



REGIONAL COORDINATION MEETING, JANUARY 28TH TO 30TH 2026

MEDICINE SHOPPE BANQUET HALL, LIMBE

Theme: “Integrating Traditional Medicine to Strengthen Primary Health Care and Advance Universal Health Coverage in the Region

The first regional coordination meeting of health actors for the year 2026 kick started on the 28th January with theme, “Integrating Traditional Medicine to Strengthen Primary Health Care and Advance Universal Health Coverage in the South West Region. It started with a welcome word from the regional delegate of public health who emphasized on the need for active participation by all during this meeting to advance collaboration between all stakeholders for a healthy population of South West Region.

This welcome word set the pace for the presentation on evaluation of level of implementation of recommendations of the previous meeting. The following points were highlighted and discussed during this presentation;

- Only 12% (6/53) of concerned health facilities organized at least 1 data review meeting over the 6-month period since the last coordination meeting and only 3 (of 54 concerned health facilities regularly organized data review meetings
- One of the health facilities who regularly organize monthly data review meetings shared their experience on how it has helped improved their data quality and use of data for decision making through a collaborative approach resulting in recognition for excellence by the district health service for the year 2025.
- 10% increase in procurement from the South West Regional Fund for Health Promotion

Following the evaluation of recommendations, the first presentation of the day to set the way for the brainstorming session on “Autonomization of the health districts” was done by the Regional Delegate of Public Health on the regional vision for health development. During his presentation, the following key points can be noted:

- The vision of the region for the year is “a healthy south west region with auto sufficient health development for a healthy population”

- Minister’s instructions to health districts to “*assure proper follow up of activities within your various districts in order to assure measurable progression towards the phase of autonomization which should be materialized by the capacity of health district to satisfactorily solve majority of their problems, hence reducing considerably the need for higher level support*”.
- Need for regular situational analysis and reporting of Routine activities and deliverables of the health districts.
- Need for district to master the strategic objectives and plan of the various departments of the Ministry of Public Health which include: health care organization, disease prevention, family health, Health promotion, pharmacy-drugs-laboratories, human resources, Financial Resources, cooperation, studies and projects, health information) and properly liaise with regional focal persons for optimal implementation.
- In accordance to ministerial instructions, emphasis was made on need to follow up health facilities to procure medications exclusively from the SWRFHP
- Redeployment of staff appointed by hierarchy is not the competence of the district and should be avoided.
- Need for local resource mobilization from partners.

The RDPH after highlighting the responsibilities of the district presented the following strategies for consideration during brainstorming sessions:

1. Partner mapping and coordination.
2. Encourage community participation.
3. Regular inventory of service, infrastructure and personnel needs (Need analysis).
4. Strategic Communication via mainstream and other media.

Following his presentation and discussions, the following concerns and strategies were highlighted;

SUBJECT	DISCUSSION POINTS	RESOLUTIONS/RESPONSE
Partner coordination	Request for RDPH to consider recommendation from health district before establishing authorization letters for partners	-The districts are often consulted, when necessary, before providing administrative authorization. -District to always update and share mapping of partners every semester.
Resource Mobilization	Concerns were raised on feasibility of self-sufficiency and district autonomy in the context of declining international funding	Limitation in external funding further justifies the urgency and need for local resource mobilization to complement international funding for auto sufficiency and autonomy of health districts
	Need to develop proposals for resource mobilization	RDPH in collaboration with partners to mobilize resources to organize workshop on proposal writing and resource mobilization

The next presentation of the day was on epidemiological situation of the region for the year 2025. The main points highlighted and discussions are summarized below;

SUBJECT	HIGHLIGHTS	DISCUSSION	RESOLUTION
Reporting Rate	62% timeliness and 88% completeness of reports in DHIS2	Incomplete reporting of data elements and inconsistency between related variables making use of data for decision making challenging	Health districts and health facilities should organize monthly data review/evaluation meetings and forward reports to the hierarchy Need to clearly outline the barriers districts are facing with reporting and use of quality data for decision making
Response to epidemic prone diseases	-Important role of CHWs and health facilities to identify early warnings and alerts -Timely response to alerts or epidemics notably Monkey Pox outbreak, response to bed bugs outbreak in Mutengene, suspected cholera in Bamusso, animal rabies in Mamfeand Guillian Barre syndrome, Mpox and timely interventions to other incidents.	Need to reinforce EWARS, reporting in DHIS2 and routine data quality.	

