent, together with "initial application".
- On receipt of the application at MHO office, the Administrator and relevant Co-ordinator will decide upon the relevant plan of action.

Conditions to be met.

- The population to be served should be at least 1000 people.
- Distance to the nearest health facility must be at least one hours trek or 5 km, unless there are exceptional circumstances.
- The community is otherwise underserved.
- The responsible area Integrated Health Center (IHC) should be able to provide an adequate referral service.
- The area Co-ordinator must have adequate resources-time, finance and transport – in order to provide the the necessary supervision. This will almost invariably mean that the new CPHC is, or will very shortly become, one of a cluster.
- It is imperative that government permission to obtained before the Center may be opened.

Stage Two

If the above criteria have been met then the Co-ordinator and team will arrange to visit the village and site of the proposed Health Centre.

- The Administrator and the Co-ordinator agree with the chief or other responsible person, a date and a time to visit.
- The village should demonstrate an interest in MPHP by supporting the meeting, asking questions, providing food and accommodation.
- Infromation that will be given at this meeting includes :
  -MHO's Aims and Objectives.
  -MHO's relationship to Government.
  -How the new CPHC might possibly progress, PHC – MCH – EHC – IHC etc.
  -Promoters role and function. Job description, notes on initial stages - training and opening costs
  -PHC plan initial contributions are made towards opening expenses.
- Adequate time is given to answering questions and listening to the people.
- Government approval must be sought and granted at this stage, otherwise further progress may be blocked.

Stage Three

If Stage two is completed satisfactorily then-

- A letter is sent to the Chairman of the meeting stating clearly what has been discussed, decided and accepted by both sides. Any outstanding questions should be answered by this stage.
- The village is asked to form a VHC - a Chairman, Secretary, Treasurer - all of whom should be literate. If the Treasurer is not literate, there should be a "Secretary to the Treasurer".
- There will be representatives from each quarter, some male, some female. Total 14 in all.
- The denominational leaders, chiefs, school masters or other notables may serve as Advisors. Other, interested younger men or women (who may be interested in becoming Promoters) may be invited to take part in these early proceedings.
- The village is asked to find land and/or a suitable building for their new PHC.
- Methods of depositing the savings money are explained.

Stage Four

The second meeting is held at an appropriate time – something like three to six months will probably have elapsed since the previous meeting.

- The Committee must be organised and present
- The community must be enthusiastic and present. They should also have made adequate preparations to receive the MPHP team.
- Further financial deposits will have been made (signifying continued interest).
- Suitable candidates are put forward to that one may be chosen to go for Promoter Basic Training .
- Baseline Health Survey. This exercise will be carried out at this time. The community should contribute personnel (guides), accomodation and some of the food.

The Co-ordinator will continue to visit during this period subject to the limitations imposed by his resources (as already explained). He will, however, promote village health awareness at every opportunity and look for ways in which the community can bring about "change for health".

Stage Five

Requirements

- Satisfactory meetings with the Co-ordinator.
- Deposit of the remaining monies necessary for Basic Training and opening.
- Approval of MHO staff, COP of each area IHC, and Government.
- Candidates are interviewed by the Co-ordinator and a suitable person or persons chosen.
- Committee agrees to pay costs of transportation etc. for its trainee.
- Invitation for Promoter to attend Basic Training is sent to Village Health Committee and trainee(s).

Training

- Trainee(s) leave for 7 weeks Basic Training.
- Committee and community continue to prepare their building for PHC.
- Promoter returns and – if he has passed his course work and end of training exams - meets with village Health Committee and impresses them with his grasp of the course material and his suitability to be the Promoter of their health.
- Promoter goes for 1 month practical training at the local IHC.
- Date is fixed for the official opening.

Stage Six

Opening – this will take place at any time between 9 months and 3 years after the commencement of negotiations (Stage 1). Any longer than this is probably an indicator that something is wrong and an ultimatum needs to be delivered.