6 310201-(4)
PD-AAB-755-A1

CLASSIFICATION

PROJECT EVALUATION SUMMARY (PES) — PART I

1. PROJECT TITLE	2. PROJECT NUMBER	3. [illegible]
North Cameroon Rural Health	631-0301	USAID/T

4. EVALUATION NUMBER (Enter [illegible] reporting unit e.g., Country or AID/W [illegible] Fiscal Year, Serial No. beginning with No. 1 each FY)
G 1165

☒ REGULAR EVALUATION ☐ SPECIAL EVALUATION

5. KEY PROJECT IMPLEMENTATION DATES	6. ESTIMATED PROJECT FUNDING	7. PERIOD COVERED BY EVALUATION
A. First PIO/A/C or equivalent FY 78	A. Total $ 469,000	From (month/yr.) 1/1/78
B. Final Obligation Expected FY 79	B. U.S. $ 469,000	To (month/yr.) 3/30/79
C. Final Input Delivery FY 83		Date of Evaluation Review 4/8-11/79

8. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR 4/11/79

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
See Attachment A	1. CRS	8/1/79
	2. CRS	Completed
	3. CRS	7/30/79
	4. CRS	8/1/79
	5. CRS -	ASAP

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS

- ☐ Project Paper
- ☒ Financial Plan
- ☐ Logical Framework
- ☒ Project Agreement
- ☒ Implementation Plan e.g., CPI Network
- ☐ PIO/T
- ☒ PIO/C
- ☐ PIO/P
- ☐ Other (Specify) _____
- ☐ Other (Specify) _____

10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT

- A. ☐ Continue Project Without Change
- B. ☒ Change Project Design and/or
- ☒ Change [illegible] Financial Plan
- C. ☐ Discontinue Project

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)

USAID: Theodor H. Bratrud, Evaluation Officer
Eilene Oldwine, USAID Project Manager
CRS: Kathy Kelleher, CRS Country Director
Sister Gay, Project Field Coordinator

12. Mission/AID/W Office Director (Approval)

Signature [signature]

Typed Name James H. Williams

Date

AID 1330-15 (3-78)

1) LA P.M.I facteur de développement du village

La P.M.I est le lieu de la surveillance des enfants du village de 0 à 5 ans et de formation des parents à une bonne croissance de leurs enfants.

La protection maternelle et infantile doit être prise en charge par le village, au moyen des responsables villageois formés par le centre de santé (dispensaire, hôpital) et choisis par les gens du village. Ces responsables pour la P.M.I travaillent en commun pour la construction d'une case où se déroulent les consultations d'enfants, s'occupent des cotisations pour l'obtention d'une pharmacie de village et organisent des séances d'animation dans les quartiers pour promouvoir la santé au village.

La consultation de la santé pour enfants de moins de 5 ans vise à étendre à peu de frais la surveillance et la prévention des maladies à une proportion aussi vaste que possible de la population. Qu'elle se situe dans un village reculé ou au sein d'un ensemble hospitalier, ses services sont les mêmes.

La protection maternelle et infantile contribue à un mieux - être de toute la famille. La santé des femmes et des enfants doit intéresser les hommes du village et doit être un thème de discussion dans les réunions au village et aussi dans les foyers.

2) Organisation du Centre P.M.I

Concrètement, il doit y avoir un groupe P.M.I par quartier ou village. Ces groupes (3- 4) se rejoignent dans un CENTRE P.M.I. Chaque groupe a une séance de pesée des enfants (le kg) chaque mois.

Il doit y avoir 1 ou 2 séance d'animation et de démonstration dans chaque quartier chaque mois. Ces séances sont faites avec l'aide soignant, l'agent itinérant et les responsables villageois.

L'équipe P.M.I : elle comprend
- l'aide soignant responsable
- 1 auxiliaire
- l'agent itinérant
- 3 responsables du village

Chaque séance de P.M.I comprend :
- la pesée
- la mise à jour de la courbe de poids
- un bref entretien avec la mère
- un rapide examen de l'enfant
- les petits soins nécessaires
- la distribution de nivaquine

Les responsables du village préparent la séance : nettoyage du lieu, mise en place des femmes quand elles arrivent.

L'aide soignant ou l'auxiliaire aidé d'un responsable du village pèse l'enfant et fait la courbe.

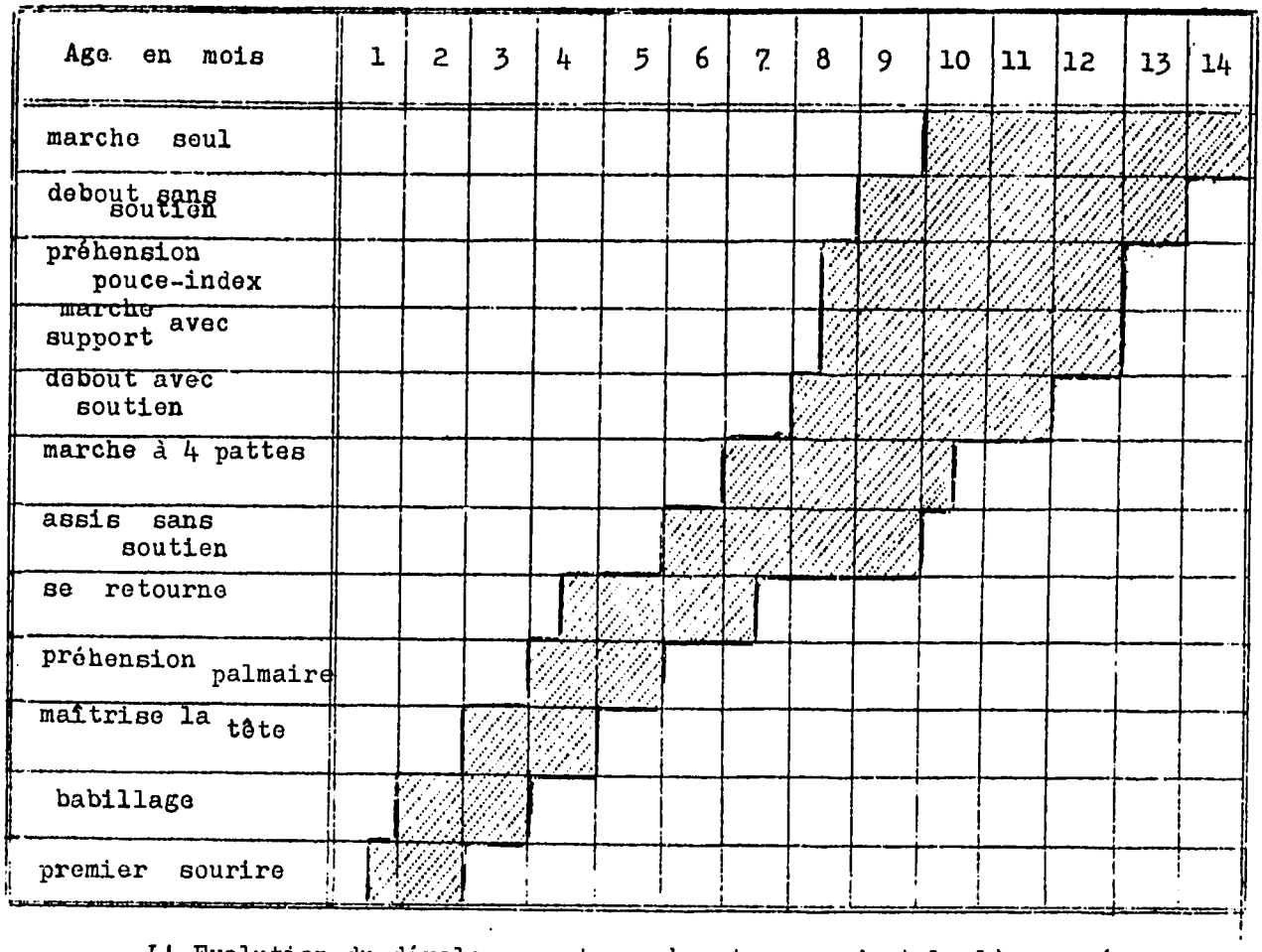
L'aide soignant examine l'enfant

Un responsable de village donne la nivaquine. Un ou deux responsables de village fait les soins des yeux, du nez, des plaies

Remarque

On n'examine pas un enfant si ce n'est pas son jour de pesée
Si c'est une urgence, on l'envoie à l'hôpital
Si c'est une petite maladie, on l'envoie à la pharmacie du village