The Fourth presentation was on the template of the annual review and annual work plans for the district health services and facilities in the various strategic pillars and objectives of the ministry of public health and WHO respectively. Following the presentation of the templates, participants proceeded to work as groups with all health districts and facilities from each division constituting a group to review the drafts they had filled prior to the meeting, share experiences and consolidate in one document per group. This validated document will serve as reference for contextualization by other health facilities and districts after the data review meeting before eventual sharing with the region for monitoring. It was also highlighted that participants should focus on novel activities at the district for eventual incorporation of other vertical activity that will come from programs or central departments of the ministry.

Furthermore, it was emphasized that health districts should incorporate activities of all partners working in their respective health districts in their annual workplans to ease coordination and follow up. Another group of multisectoral stakeholders was created to develop a road map, mission and objectives of the automatization of health districts

This presentation was followed by a 1 hour 30 mins session of group work and eventual restitution, the main discussion points are summarized in the table below;

GROUP/SUBJECT	DISCUSSION POINTS	RESOLUTION
District autonomization and self sufficiency	District situational analysis; co-create theory of change, develop strategic plan and workplan, create suitable partner collaboration/communication platform	-RDPH/partners to design a situation analysis template. -RDPH/ partners to design a strategic plan and work plan templates.
	Address local resource mobilization Leverage on resource mobilization from external/ international funders	-Districts to be work with partners to elaborate concept notes and source external funding -District to map out local opportunities for funding
District	Noninvolvement of partners activities in the district workplan	Districts should include workplans of all partners in the district workplan
	Need to use the AWP to develop quarterly workplans with specified implementation dates	
Hospitals /CMA	Need to include health campaigns and outreach activities in the work plan	
	Need to consider including activities for advocacy for community and multisectoral engagement as well as other community directed interventions	

NO.	PROBLEM	RECOMMENDATION	PERSON RESPONSIBLE	PERSON TO FOLLOW UP	TIME FRAME	MEANS OF VERIFICATION
01	Low procurement rate of pharmaceutical commodities and obstetric kits from the South West Regional Fund for Health Promotion (SWRFHP) by health facilities	Enforce compliance with ministerial instructions designating the SWRFHP as the first-line procurement source for essential medicines, obstetric kits, and related inputs	Heads of Health Facilities	Regional Chief of Brigade, South West Region	Monthly	SWRFHP Stock movement reports, Health faciliot, procurement reports, supervision reports
02	Poor integration of partner activities into District Health Plans, limiting effective follow-up and coordination.	All partners should co design activities, plan and submit their validated work plans to health districts	All Partners	RCB. Partnership	semester	Validated partner workplans
03		Ensure integration of partner activities in district work plan for proper coordination and monitoring.	CHDs	RCS.HIP	Ongoing	Integrated district work plan.
04	Inadequate initiation of district and regional projects due to absence of concept notes	Collaborate with partners to Organize capacity-building sessions for regional and district teams on concept note development and resource mobilization.	Chief of Service, Planning	Regional Delegate of Public Health, South West	31 st March 2026	Training reports,
05	Poor data quality being captured at facility level into the DHIS 2 platform (incoherent	To enhance data quality at facility level: Organize monthly health facility data review/validation meetings	Heads of Health facilities (RH,DH and CMAs)	RCSHIP, CHDs	Before the 10 th of every month	Meeting reports

	& missed data), sub optima use of data for Decision Making					
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The meeting ended with closing remarks from the regional delegate expressing his sincere joy and gratitude to see every one engaged and committed in the brainstorming and discussions to improve health in the region. He re-iterated the need to start day 2 early and rendezvous was taken for 8:30 am the next day

Day 2 started at 9:30 am arrival and registration of participants, there after we welcomed in the Regional Delegate of Public health of the Southwest Region, the Central level Representative and the Governor’s representative.

We then proceeded to the singing of the National Anthem followed by a word of prayer from one participant. The report of day 1 was read corrected and adopted by participants.

The Regional delegate then took the floor and gave us a welcome speech in which he started by saying Health is wealth, he reminded us of the theme of the coordination meeting which is INTEGRATING TRADITIONAL MEDICINE TO STRENGTHEN PRIMARY HEALTH CARE AND ADVANCE UNIVERSAL HEALTH COVERAGE. This is in a beat to cause us to be auto sufficient in order for us to able to better serve our population. He thanked the partners for following us in our mission to promote health care services in our region. He called on all Chiefs of Districts, Directors and all collaborators the work we have to do at heart and make it a reality so our vision can be realized. He finished by thanking the Governor for the support he has always given him and the Regional delegation of Public Health Southwest.

The Governor’s representative in turn gave her own speech in which she started by congratulating all health soldiers for the great work done so far, she then recognized the harsh conditions in which some of us work and also the long distances some had to cover to be in this meeting. She was happy with the theme of the meeting owing to the fact that traditional medicine has been a part of us from the time of our ancestors and integrating it with the modern medicine is a great idea. She looked at the difficulties faced citing the burning of the Mamfe district hospital out of many and in the mist of all this the health care workers are still on the field, she pointed out the Government’s engagement in rebuilding the structures and the health care system to make it stronger.

The Coordinator of RTG-Malaria did the first presentation on the Term of Reference of Health Facility data review meeting. He expressed worry with regard to the poor data quality still reported by many health facility as a result of no data review and validation meetings. The steps involved in organizing a data review meeting were discussed with the main objective being to improve quality of data for decision making at the health facility and the South West Region. The first step is to ensure all variables are correctly filled in the MAR as well as in the Dhis2 followed by incoherence check before validation proper. The Coordinator shared an agenda for a review meeting to ease implementation. A regional participant remarked that data recorded in the registers at times is not captured online due to under reporting by some health facilities. Another worry raised was the numerous voluminous registers to be filled daily thus data errors as a result of workload. More so, he suggested the need for electronic registers to ease data entry. Furthermore, another participant

talked on the absence of an English version of the newly updated MAR booklets for 2026 and inquired if the previous version of MAR booklet in English can still be used while waiting for the translated version. In response the Regional Chief of planning explained that translation is ongoing for the English version. With regard to an electronic register, he said is an activity still to be realized taking into consideration internet connect and the App to be developed.

The next presentation was done by the chief of service for Traditional Medicine at the Ministry. He started by saying 80% of Africans rely on traditional medicine when they are sick and in the case of Cameroon 70% prefer traditional medicine and so traditional Medicine (T.M) occupies a big role in the life of Cameroonians. The law of traditional medicine took a while to be made available and Cameroon has the best laws on traditional medicine in Africa. The law is made of 7 Chapters and 44 articles. He explained that the laws are to protect the population and regulate the practice of TM.

There have been many innovations made to the law over time and it gives us a clear indication of

- Who a traditional practitioner is
- A traditional center is
- A collaboration between modern and traditional medicine

More so, we have as duty and obligation to collaborate with the trade- practitioners as many of our clients sometimes start with the traditional medicine before going for modern medicine and in some cases some patients still take traditional medicine while taking modern medications.

He also discussed on ways of referral from traditional medicine to modern medicine and why not the other way round too. One big innovation in the law is to protect tradi-practitioners the same way medical doctors are protected. Many advocacy meetings were organized at the Prime Minister's office and the Presidency before the laws were established.