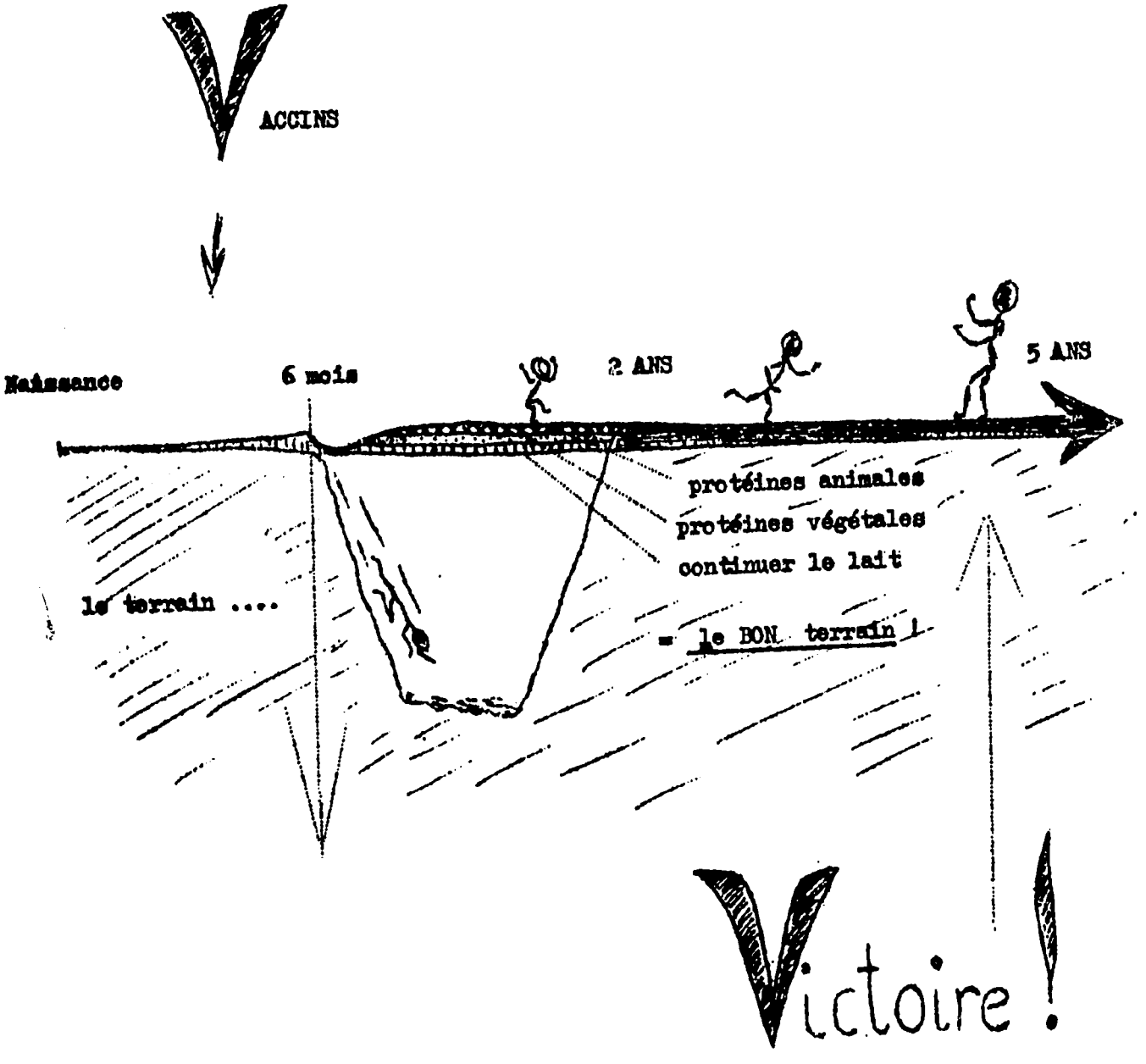
LE DEVELOPPEMENT PSYCHOMOTEUR



L' Evolution du développement psychomoteur pendant la 1ère année

Le développement psychomoteur de l'enfant est variable. Par exemple, pendant la première année de la vie, il est habituellement rapide et relativement plus précoce chez le bébé africain que chez le bébé européen. Cette avance est importante au cours des premiers mois. Le bébé africain sourit et tient sa tête à un mois. Souvent à 4 mois, il se tient assis, le dos bien droit, et il manipule déjà les objets. Il marche parfois très tôt, vers 10 mois. Mais l'avance devient de moins en moins importante et à 18 mois ou 2 ans, il est rejoint dans son développement psychomoteur par l'enfant européen.

On considère que cette avance est due au CONTACT étroit de la mère avec son enfant et à l' ALLAITEMENT MATERNEL. Le sevrage ou la naissance d'un autre enfant en marque souvent la fin.


VACCINS
Naissance
6 mois
2 ANS
5 ANS
protéines animales
protéines végétales
continuer le lait
le terrain ....
= le BON terrain !
Victoire !

Après avoir observé des enfants , normaux et d'autres malnourris, chacun a pu peser , mesurer la taille , le périmètre du crâne et le périmètre du thorax , toucher une fontanelle normale , et la fontanelle d'un bébé qui avait une forte diarrhée , pour voir la différence , chacun a tout inscrit sur un papier , des renseignements pris à la naissance qui pourraient lui servir de repère pour surveiller la croissance de l'enfant dans ses 5 premières années .

Nous retenons très fort l'intérêt d'avoir toute l'histoire de la croissance et de la santé d'un enfant sur SON CARNET soigneusement gardé dans un plastique . Et que chaque enfant ait son carnet à lui . Et puis,plus d'enfant sans carnet !

Nous avons bien compris aussi que la courbe de poids est facile à comprendre pour la maman qui voit bien si son enfant est dans le chemin de la santé . Nous avons fait des exercices pour savoir inscrire le poids de l'enfant sur la courbe .

ENTRE LA 5ème ETAPE ET LA 6ème , dont on précisera la date après les pluies , mais qui aura lieu à TOKOMBERE , il nous faut CONTINUER

LE CAHIER

1° - l'ENQUETE

2° - Chaque préparation , compte-rendu et conclusion des REUNIONS, que nous ne devons pas arrêter pendant les cultures , même si elles sont moins nombreuses .

NOTRE SARE

Maintenir au mieux ce qui a déjà été fait ,

Le problème des latrines et de l'eau potable doit ETRE UN EXEMPLE pour TOUS !

*
* *

ETAIENT PARTICIPANTS A CETTE 5ème ETAPE :

SOULONA Pascal de GUEME
GABAM Alain de VIRI
MOROM Lazare de VIRI
TCHADOUE Jacques de GOBO
LANTOKNA Abel de GOBO
HOUMDI Charles de DZIGUILAO
PAPIER Jean-Pierre de TOKOMBERE

Marianne BOCCARD
Soeur Catherine TROADEC
Annie DUFOUR

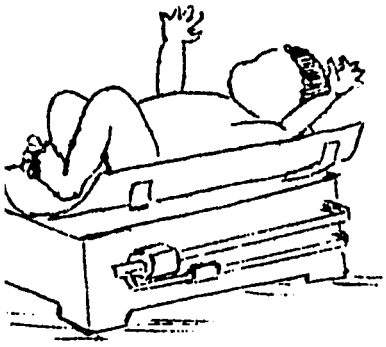
il nous manquait FIDI GWEDJEKWE de DJINGLIYA ? ? ?

B O N T R A V A I L et B O N C O U R A G E !

SURVEILLANCE DU DEVELOPPEMENT PHYSIQUE DU NOURRISSON

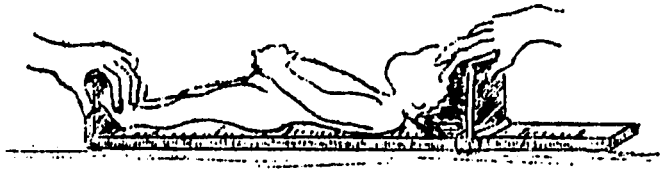
EXAMENS FONDAMENTAUX

1 - LA PESEE (la courbe de poids)

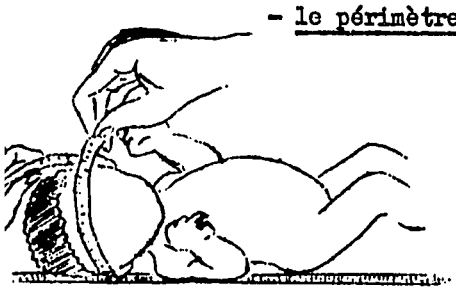


2 - LES MENSURATIONS

- avant 3 ans

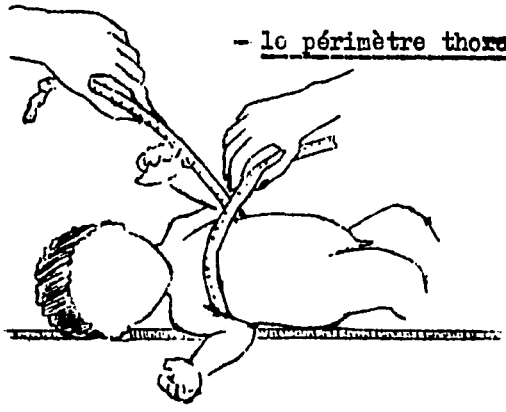


- le périmètre crânien



- après 3 ans

- le périmètre thoracique



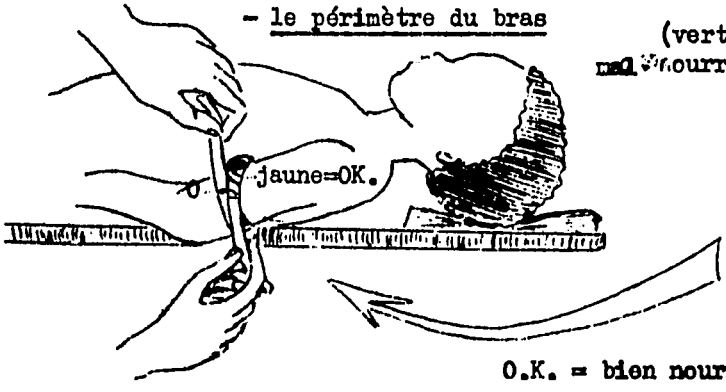
(jaune)= O.K.

(rouge) 13,5 cm

12,5 cm

(vert)= mal nourri

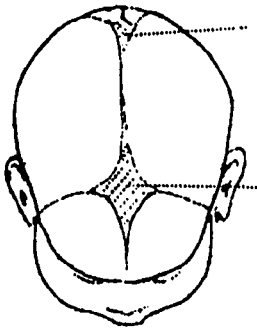
- le périmètre du bras



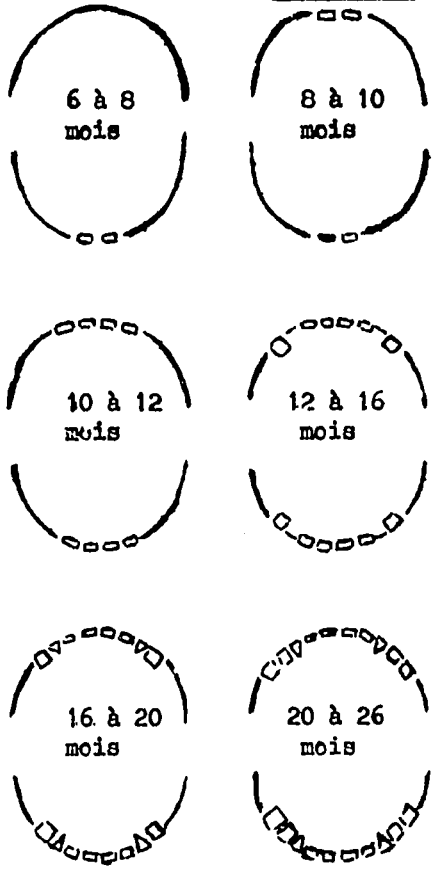
0 cm =point de repère

O.K. = bien nourri !