He then looked at sales of herbs in cars/buses and let us know it is a prohibited practice by the TM laws.

Who is a tradi practitioner ; he is any one who is known in his community for healing and has an authorization from the Ministry of Public Health. We have a range of TP

- Traditional birth attendance
- Born sitter
- Herbalist
- Spiritualist

So far it is not possible for the same person to practice both modern and traditional medicine at the time and all TP have 24 months that is up to December 2026 to conform to this TM laws in other to practice.

This was followed by reactions from the participants. The first of which came from the director of regional hospital annex Kumba who was happy to hear of this law and to encourage the collaboration between modern and traditional medicine

Participants then took a family picture.

Some points with regard to Traditional medicine practice were reviewed. The first focused on the coordination mechanism of traditional practice in the SWR. The central level chief, said that there exist a law for traditional medicine practice but not a national council to properly coordinate affairs. At the level of the region, there is a similar group for same purpose whereby ideas can be shared.

The second point was on the existing systems for quality Assurance and quality control and how it can be improved. Some labs earmarked that can be followed up to assist in quality assurance within the region included: The lab at Regional Fund for Health Promotion, The lab for emerging Infectious Diseases at UB and the lab at Baptist Health Complex in Mutengene. The central level chief remarked that the law put in place is for the traditional medicine and not the practice. The ministry of Scientific research has to create a milieu for quality assurance alongside other stakeholders.

A second presenter from central level focused on district coaching. A review of the health pyramid was done followed by the steps involved in carrying out effective coaching.

The next presentation focused on the role of Health districts and Facilities in Overcoming challenges in implementing strategic plan and perspectives in the fight against malaria.

The epidemiological situation of the disease was highlighted. 263 million cases of malaria globally (WMR 2024) and Cameroon being among the 11 most affected countries. 1.2% proportional mortality in the SWR which is the lowest in the country. Over the past 4 years the burden of malaria has significantly reduced.

With the national strategic plan 2024-2028, we have 4 main pillars.

- Strengthening political commitment
- Strategic use of information for decision making
- Main policies and anti malaria policies.
- Coordination of the national response

There is need to reinforce advocacy and engagement meetings as well as communication for behavior change for the fight against malaria.

This was followed by participants' reactions. One participant had a worry on commodities not being accessible to some private health facilities. The presenter remarked that most privates do not respect free treatment policies and priority is given to sites that implement fully the free treatment policy.

The regional delegate then commended the moderator for a job well done as the presentations ended an hour before time. He emphasized that presentations should be available on time before the meeting to facilitate coordination. With regard to medical campaigns carried out by foreign teams, he cautioned that there is a law to guide such activities and authorization must be granted by the Ministry of Public health. Following a meeting held in December between the 2 ministries (Higher Education and Public health), they arrived at a consensus that was endorsed by the Prime Minister.

Aptitude test be organized for graduates with certificates not recognized by Minsante. The 3 letters were projected and would be forwarded to participants. Students admitted for the academic year 2024/2025 would be trained using the curriculum of the ministry of public health. Internships are supposed to be carried out within the region of studies. Following the December 2024 declarations, all health training institutions must be jointly approved by both Ministries of Higher Education and Public health.

The regional delegate also talked on the regional sporting activity launched by the delegation of sports and physical education of which public health was invited to participate. All the heads of services were encouraged to participate especially with raising of funds giving the deadline was the following day. To conclude, he appreciated participants and also encouraged participants to respect time the following day so as to finish and depart early.

Day three started with the arrival and registration of participants at 9:00 a.m., followed by a word of prayer, and then the reading of the Day Two report by the Day Two reporters. Key points from the minutes were corrected and adopted. The first presentation of the day was on EPI, delivered by the Regional EPI Coordinator. This presentation focused on data quality, completeness, and timeliness, as well as surveillance indicators. The completeness of reporting stood at 95%; however, some districts such as Bangem, Limbe, Mundemba, Kumba North, and Kumba South still need to improve their completeness.