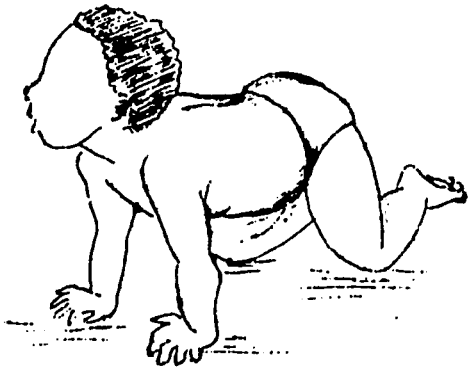
3 - SURVEILLANCE DE LA FERMETURE DES FONTANELLES



4 - SURVEILLANCE DE L'APPARITION DES DENTS

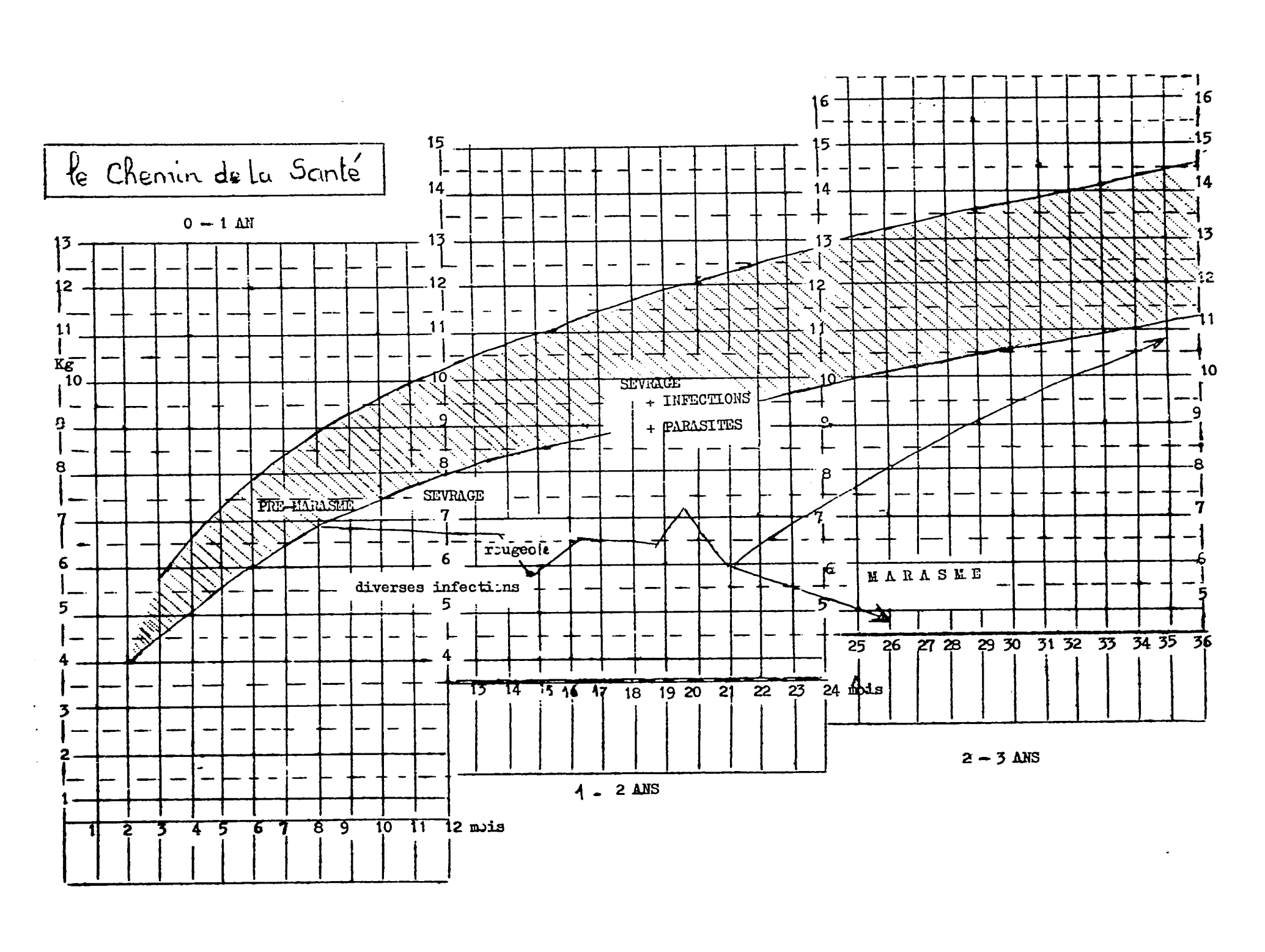


à 9 mois (doit marcher à 4 pattes)



EN RESUME : QUELQUES CHIFFRES

AGE DE L'ENFANT	POIDS	TAILLE	PERIMETRE CRANIEN	DENTITION
Naissance	3 kg	50 cm	35 cm	.....
6 mois	7 kg	65 cm	45 cm	1ère incisive
1 an	9 kg	75 cm	47 cm	8 incisives
18 mois				4 prémolaires
2 ans	11 kg	86 cm	49 cm	4 canines
3 ans	13 kg	95 cm	50 cm	4 prémolaires
4 ans	15 kg	102 cm	51 cm	
5 ans	17 kg	108 cm	52 cm	Premières grosses molaires


le Chemin de la Santé
0 – 1 AN
1 - 2 ANS
2 – 3 ANS
Kg
PRE-MARASME
SEVRAGE
rougeole
diverses infections
SEVRAGE
+ INFECTIONS
+ PARASITES
MARASME
mois

E X A M E N D E L' E N F A N T

(suite)

- MESURER l'enfant, noter sa taille
  son périmètre cranien
  son tour de poitrine > (important jusqu'à 8 mois)
- PALPER LES FONTANELLES : vérifier si à partir de 18 mois, les deux sont bien fermées.
- VERIFIER LA DENTITION (noter si l'apparition des dents se fait dans les délais normaux
- EXAMINER LES CONJONCTIVES : noter si pâleur ou conjonctivite
- EXAMINER LES OREILLES
- INSPECTER LA PEAU ENTIERE
- PALPER LES GANGLIONS (sous-mentoniers, sous-axillaire, inguinaux)
- PALPER LES MUSCLES et voir s'il y a déshydratation
- PALPER LA RATE et faire un DOSAGE DE L' HEMOGLOBINE
- SURVEILLER LE DEVELOPPEMENT PSYCHOMOTEUR

A L' ISSUE DE CET EXAMEN :

- on évalue l'état nutritionnel de l'enfant
  1) en regardant si la courbe de poids et celle de la taille sont régulières et dans les limites de la normale
  2) en évaluant la présence ou non d'une anémie
  3) en se faisant une idée de la qualité de la nourriture que reçoit l'enfant en questionnant la mère
- on évalue les risques de maladies infectieuses ou parasitaires
  - présence ou non d'une grosse rate
  - présence ou non d'une anémie
  - antécédents récents d'accès fébriles fréquents, de diarrhées, de vomissements fréquents, toux, etc.
- on programme les VACCINATIONS

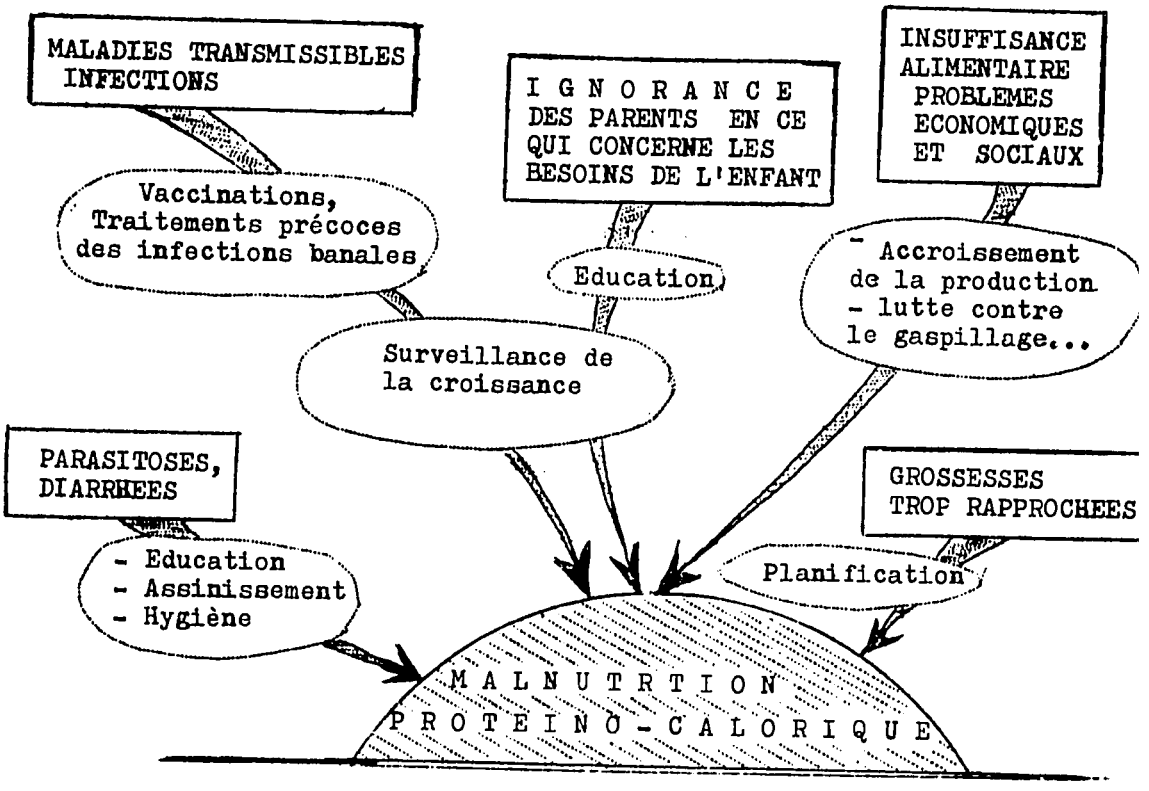
E N S U I T E

- ON DONNE DES CONSEILS A LA MERE sur un des points de surveillance ou de soins à l'enfant selon son état
- LA MERE ASSISTERA A UNE SEANCE D' EDUCATION SANITAIRE soit sur la nutrition, soit sur un autre sujet

POUR FINIR

- la mère recevra une petite provision de NIVAQUINE pour son enfant en prévention du paludisme
- On reprend un rendez-vous pour la prochaine consultation
- on demande à la mère de garder son carnet BIEN PROPRE !