Marked improvements were noticed across all antigens due to assistance from partners such as Gavi and CDC, as well as intensive supervision, coordination, data review, and validation meetings from the regional level. The low coverage (60%) recorded for the malaria vaccine was due to the fact that children in this target group do not frequently visit health facilities. For the HPV vaccine, coverage was 74% for girls and 41% for boys. The improvement in HPV vaccination coverage was attributed to multiple PIRI, BCU, and outreach sessions organized in several districts.

From the presentation, a participant sought clarification on some of the reasons for underreporting, and the presenter provided the following possible reasons: poor understanding of reporting tools, absence of data review at the health facility level, double reporting, and poor data entry into the system. The second question was based on understanding the strengths that led to the realization of the extraordinary results. The coordinator responded that all districts had received feedback reports and that the region used strong follow-up measures to ensure complete and timely reporting, as well as coordination meetings organized to review data. Another reason put forward by the CHD for Tiko, contributing to the improvement, was the presence of CHWs involved in community sensitization, referrals, and outreach sessions.

Another question raised was whether the malaria vaccine would be extended to other districts, to which the presenter responded that she could not give a definite answer at the moment. The regional delegate also requested to understand the cartography of partner interventions in the region in order to avoid duplication of interventions.

The next presentation was on Reproductive Health and Kangaroo Mother Care (KMC), presented by the respective focal persons. Beginning with the first presenter, she highlighted that according to the WHO, reproductive health involves sexual and reproductive choices covering five components. She further presented key data on assisted deliveries, caesarean section rates, maternal mortality rates, neonatal mortality rates, among others. Emphasis was placed on

districts that were not reporting reproductive health data, such as Toko, Wabane, Bakassi, and Akwaya. However, Limbe and Tiko Health Districts were appreciated for their monthly district data review meetings.

Major causes of maternal deaths were presented, including post-partum haemorrhage (PPH) and eclampsia. It was equally noted that delays in health care delivery were a contributing factor, and with dissatisfaction it was observed that the greatest delay was the third delay (at the health facility level). These delays may result from late attendance to patients, delayed referrals, among others. Causes of neonatal deaths identified included birth asphyxia and congenital malformations, among others. Obstacles to care were presented, followed by recommendations to curb maternal and neonatal mortality.

The second presentation on reproductive health focused on the Kangaroo Mother Care (KMC) approach, citing epidemiological data necessitating its introduction and implementation in Cameroon. KMC was introduced in Cameroon in 2019; prior to that, the country recorded 8 neonatal deaths per 1,000 live births. This ratio dropped to 6 per 1,000 in 2020, but increased to 8 per 1,000 in 2023 because not all facilities were implementing the KMC approach. However, consistent implementation led to a significant reduction to 6 per 1,000 live births in 2025.

An increase in the use of resuscitation masks and bag-and-mask devices (78.6%) was noted across 74.8% of supported sites. Despite these improvements, there is still an increasing trend in the number of newborn deaths within the first week of life from 2023 to 2025. Challenges to the implementation of the KMC method were presented, and the floor was opened for questions.

The first reaction concerned blood banks, with participants questioning whether they could be supplied with solar refrigerators, as is the case with EPI, to help curb maternal mortality. The next question addressed what has been done or still needs to be done to prevent eclampsia, as it is one of the leading causes of maternal deaths. The presenter stated that there are adequate stocks of magnesium sulphate supplied and encouraged facilities to respect protocols, test clients, and strictly follow up women with respect to their respective conditions.

The next reaction came from the UNICEF representative, who noted that the maternal mortality target for Cameroon is 140 per 100,000 live births and advised that ratios should not be used to measure annual impact, recommending instead the use of more operational indicators. Another question raised was whether health facilities have been able to work with Traditional Birth Attendants (TBAs) in communities to identify concoctions used by pregnant women in an attempt to provoke contractions and how these traditional medicines could be leveraged in modern medicine.