PRÉPARER LE TERRAIN



OU LES BARRAGES A LA MALNUTRITION

DEROULEMENT D' UNE CONSULTATION D' ENFANTS DE 0 à 5 ANS

Elle a pour but de :
- Dépister les états pathologiques débutants
  - . malnutrition
  - . infections
  - . parasitose
- D'éduquer les mères
- De donner à l'enfant un traitement préventif
- D'établir une courbe de croissance (physique et psycho-motrice)

CHAQUE RENSEIGNEMENT RECU DOIT ETRE SOIGNEUSEMENT NOTE SUR UN CARNET OU UNE FICHE

avec l'identité : Nom, prénom de l'enfant,
Nom de sa mère et de son père
Lieu d'habitation (pour évaluer la distance que la mère parcourt pour venir et situer le village, s'il y a une P.M.I. ;)

SI L' ENFANT EST VU POUR LA PREMIERE FOIS, FAIRE UN CARNET DE SURVEILLANCE SUR LEQUEL ON NOTE :

- Date et lieu de naissance de l'enfant
- nombre de frères et de soeurs avec leurs ages en demandant
  - . si leur accouchement s'est bien passé
  - . si tous sont vivants ou s'ils sont morts, de quoi sont-ils décédés (pour apprécier les risques que court l'enfant présent)
- L'accouchement de cet enfant s'est-il bien passé ? Est-il né au village ou à la maternité ?
- Le développement de l'enfant a-t-il été normal jusqu'à présent ?
- Quelles sont les maladies antécédentes, surtout les complications et les hospitalisations ?
- A-t-il déjà reçu des vaccinations ?
- Prend-il actuellement des medicaments ?

SI L' ENFANT EST DEJA CONNU, PRENDRE LE CARNET OU LA FICHE , Mettre LA DATE DU JOUR ET NOTER :

- Comment va l'enfant depuis la dernière visite ?
- Mange-t-il bien ? Que mange-t-il ? Prend-t-il toujours le sein ? Mange-t-il de la nourriture familiale ? de la viande? des oeufs ? du poisson ?
  (noter soigneusement le régime alimentaire sur le carnet)
- L'enfant a-t-il souvent de la température ?
- Vomit-il? - A-t-il de la diarrhée ?
- Tousse-t-il? Souvent? Depuis combien de temps ?
- Est-ce qu'il urine du sang ?
- Quel est son niveau actuel de développement ? S'assied-t-il tout seul ? Marche-t-il ? Parle-t-il ?

E X A M E N DE L ' E N F A N T

PESER l'enfant d'une façon correcte (balance correcte, enfant déshabillé...)
notor ce poids à chaque consultation et

TRACER LA COURBE DE POIDS.

Vérifier si le poids reste dans les limites de la normale et si la courbe progresse r é g u l i è r e m e n t (rappelez-vous la malnutrition "cachée").

EN GRANDISSANT , CHAQUE JOUR UN PEU , L'ENFANT
BRULE SES FORCES ... comme les tiges dans le feu.
IL FAUT TOUJOURS REMETTRE DE QUOI ALIMENTER
LE FEU ...

POUR DONNER LA FORCE ,
il faut :

DES GLUCIDES

- mil, maïs, riz ,
- baignets, pain,
- soja ,patate
- papaye, goyave, citron, mangue, tomate...

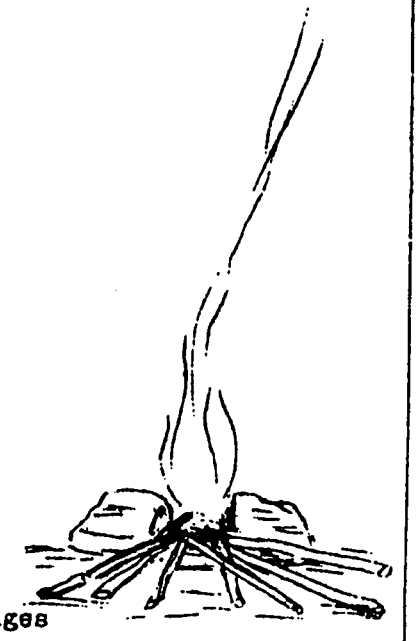
DES LIPIDES

- arachides
- huile
- beurre

et

DE L'AIR PUR

- oxygène d'une case bien aérée la nuit !



L'air
+
les tiges
= FEU-CHALEUR-ENERGIE

POUR BIEN GARDER LA SANTE , TU AS BESOIN
DE LA PROTEGER ...

POUR LA PROPTECTION
L'ORGANISME A BESOIN

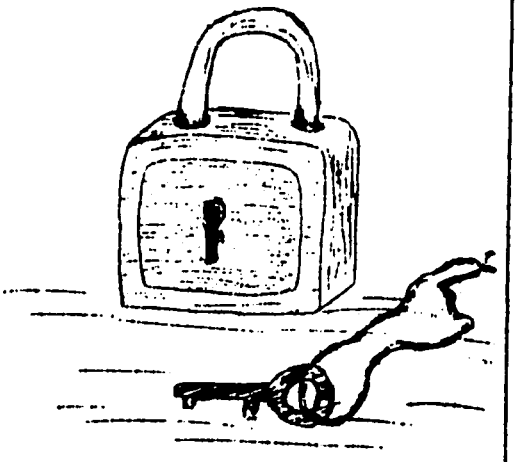
DES VITAMINES

on en trouve dans
tous les fruits

et

DE PLUSIEURS SORTE DE SELS

- légumes. gombos,
- petites tomates,
- feuilles vertes,
- feuilles séchées .



Pas besoin de beaucoup , MAIS TOUS LES JOURS , un peu .

IL EST NECESSAIRE DE PREPARER LE TERRAIN ....

Pour que les pères et les mères comprennent , il faut aller progressivement , et avec patience , mais ne pas se décourager Par étapes :

- Il faut leur apprendre ce qu'est la maladie qui vient d'une alimentation mal choisie , ou mal donnée .
  - le manque d'un des matériaux pour la CONSTRUCTION ...
  - le manque de plusieurs matériaux ...
  - l'eau , mal donnée (le gavage) , ou pleine de microbes...
  - la brusque séparation de la maman fait aussi que la santé de l'enfant qui a besoin d'elle et de son contact , va s'écrouler ...

- Il faut faire des démonstrations , leur montrer de quelle manière on prépare une bouillie adaptée aux besoins de l'enfant , avec les produits qu'elle a l'habitude d'employer , qu'elle peut se procurer .

  Ensuite , devant toi , la mère nourrit son enfant à la cuillère .

  Cette bouillie doit être simple , facile et rapide à faire .

  Il est bon de faire la démonstration , chez une des mères .

- Il faut faire exécuter une bouillie par la mère elle-même.

- Il faut visiter les familles où se trouvent de petits enfants . Ces visites permettent de se rendre compte de l'efficacité de l'éducation donnée :

  la bouillie est-elle bien préparée ?
  dans quelles conditions ?
  comment l'enfant la mange-t-il ?

  Cette évaluation à domicile permet de juger de la valeur du travail éducatif , de chercher les causes d'un échec et de réadapter ce travail s'il n'a pas été réussi , ou mal saisi .

  Veiller discrètement mais sûrement sur le rôle du père , dans ce travail de construction de son enfant ...

Le rôle de l'AI est encore de remarquer ,pendant ces démonstrations, certaines mères qui s'expriment plus facilement et comprennent plus vite que les autres , qui ont un bon contact humain et le désir de convaincre , qui semble avoir une influence sur le groupe .

Avec une formation supplémentaire , elles peuvent devenir de précieuses aides . Il est bon de provoquer l'action de ces femmes qui pourraient avoir un rôle de premier plan dans le village , sans pour cela avoir tendance à se décharger sur elles des tâches et des responsabilités . Au contraire , il faut continuer à les aider , à les conseiller et à les former .

LA PREPARATION DU TERRAIN DE LA SANTE SE VERIFIE ...

Il est indispensable de suivre chaque enfant -régulièrement- sur le plan de sa croissance et de l'inscrire dans un carnet qui est comme son histoire à lui . La courbe de son poids , son carnet sont soigneusement garde. dans un plastique .

LES TOUT-PETITS ENFANTS MEURENT TROP .... QUE FAIRE ?

Observations par proupes :

SUR 46 ENFANTS DE MOINS DE 5 ANS ,

. 20 SONT MORTS .

: 12 AVANT D'AVOIR EU 1 AN !

: 7 ENTRE 1 AN ET 2 ANS !

: 1 ENTRE 2 ET 5 ANS !

Nous cherchons les causes de ces décès :

Tétanos ombilical, mauvais lait de la mère, D.C. de la mère à l'accouchement, mauvaise alimentation ,diarrhées . Le gavage (noyade) , la bronchopneumonie , le paludisme , la déshydratation , les lavements avec des feuilles qui mal dosées tuent l'enfant , l'anémie , les amibes . La rougeole (près d'un an) la coqueluche , la malnutrition de la mère et le mauvais sevrage de l'enfant . les accidents : noyade , brûlures , voitures, serpents .

Pourquoi ceux qui ont passé les 5 ans grandissent mal ?

une grosse rate , ne mangent pas bien , font trop de paludisme , on ne s'occupe pas assez d'eux , déjà , ils se débrouillent ...

QUE POUVONS-NOUS FAIRE

→ LAISSER LES MICROBES FAIRE UN DESORDRE ?

(ou)

→ ETRE PLUS FORTS QU'EUX ? ? ?

le PALUDISME
Tous les PARASITES

← PMI ; nivaquine ; assainissement , moustiquaire .
Latrines , EAU POTABLE ,
souliers , propreté sur soi , sur les habits , dans la préparation des aliments

le TETANOS ,
la ROUGEOLE,
la COQUELUCHE,
la POLIO,
la TUBERCULOSE

← PMI : les VACCINS , les RAPPELS !

IL NOUS FAUT BEAUCOUP TRAVAILLER pour une éducation patiente ,

l'ALIMENTATION des mères et des enfants ,
l'IGNORANCE des VRAIS BESOINS de l'enfant pour sa croissance . Et l'IGNORANCE DU MAL qu'une mère peut faire à son enfant avec certaines coutumes ... et par manque de surveillance , lorsqu'il grandit !

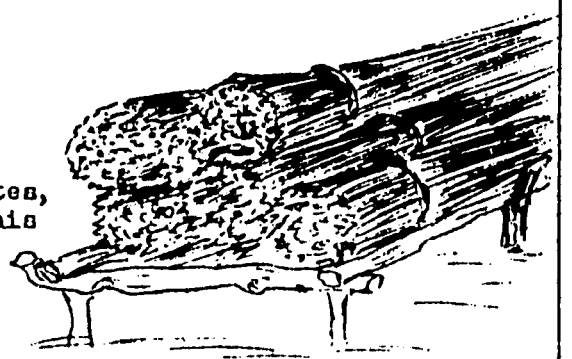
LE TERRAIN DE LA SANTE SE PREPARE CHAQUE JOUR , PLUSIEURS FOIS PAR JOUR , DANS LA VIE DE TOUS LES JOURS AVEC L'ALIMENTATION .

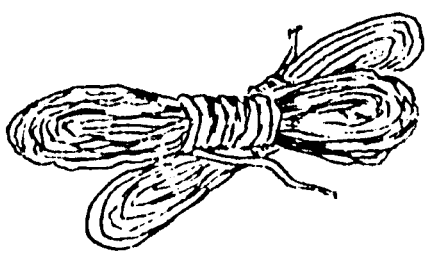
POUR CONSTRUIRE
IL FAUT DES MATERIAUX
SOLIDES ET SUFFISANTS

DES PROTEINES
****

qui serviront à fabriquer
toujours des cellules nouvelles...

- le lait
- la viande, les insectes adultes,
- le poisson séché, l'oeuf frais
- les arachides séchées,
- le soja, les haricots ,
- les pois secs
- le sésame



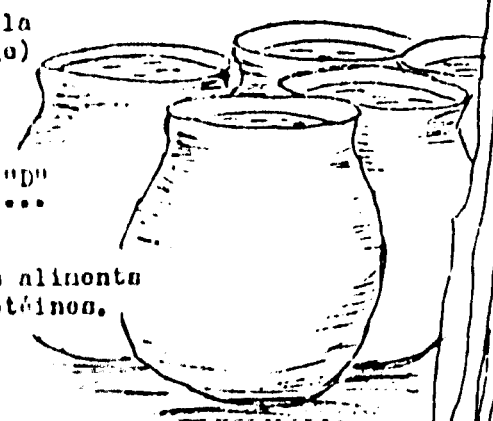


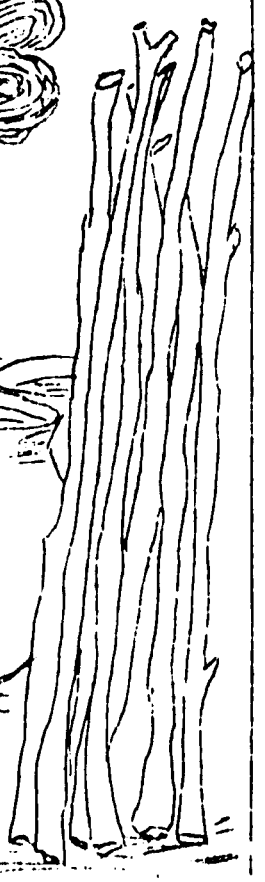
BEAUCOUP D'EAU
****

pour nourrir chaque cellule,

- donner de petites quantités à la fois , avant les tétées par ex : 2 cuillères...
- et donner davantage dès qu'il fait chaud .

Mais une grosse quantité à la fois ,c'est mauvais .(gavage)





DU CALCIUM et VITAMINE "D"
****

pour la croissance de son os.

On en trouve dans les mêmes aliments qui sont cités pour les protéines.

DU FER
******

pour fabriquer le sang ,et contre l'anémie .

On trouve aussi dans les mêmes aliments . Ce qui veut dire que si l'on ne donne pas un de ces aliments , chaque jour , on ne veut pas que l'enfant se développe bien .

HORAIRE DE LA 5ème ETAPE DE LA FORMATION
DU 3ème CONTINGENT D'AGENTS ITINERANTS

****

LUNDI 26 MARS 79

* on regarde les cahiers , enquête faite , compte-rendu des réunions .
* Ier tour de table : les améliorations dans nos sarés, avec des amis , puis chez eux avec eux ...

(pause)

* 2ème tour de table : compte-rendus des réunions faites avec maris et femmes, sur les besoins de la femme enceinte ...

après-midi

* CARREFOUR sur - les % de DC de 0 à 2 ans
  - les % de DC des moins de 5 ans dites de quoi ils meurent dans chacune de ces tranches d'âge .
  - d'après vous , quelles sont les autres maladies qui dérangent leur croissance ?
* MISE EN COMMUN

MARDI 27 MARS 79

* NECESSITE de préparer le "TERRAIN" de la santé, qui est notre richesse .

(pause)

* CARREFOUR : - Que croyez-vous que l'on peut surveiller ,pour qu'un enfant grandisse BIEN ?
  - Quels sont les gestes que l'on peut faire pour les enfants qui viennent à la PMI ? et déjà pour vos propres enfants...

après-midi

* MISE EN COMMUN suivie du
* Déroulement de la consultation pour un enfant de moins de 5 ans

MERCREDI 28 MARS79

* INTERET de la COURBE de POIDS , et du CARNET . Exercices pratiques sur les courbes ...

(pause)

* Démonstration de comment on MESURE { cm / toise / bracelet
* Explication de ce qu'on attend d'une PMI.

après-midi

* confection ,chacun pour lui , du flanellographe sur la courbe de poids et son exploitation.
* et du bracelet .

RENDEZ-VOUS POUR LA 6ème ETAPE ,
APRÈS LES PROCHAINES RECOLTES .

BILAN DE CE QUI A ETE FAIT DEPUIS LA 4ème ETAPE

1 - Les CAHIERS :

Deux , n'ont rien pu faire , étant occupés par leur formation préparatoire à A.S.

Un , s'est trompé de cahier , il a apporté le cahier de brouillon ... mais il a fait son enquête : sa femme a mis au monde son deuxième enfant , un fils , juste ces tous derniers jours , faut comprendre ...!

Trois autres ont bien avancé dans leur enquête , bien clairement disposée dans le cahier , ou encore à recopier.

Un , s'est bien lancé dans les réunions , et a noté : préparation de la réunion , chaque fois , compte-rendu ; mais pas de conclusion , pas de suite d'une réunion à l'autre ; et réunions nombreuses , avec l'infirmier Chef de Poste du village (DZIGUILAO) , mais presque toujours avec des groupes différents ... C'est un début bien positif ; il faut organiser mieux , et pour cela relire le rapport de la 4ème Etape , la sensibilisation des pères au problèmes des femmes enceintes et de la PMI.

2 - AMELIORATIONS DANS SON PROPRE SARE ...

Très PEU ...

- Alain , sa douche , ses latrines .
- Charles , ses latrines ,non terminées encore ...

La saison avance , pour trop encore l'effort chez soi est insuffisant ... COMMENT ceux qui nous regardent pourront Y CROIRE ? COMMENT POURRONS-NOUS PARLER AVEC CONVICTION ?