The regional delegate emphasized that everyone should show interest in improving maternal and child health at all levels and questioned how the third delay at the health facility level could still be the greatest delay faced by patients in 2025. To address PPH, there is a need for training in evaluating and identifying risk factors and following up patients according to their specific conditions. Health facilities were advised to stop managing cases beyond their level of competence. Alternative medications to magnesium sulphate used in the management of pre-eclampsia are now available at the regional level and will be made available to health facilities once sufficient quantities are secured.

In collaboration with the Reproductive Health Focal Person (Dr. Assonganyi), a list of services to be offered at different levels of each facility will be developed for the region. The delegate concluded by stating that *“all efforts should be made to ensure that women who visit our maternities do not die.”*

The next presentation focused on Early Action Review using the 7-1-7 concept, a matrix designed to benchmark the effectiveness of outbreak detection and response. The concept emphasizes early detection and management of disease outbreaks. Insecurity and population displacement have increased the risk of outbreaks and disease spread in the region, in addition to other factors such as disruption of health facilities and poor data quality. Each outbreak should be detected within 7 days, notified and investigated within 1 day, and responded to within 7 days. Events per health district against the 7-1-7 targets were presented, showing 81% detection, 78% notification, 52% response, and 48% achievement of the 7-1-7 targets.

The monkeypox response in Akwaya using the 7-1-7 approach on 18/10/2025 was presented as a practical example. During the discussion, the Director of KRHA questioned why Akwaya was used as an example instead of Mbonge, which had the highest number of treated patients, and why no assistance in terms of personnel or medication was mentioned. He noted that staff involved worked without any motivation. In response, the presenter explained that Akwaya was selected because it is remote, currently experiencing an epidemic, and is a cross-border district, with the aim of demonstrating applicability to other districts. The delegate commended the presenter for her mastery of the topic, despite not being initially scheduled, and emphasized the need for the region to develop a sustainable preparedness and response plan for emergencies.

After the coffee break, three regional staff members who had recently completed a Frontline Epidemiology course offered by CDC Atlanta were acknowledged.

The next presentation was a joint session on Universal Health Coverage (UHC) and the Drug Fund. The UHC presentation focused on visualization of pre-enrolment, production, and performance indicators. Districts such as Toko, Bakassi, Akwaya, Wabane, and Mbonge were noted as quiet districts, with no reports on UHC activities. Out of 21 districts, only 8 were reporting weekly on UHC card distribution. UHC budget consumption for 2025 was very low, standing at 40%, which is below average.

Concerns were raised regarding non-reimbursement. The delegate advised that health facilities should emulate BRH by recruiting personnel responsible for entering data into the OpenIMIS platform. Although TB showed one of the lowest consumption rates across districts, supervision revealed that TB cases were being treated at health facilities but not enrolled or declared. The presenter emphasized financial traceability.

During the question-and-answer session, participants asked why enrolment data was not compared to baseline data. It was recommended that future presentations compare results with baseline data or set objectives. Another participant questioned why UHC vouchers were not used in some facilities, citing reimbursement challenges, and asked how automation could be achieved given this bottleneck. The delegate reiterated that UHC is a Head of State initiative and that all health facilities are obligated to implement it.

The Administrator of the Fund referred the issue of delayed reimbursement to the central representative but added that the Fund supports health facilities and districts through capacity building and provision of commodities on credit. She emphasized that health districts should understand their roles and strengthen data verification and validation. It was recommended that data from OpenIMIS, DHIS2, and manual registers be triangulated in future presentations, and that quarterly validation meetings be held to validate data from the preceding three months.

The subsequent presentation was on CNPS, responsible for managing the working life of employees, followed by a question-and-answer session. This was followed by a presentation from the Empower Women Foundation (EWF), active in the Tiko, Mamfe, and Limbe Health Districts, which reported on community activities including supervision, staff motivation, equipment provision, training, and purchase of health vouchers. The organization also presented its 2026 plan, which includes expansion to additional districts and collaboration with international NGOs such as UNICEF. The Administrator of the Fund noted that since the organization supports the purchase of UHC vouchers, this should be considered during supervision to avoid duplication of services.