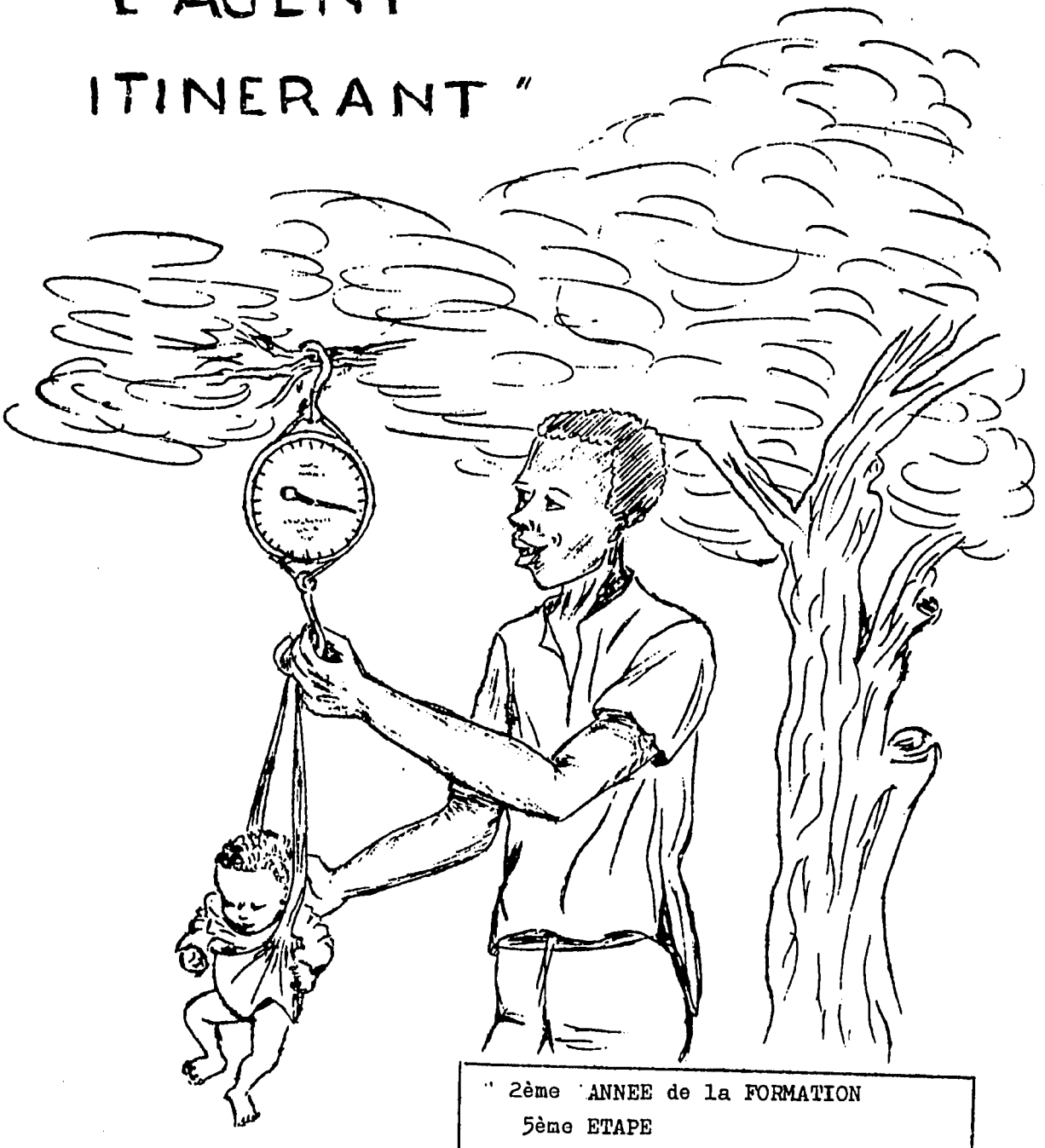
IL NOUS FAUT , entre le temps des sessions , RELIRE CHACUN DES RAPPORTS : c'est ici le 5ème ! SINON , NOUS OUBLIONS , car c'est NOUVEAU pour nous aussi ! ET , IL FAUT NOUS DECIDER A PASSER AUX ACTES .

Même pendant la période des cultures ...

Toute une rencontre des gens peut se faire ;

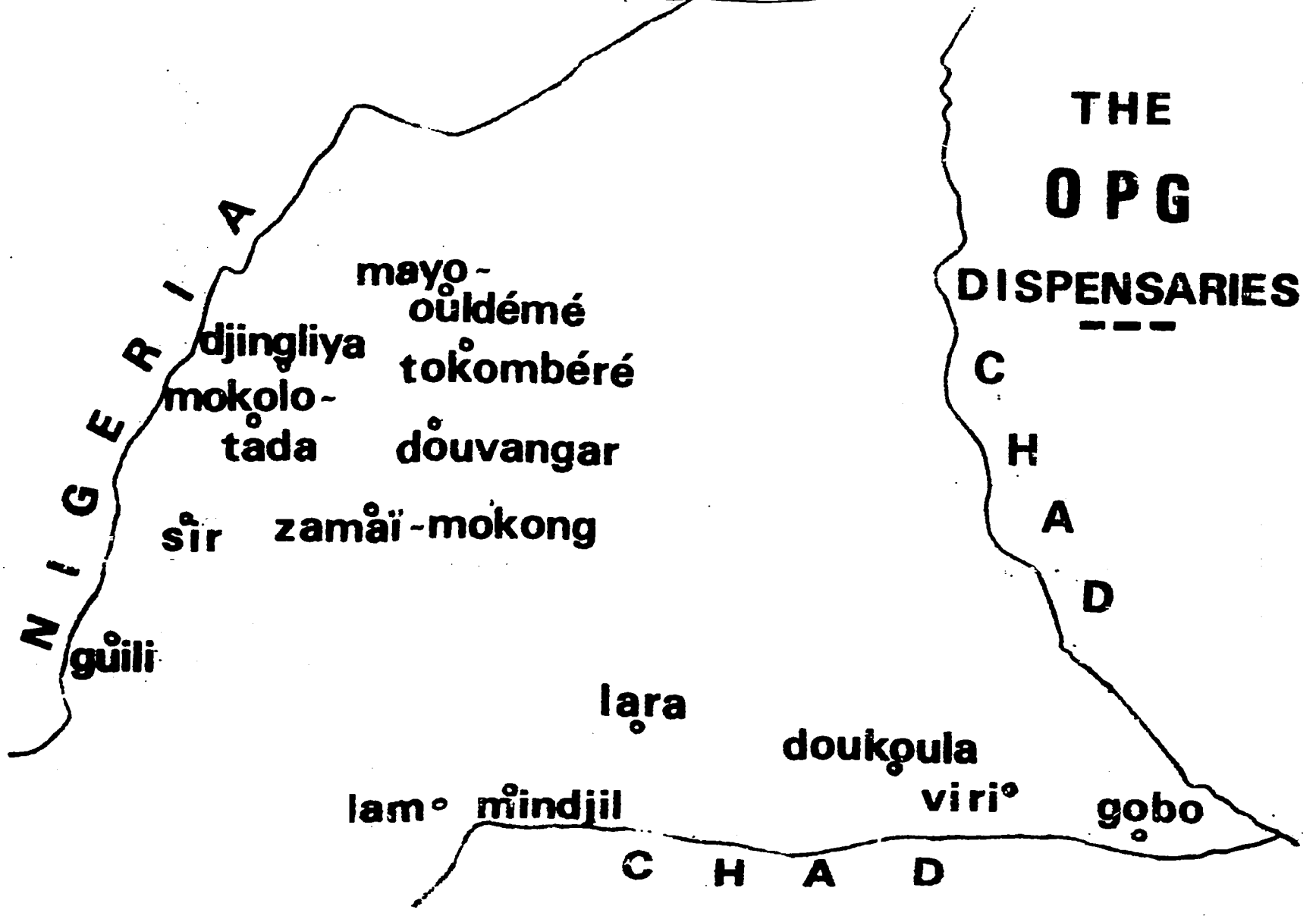
Il y a tellement à dire et à échanger avec eux pour les aider à mieux comprendre et préparer un vrai travail de Protection pour les femmes enceintes , celles qui allaitent et leurs enfants ...

L'AGENT ITINERANT "



" 2ème ANNEE de la FORMATION
5ème ETAPE
du 3ème CONTINGENT
TOKOMBERE : 26 - 27 - 28 Mars 79

ATTACHMENT B



PROGRAM

DEPARTMENT OF STATE

631

631-0201 (CRS/OPG)

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INFO: PPC/E/PDES

FROM · USAID/YAOUNDE

SUBJECT · Project Evaluation Narrative: PES Part II.

REFERENCE ·

13. Summary: This is the third annual evaluation report of the Catholic Relief Services (CRS) Rural Health Education OPG project which is being implemented entirely by CRS. It covers the period from the last evaluation (January 1978) to March 31, 1979. The total amount of $469,000 LOP funding has been obligated for this project. However, accumulated expenditures as of March 1979 are about $128,000.

The Catholic Relief Services Rural Health Education Project is centered in the Catholic Dioceses of Maroua-Mokolo and Yagoua in the Northern Province of Cameroon. Begun in July 1975, the project was originally financed by AID under an OPG grant for five years, but a two-year extension (until December 1982) was approved by A.I.D. The life of project financial contribution by A.I.D. remains at $469,000.

The purpose of the project is to promote health education in the rural areas served by the fourteen Mission dispensaries in the two

Attachment A: Decisions
Attachment B: Map of OPG Sites
Attachment C: Booklet "L'Agent Itinerant"

RUN ATTACTMENT W/AIRGRAM

PAGE 1 OF PAGES 20

DRAFTED BY	OFFICE	PHONE NO	DATE	APPROVED BY
EOldwine TBratrud:rm	Program		5/1/79	James E. Williams

AID AND OTHER CLEARANCES
HNPO:RCBrown (draft)
AHDO:RLThornton (draft)
PRM:JBWoods (draft)

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Dioceses (eight of the dispensaries are in the Maroua-Mokolo Diocese; the other six are in the Yagoua Diocese (see map Attachment B). The project health program has three aspects:

(a) curative aspect (dressing wounds at the dispensary, for example);

(b) a preventative aspect (vaccinations against the major diseases); and

(c) a "promotional" aspect, in which villagers are encouraged, through health education discussion sessions and community work groups, to improve the hygienic conditions of their environment and to adopt basic first aid measures to combat the onset of infection and disease.

To achieve this, the project provides funds for the local training of what are called "health extension agents" ("agents itinérants"). These people are generally salaried personnel given the additional responsibility for promoting health education in a small number of villages near their dispensaries. Conditions vary greatly in the project area, but in theory the extension agents leave their dispensaries for one or two days each week to animate group health education sessions, usually with the use of visual aid charts, in the villages under their supervision. The goal of a health extension agents is to help organize a health "committee" in the village where he is working. A committee is comprised of a half a dozen responsible and respected members of the village community (although they are not necessarily the most influential or powerful members) whose job theoretically is to continue the work of the extension agent when he is not there. The training emphasis is placed on this core group of villagers to create a new awareness of health needs and to develop possi-

bilities for improving health conditions for specific interventions. The extension agent, ideally, serves only as a catalyst for discussions, based on the day-to-day problems of the village he is visiting, and encouraging work groups to deal with the health needs that are defined in the discussions (latrine construction, disposal of wastes, well repair and water hygiene, etc.). In theory at least, it is the health committee which must do the real work of organizing the other villagers to think and act in new ways towards health.