The final presentation was delivered by the CHRIHSS Foundation, an NGO implementing the INTRASSAT project under CDC-PEPFAR. The organization operates in all 10 regions with 136 transport agents nationwide, ensuring timely transportation of samples and prompt return of results to patients in good condition. This was followed by the recommendations, presented by the recommendation committee.

A price award in recognition of some hospitals and district health services in the region was coordinated by Mr. Ebah. Electronic gadgets for improving work in the field were distributed, an activity coordinated by regional EPI coordinator. The meeting ended at 6pm closing remarks from the regional delegate, followed by departure of participants.

RECOMMENDATIONS

NO.	PROBLEM	RECOMMENDATION	PERSON RESPONSIBLE	PERSON TO FOLLOW UP	TIME FRAME	MEANS OF VERIFICATION
01	Low procurement rate of pharmaceutical commodities and obstetric kits from the South West Regional Fund for Health Promotion (SWRFHP) by health facilities	Enforce compliance with ministerial instructions designating the SWRFHP as the first-line procurement source for essential medicines, obstetric kits, and related inputs	Heads of Health Facilities	Regional Chief of Brigade, South West Region	Monthly	SWRFHP Stock movement reports, Health facility, procurement reports, supervision reports
02	Poor integration of partner activities into District Health Plans,	All partners should co design activities, plan and submit their validated work plans to health districts	All Partners	RCB. Partnership	semester	Validated partner workplans

	limiting effective follow-up and coordination.	Ensure integration of partner activities in district work plan for proper coordination and monitoring.	CHDs	RCS.HIP	Ongoing	Integrated district work plan.
03	Inadequate initiation of district and regional projects due to absence of concept notes	Collaborate with partners to Organize capacity-building sessions for regional and district teams on concept note development and resource mobilization.	Chief of Service, Planning	Regional Delegate of Public Health, South West	31 st March 2026	Training reports,
04	Poor data quality being captured at facility level into the DHIS 2 platform (incoherent & missed data), sub optima use of data for Decision Making	To enhance data quality at facility level: Organize monthly health facility data review/validation meetings	Heads of Health facilities (RH,DH and CMAs)	RCSHIP, CHDs	Before the 10 th of every month	Meeting reports
05	Inadequate information on the numbers /area of specialty of Tradi-practitioner at Districts and Regional level.	All health districts to map out the list of all Tradi-practitioner at their level and share to the Region.	All CHDs	Partnership	Before 30 th of march 2026	List of all Tradi-practitioner
06	Poor update at the regional level UHC cards that were distributed to the districts.	All health districts that have not updated their UHC cards distribution situation to do that as fast as possible.	All CHDs	UHC Unit	28 th of February 2026	Updated reports
07	Divisional workplans developed during workgroup sessions were incomplete	Ensure that all divisional workplans initiated during workgroup sessions are finalized, completed, and formally validated before implementation	Heads of Divisional Workgroups	Chief of Service, Planning	28 th of February 2026	Completed and validated divisional workplans, endorsement minutes

08	Inconsistent submission of financial reports by health facilities across hospital categories	Enforce mandatory monthly submission of financial reports for all categories of hospitals in the region, in line with existing financial and administrative guidelines	Heads of Health Facilities	Regional Chief of General Affairs	Monthly before 10th	Monthly financial reports submitted, acknowledgment receipts, review checklists
08	Absence of a standardized tool to assess district readiness for automation processes	Design and validate a standardized template to assess district readiness for automation, including governance, infrastructure, human resources, and data systems	Dr. Njang Emmanuel, Dr. Itoe Besong, Mr. Alain Ebah, UNICEF	Regional Delegate of Public Health, South West	By 30 April 2026	Approved readiness assessment template, pilot reports, dissemination records

APPENDIX

