In North Cameroon, however, the reality of creating fully functioning health committees is a long and arduous task and proving to be difficult. When the extension agent finds villagers uncooperative or runs into obstacles for creating committees, the emphasis shifts to the training of a "village leader" ("animateurs sanitaires") or one or two interested persons in a village who, although they cannot exert the influence of a whole committee, can nevertheless follow up questions of health education in the absence of the extension agent. The second alternative is showing signs of success.

The Mission dispensaries are the only functioning medical centers in very large, rural areas of the North and all of them serve large numbers of people in those areas. (The dispensary at Lara serves an estimated 15,000 people in an area of 150 sq kilometers; Gobo serves 20,000 people in an area of 1,350 sq kilometers; Lam, at the edge of the Mandara Mountains, serves 40,000 people in an area of 2,000 sq kilometers; and Sir, in the heart of the mountains, estimates that in an area of 50 sq kilometers it serves 25,000 people).

Because of this, it is impossible to reach all of the people through health education sessions. The health committees and village leaders, then, should set examples that other villagers, not in direct contact with a health extension agent, may follow. This is an incredibly difficult way to promote better health in rural areas, but at the present time in North Cameroon, it appears to be the most feasible.

The project also provides funds for the training of supportive dispensary personnel, such as auxiliary nurses, nurses, microscopists, and nurses specialized in public health training (rural health educators). Some of this training is supervised by the Missions in North Cameroon; the more specialized training is done in Yaounde at the Missionary nursing school in Yaounde, and at the recently completed center in the project area, Tokombéré (see section below on Tokombéré hospital site visit).

14. Evaluation Methodology: The reason for this evaluation was to clarify project design, measure training progress and improve project implementation. A thorough review of all project documentation was undertaken in Yaounde by the health specialist on the team and the evaluation officer, prior to the site visits between April 6th and 11th. Numerous discussions were also held with the CRS Country Representative, Ms. Kathy Kelleher, both before and during the field site visits. She also accompanied the team throughout our trip and provided valuable insights. CRS invited Mr. Elias Joe, Chef de Service, Health Education Unit to accompany the team, but prior commitments prevented him from doing so.

15. External Factors: There have been no major changes in the project setting. The host government still puts very meager resources into the health sector in the North. Only one dispensary of the 14 in the project receives GURC support. That dispensary is Doukoula and according to the sisters, it has recently received 410,000 CFA from the Ministry of Health. It serves one of the poorest and remote areas in the North.

16. Inputs: There are no significant problem with commodities. However, additional training commodities and four vehicles should be added. No additional funds are required since there are sufficient funds in the current commodity budget and the technical services component to cover these costs. Additional management inputs are needed by CRS and these are discussed at length below. These needs can be met by CRS without increased funding for technical services.

17. Outputs: Project outputs were revised downward as a result of last years evaluation. These are presented below along with this year's recommended revisions stemming from this evaluation. Over the first 2 1/2 years of the project we learned the level of education of potential candidates for training was so low that outputs had had to be continually revised downward. This evaluation verified that this problem persists. One common denominator throughout all visits to the dispensaries was the unavailability of French speaking candidates able to be trained and willing to continue to work in the project once trained. French speakers are a necessity, as often one

clinic will serve a population of six or seven different language groups. French serves as a lingua-franca as there is often someone in the village who is French speaking.

The requirement for establishment of 360 village health stations should be deleted in its entirety.

	1978 Revised Outputs	To date		Current Recommendations for number of personnel trained at end of project.
		Trained	In Training	
Health Extension Agents	70	20	15	55
Auxiliary Nurses	23	5	6	16
Microscopists	25	12	3	20
Nurses	10	0	2	4
Rural Health Education (animator at village level)	5	3	0	4
Special training	20	6	0	16
Outreach stations Establishment	360*	-	-	-
Village Health Committees	120*	-	-	-

* Protection maternal infantile: PMI's are the same thing as village outreach stations.

*As in previous evaluations the team discovered that village health committees really consist of the chief's selections of people who only meet when the rural health educator pays a visit to the village.

The 1973 evaluation (PAR) stated that the revised outputs appeared to be optimistic. This still appears to be true. The evaluation team was unable to make a reliable distinction between outreach stations (PMI's) and village health committees. Everyone acknowledged that they are moving slowly in creating PMI's and village health committees. We were unable to quantify results. While the dispensaries collect some data on illnesses, ages, sex, etc., for the GURC, there is no central source within the confines of the project where useful and meaningful numbers are available. Nor is there systematic feedback to the project field coordinator specifically designed to provide this kind of information. One of the original outputs included a system to collect baseline data for evaluation purposes through the use of 'Student Data Gatherers' from the Yaounde Medical School. For a variety of reasons this still has not been done. And it is recommended that it be eliminated from the project.

18. Purpose: The purpose of this grant is to provide support to a Basic Rural Health Education/Community Health System, serviced by a local cadre of low and middle level health workers. With the two-year extension to the project, achievement of revised EOPS (see outputs above) recommended in this evaluation are a reasonable possibility provided CRS gives priority to improved project management and implementation. This should be reflected in the revised implementation financial plan to be submitted by CRS.

19. Goal/Subgoal: It should be possible to cite evidence of goal/subgoal achievement nearer to the end of the project. Presently, progress can be summed up as being made slowly but measurably. Actions recommended in this evaluation, once implemented, are expected to result in significant output improvement by 1982. A comprehensive ex-post factor evaluation to be carried out early 1983 should confirm this. At that time it will be more appropriate to try and measure to what extent progress is being made toward goal achievement.

20. Beneficiaries. This group includes subsistence farmers living within 50 kilometers of each of the 12 dispensaries operating in the project area: Gobo, Viri, Doukoula, Lara, Hindjil, Lam Zamai-Hokong, Douvangar, Tokombéré, Mayo-Guldémé, Djingliya, Mokolo, Tada, Sir and Guili. The population affected exceeds 200,000, with more than 100,000 concentrated around Lara, Gobo, Lam and Sir, which are the 4 most remotely located dispensaries and serve the poorest villagers.

According to GTRC statistics and the dispensary staffs, the highest proportion of children with acute to mild malnutrition live in these areas. Per capita income is among the lowest in the entire country, school attendance is one third the national average, (only 22% of children attend school), toilet facilities are rarely found, population per health worker is the highest in the country. The percentage of health facilities to the population is the lowest in Cameroon, potable water is a critical problem throughout the year

but especially in the 6-month dry season. It is estimated that the direct and indirect beneficiaries of this CRS project actually may toal 200,000 people. Direct beneficiaries include those reached by village health committees, health extension workers, and those who visit one of the dispensaries, certainly exceeds 50,000 annually, The CRS project facilities are the only functioning rural health facilities in the North, i.e. 40 kilometers outside the centers of Maroua, Mokolo, Mora, Meri, Koza, Doukoula, Yagoua and Kaele. There are GURC hospitals in Maroua, Mokolo, and Mogode which are neither well equiped, nor well staffed.

21. Unplanned Effects: The increase in community outreach health activities has created two problems for the health facilities:

(1) Exposure to health information and practices at the village level has increased the number of patients seeking care at the dispensaries;

(2) This in turn has forced the health extension workers to decrease the number of visits to villages as the demands on their time increase at the dispensaries.

22. Lessons learned: The idea behind this project is to train health extension workers to promote health education in the areas served by the CRS dispensaries and we believe it is a sound one. The difficulties lie in the concept of establishing village health committees in each principal village. For example, tribal traditional healers and chiefs resist the advance of western health education to the detriment of the project.

While this is slowly breaking down because more and more villagers are besieging their chiefs to permit them to participate in the more formal health delivery services, the process is extremely difficult and slow. Consequently, it is not possible to meaningfully measure quantitative change in terms of outputs at this juncture in the project but we believe this will change over time. There also has to be improved communications among project staff at the various dispensaries; especially between the field co-ordinator and the project implementors at the dispensary level. (See recommendations section). There is not sufficient idea and problem exchange and it is inhibiting what progress is being made. CRS management must address this problem. Finally, the staffs at four of the more isolated dispensaries need additional project commodities including a 4-wheel drive vehicle each. This will permit them to carry out village visits in the five-month rainy season. Also certain other equipment is needed to support well improvement programs (i.e. cement, spare parts); microscopes and possibly other laboratory equipment to help in both the training programs and curative and preventive aspects of the project related training efforts.

23. Special Comments: The CRS personnel implementing the project do not view the project as a "project" with specific goals and time frames per se. Rather, the Catholic sisters consider this effort as part of their life long effort to improve local health conditions where they are working.

This of course may conflict with AID's concept of a rigid time frame for project implementation. In our opinion, this could be partially resolved by better and more frequent discussion, collaboration and "feedback" between USAID and the project personnel at all levels. Despite the project's size, this particularly would be worth AID's effort and will help provide valuable data and insights on project implementation in the North. Lastly and most importantly, this project, while suffering implementation difficulties, is a good project conceptually in terms of meeting a critical health need in North Cameroon. There are many lessons yet to be learned from this project and for this reason alone, A.I.D. should continue to support it in every way it can, including now an attempt to strengthen project management and improve implementation where ever feasible and practicable.

24. Site Visits: Specific Findings and Conclusions

General: Both the USAID team and CRS feel that over the seven-year LOP, this A.I.D.-funded activity will have a modest but still significant impact in the project area. The reasons for this are discussed above. We strongly believe the project should be modified and continued because the qualitative change it is making in health training is worthwhile. It has more than symbolic value in that it is the only functioning health effort being undertaken in the project rural areas of the extreme North, Northwest and Northeast Cameroon. A revised implementation and financial plan covering the period from March 1979 through the revised LOP of December 31, 1982 needs to be submitted by CRS.

When this is done, it is the opinion of the evaluation team, that many of the revised projected outputs can be achieved, concurrently with a more concerted effort by CRS to impsove project implementation. Particularly, better communications are needed between the field coordinator and the local CRS field representatives actually implementing the project at the dispensary level.

At the outset this project was hampered by an unrealistic design in terms of what CRS could be expected to accomplish. When the PP was prepared a social analysis was not required and sufficient consideration was not given to the complications of doing this type of project in North Cameroon. For example a problem perceived by the evaluation team is that CRS is politically hampered by the contraints resulting from populations having either strong local Moslem or Animist leadership. In the team's opinion this poses severe limits to project implementation. For example the dispensaries are very careful to identify themselves as private or non-governmental rather than catholic, also, acceptance by local tribal chiefs of the projects western health delivery services philosophy and use of the subsequent 14 rural dispensaries has been painfully slow. According to one nun at the isolated dispensary of Sir, the local chief forbid his tribe from abandoning the indigenous health practitioners, or folk healers, in favor of more conventional, western medicine. The villagers then took patients to the chief's house and asked that he cure the sick. After 3 days he relented and permitted villagers to use Sir's facilities. The next significant change, getting the mothers to put clothes on infants, took months in many near by villages. The concept of rural health

training is especially difficult to inculcate in the minds of these villagers where so little is known about their attitudes toward co-operating with the more formal elements of a western oriented health delivery system. While they may serve as handy tools for AID, concepts like costs/benefits analysis have practically no meaning in a project setting of this sort.

It has been CRS's perseption all along that qualitative change is more important than quantitative change in the project. Because the project setting is not conducive to rapid, numerically larger training programs, they have a valid point. It is much more important to them, and we believe to the project as well, to have 10 higher trained dedicated extension agents or nurses as opposed to 100 trained health workers who end up leaving the area to join the army in order to earn a better livehood in a material sense. Emphasis on numbers per se when evaluating outputs is not as important or useful as analysing the type of change being produced by this project.

Villagers served by the project dispensaries are beginning to severely tax the curative facilities of the CRS project. As a result, the training effort focusing on prevention, which is the major goal of the project is further inhibited because health workers and nurses are tied more closely to the dispensary and can't carry out extension work. Very useful discussions were held with the local CRS Country Representative, Kathy Kelleher, project field coordinator, sister Guy, the nurses administering the various dispensaries and the young, very promising Cameroonian health workers who have been trained and are being trained to work closely with the village health committees. The following sites were visited and evaluated.

LARA: (See last years PAR for demographic data on LARA and the other dispensaries). At Lara the team met with the "Agent Itinerant", Mr. Pierre Wassi. He is well trained and very dedicated. He was in charge of the entire dispensary program while we were there. In addition to Mr. Wassi there are 4 Catholic sisters at Lara. The major problem at this center is lack of water for the dispensary and the village. CRS has recently made funds available to repair and build wells in this area. However, they are having difficulty recruiting a wells technician. The most serious problem here is the lack of suitable candidates to be trained either as an "aid soignant", dispensary nurse or health extension worker (Agent Itinerant). Candidates are carefully chosen by CRS to try to insure that they will continue to work at the center after completion of training. The literacy levels in this area are so low, that once one receives a little education or some French, one joins the army or civil service and receives good pay by local standards.

Mr. Wassi has been successful in forming two new village health committees since the last evaluation, the villages are Bilao and Marravé. However, the clinic load is such that he can only leave the dispensary twice a week to do extension training in outlying villages.

The animistic beliefs of the people make selection of village health workers difficult, although Mr. Wassi is meeting with some success. He has trained about 45 persons who work with PMI centers. It is also the job of the health extension agent to train the village animators to work in the village to give basic health education lessons. Mr. Wassi has little time for this task.

DOUKOULA: This center, serving 15 villages, was never visited by an evaluation team so we made it a point to visit. Doukoula is one of the least promising of the health facilities. While they have 2 health extension workers, the clinic load is such that little time can be spent in community level activities. Since the beginning of 1979, the health extension agents have only worked in two villages, but in these villages the villagers themselves selected the persons to be trained to run the PMI sessions. The recent arrival of sister Elizabeth at Doukoula should allow more time for the health extension agents to do more community work. Ironically, this is the one clinic we visited that is receiving a GURC contribution (approximately 410,000 CFAF/year). Water was again the most critical problem. CRS is still attempting to alleviate it with their own resources even though the last evaluation recommended making $15,000 available in project funds for potable water related needs.

MOKOLO-TADA: Here we met with sister Annuncia and two recently trained "aid soignants". Mokolo has one of the largest client populations with 2,000 to 3,000 patient visits per month. It is a large and well run center. The biggest problem is that local taboos cause patients to wait too long before seeking medical attention, causing increasing mortality, especially among children. The clinic is staffed with three sisters, two "aid soignants" and one health extension worker.

According to sister Annuncia, the health extension worker here has trained thirty "animators" who do community level health education. These "animators" come to Mokolo-Tada once a month for a day for a refresher session. The health

extension worker used to visit the villages twice a month but now only goes once a month to help the "animators". He uses his time to give health education sessions to the patients at the clinic.

Sister Annuncia expressed her desire that the project field coordinator, should visit this dispensary at least twice a year. This would permit better feedback and discussions of problems in project implementation.

SIR: This is one of the oldest dispensaries, constructed and operating since 1955. Sir is an extremely isolated facility staffed by three sisters, two health education workers and one "aid soignant" who is also the health extension worker. Another Cameroonian attending the nursing school in Yaounde returns in November. This clinic services 6 different ethnic and language groups in the area and constantly works through interpretors. The groups are Mofa, Kapsiki, Bana, Kortchi, Amsa and the Fulbae (Fulani). Sir receives many patients from Nigeria. The GURC dispensary at Mogode refers their patients to Sir since they have no way to treat patients. However, there is a French expatriate physician at Mogode who conducts examinations but due to lack of medicines, refers patients to Sir.

It should be mentioned that the sisters at Sir developed their own cloth flip charts adapted to the local area. They are used in the place of ones which were purchased by the project. The cloth is easier to carry to villages and the messages are better adapted to communicate health priority concerns to the villagers. The dispensary has trained two aids. Because of illiteracy, they dispense medicines by always measuring the same dosage levels and putting it in various bowls, a seperate color for a particular medicine. Thus, villagers learn that the red bottle cures colds, green bottle cures diarrhea, etc. Notably at

Sir, two sisters are making village visits with the wives of the clinic aides who in turn are beginning to provide health education sessions in nearby villages.

One of their biggest successes this year is that the chief of the Korchi tribe allowed his daughter to deliver her baby at the Sir dispensary. He previously refused to allow the villagers to seek treatment at the Catholic facility.

TOKOMBERE HOSPITAL : The team met with Ms. Annie Dufour. Tokombéré hospital is a private, non-government hospital with 150 beds. It is staffed by two expatriate doctors, two French nurses and eight dispensary aides. Under the supervision of the nurses and doctors, the aides perform a variety of hospital duties from the dispensing of medicines to general care of the patients.

The new training facility at Tokombéré was completed in December 1978. The center consists of one large central classroom suitable for 20 students, a room for practical exercises, i.e. how to weight and measure babies, preparation of simple audio visual aides, etc., a storage room and a small office. The center also has dormitory facilities consisting of four bungalows which can sleep twelve students. This facility is the main success story in the project.

All of the training of the health extension agents (Agents Itinerant) at Tokombéré is under the direction of Annie Dufour, a French Health Educator. She is a dynamic and creative woman who has designed all of the excellent training materials herself, adapting them to the needs of North Cameroon. (See attachment C, "l'Agent Itinerant").

The training cycle for health extension agents is three sessions per year for two years. Students come to Tokombere three times a year for training sessions which last from three days to one week. The health extension agent is usually already a paid employee of the dispensary in any of the various categories. The health extension agent receives no additional money for his health education activities. When they return to their dispensary, they are released from their regular activities to conduct health education sessions in the villages. Ms. Dufour visits the students in the field between sessions to reinforce learning and discuss problems.

During our visit we were fortunate to view a training session in progress. There were ten students who were actively involved in the lesson on well-baby care. This was the refresher course for second year students who have completed the initial two-year course.

It is hoped that during 1979-1980 that students selected for auxiliary nurses training will train at Tokombere. Previously this training was done in Yaounde at the Mission Nursing School. Auxiliary nurses training is a-one-year course leading to the auxiliary nursing degree. This mission staff believe training at Tokombere will be more suited to the particular nature of the problems and living conditions in North Cameroon. Tokombere should measurably improve final output achievement over the remaining 2 1/2 years of this project.

Ms. Dufour is developing a list of all anticipated priority training materials for the next two years and will submit it to the field coordinator in Maroua for her approval and procurement with project funds.

ATTACHMENT A

A. Decisions

1. CRS Field Coordinator and the CRS Country Director should visit each dispensary site once a year.

2. Outputs should be revised downward substantially from last year's PAR. Specific numbers are provided under the section entitled "OUTPUTS".

3. Implementation and a financial plan should be prepared that indicate planned project activities through December 31, 1982. This is needed to more clearly illustrate how project funds will be used in each remaining fiscal year of the project. CRS has agreed that this plan should be submitted by July 30, 1979.

4. Format for quarterly reports should be prepared in a more timely fashion and revised so that progress and changes of individual dispensary sites can better be monitored and measured. Much of the descriptive background material can be eliminated since it is well documented in earlier quarterly reports.

5. The need for a CRS Project Technician on site in Maroua was further discussed with CRS. The team believes that, especially in this case, a PT on site is required for significantly improved project implementation. Formerly, CRS field coordinator, Joe Payton, lived in Maroua. He provided much of the management and coordination required and was able to visit sites regularly. This situation was in response to an earlier A.I.D. recommendation to CRS for improved project management.

As of July 1979, the CRS Director reported that by September CRS hoped to have a Project Technician on site in Maroua.