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12. RECOMMENDED FUNDING SOURCE AS PER NATIONAL POLICY		13. SPECIAL COMMENTS (OTHER THAN THE FOLLOWING)													
14. PROJECT PURPOSE (GENERAL STATEMENT)		15. PROJECT PURPOSE (GENERAL STATEMENT)													
To increase the quality of the rural population and other underprivileged groups to participate in development activities by providing comprehensive health education services.		To develop and implement a practical training system of health education activities responding to the needs of the rural population and other underprivileged groups in the health and education sectors of Cameroon for use by the MHO, CUGS, COEAC and ENISRYW local-level and COEAC village-level training projects.													
17. TRAINING RESOURCES REQUIRED TO ACCOMPLISH		18. PROJECT BUDGET (US DOLLARS)													
Three man months of consulting services to operate PEP (505,000)		505,000													

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B. RECOMMENDATIONS

It is recommended that:

1. Grant funds be authorized for the Cameroon Practical Training in Health Education Project in the amount of \$1,954,000 for the life of the project;
  2. A Procurement Source/Origin Waiver under section 636 (i) of the Foreign Assistance Act of 1961 be granted for procurement of vehicles. (See Annex \_\_\_\_\_).
- 
3. That a reassessment of the number of Peace Corps Volunteers to be sent to the Kadey district be made in light of what the team has discovered in that area.
  4. That the U. S. Peace Corps, in collaboration with the Ministry of Health discuss with Z.A.P.I. de l'Est to determine whether there is a role for Peace Corps Volunteers in the health education program which is being planned by that agency.

## DESCRIPTION OF THE PROJECT

### Introduction

The Practical Training in Health Education (PTHE) project has been developed in response to a specific development problem. This development problem, common to all LDCs, is the degree to which disease interferes with the ability of people to participate fully in the development activities of their communities or to benefit fully from services already offered by their governments. Disease has been shown to reduce community activity, agricultural production and school attendance throughout the developing world.

This is true throughout most of Cameroon. In the Méfou and Kadey districts where the project activities will take place, the principal causes of morbidity and mortality are infectious diseases. The etiology of these diseases include water contamination and insect vectors. The endemicity of these diseases is so great that dealing with them with strictly curative medicine is not feasible, even if there were not a severe resources constraints. However, these are generally diseases which lend themselves to preventive medicine approaches, particularly health education, sanitation and immunization measures.

This project is further designed to combat the development constraint imposed by disease by contributing to the efforts of the Government of Cameroon and the World Health Organization to develop a comprehensive health education system in Cameroon which could be replicated throughout Africa. The specific elements of this project are described in detail subsequently and benefit from the direct participation of several government agencies, institutions, and other donors. The principal elements of the project are practical training in health education at all levels from village level itinerant agents to master's degree health educators, and the provision of health education and community organization services to rural populations and other disadvantaged groups in the project area.

During the life of the Regional Public Health Training Project (625-11-540-510) both practical training in health education and village health education services were developed on a pilot scale under the auspices of The Organization for Coordination of the Fight Against Endemic Diseases in Central Africa (OCEAC). The Ministry of Public Health has been enthusiastic about the success of the RPHT in these demonstration activities and, with the collaboration of all the participants cited herein, has designed the Practical Training in Health Education project to provide these services, albeit somewhat elaborated, on a larger scale. If, in the course of the PTHE project an adequate system is

established, it is the intention of the Ministry of Public Health to attempt the extension of project services to the national level. The project is also designed to involve students from Francophone Africa, especially the Central African states, so the training element of the project will have benefits well beyond the boundaries of Cameroon from the outset of the project.

The main reason for the enthusiasm that this project has generated among the participants, especially within the Ministry of Public Health and the donor agencies, is the fact that the project has a practical or field-oriented focus. The project is contributing to formal training programs through direct involvement in the practical application of health education services at the village level. Such an approach gives a particularly relevant frame of reference within which the classroom training of students can be kept in perspective and kept service-oriented.

(1) What is going to take place?

Practical Training in Health Education will address the problem of increasing the participation of rural populations in development activities through establishing in Cameroon a system of health education activities at three levels: National (planning and policy decisions in the Ministry of Health), middle (health training institutions preparing upper, middle and field level technicians), and field (implementing health education service for rural populations and recycling existing health workers including paraprofessional personnel). The middle level training programs will directly involve participants from African countries in field level activities and the system will be a model which can be readily implemented in each of these countries.

This project connects the health service delivery program with the manpower and educational resources, creating new relationships between educational facilities where health needs are the most critical.

Cooperative arrangements have been worked out so that existing training efforts can be coordinated in a regular orderly arrangement; expansion of current training capabilities can meet the increased demand of manpower to be trained; and practical training in health education can be introduced into the curriculum of undergraduate, in-service training, and recyclage programs. This project has three essential elements: coordination of efforts, expansion of effort, and introduction of new concepts.

The project will concentrate its efforts in the Méfou and Kadey Districts reinforcing and expanding existing efforts in Méfou but introducing totally new health education services in Kadey. The Méfou and Kadey zones of Cameroon were selected for PTHE activities by the Ministry of Public Health in collaboration with the other participants in the project design. The Méfou zone was selected because it was in this zone that the pilot activities of the RPHT project were undertaken. Furthermore, the Méfou zone is accessible from Yaoundé and can be used extensively for the practical training of students whose training programs are located in Yaoundé. There are already a handful of successfully functioning village health committees which can be utilized as demonstrations and as sources of additional outreach personnel by this project.

The Kadey zone was selected because it is a particularly disadvantaged area of Cameroon which has traditionally been the last to receive government services. It is thought that the Kadey will provide a distinctly different milieu in which to attempt the development of project health education services and will provide an opportunity for the project to compare the project's effectiveness in different social and geographic environments.

Experiences in villages will provide opportunities for students to observe motivating factors of villagers for health improvements, to identify the power structure of the village, and to learn decisions are made to improve sources of water supply, housing, garbage disposal, construct latrines, etc. Students will learn how to carry out sanitary improvements so that they will be able to demonstrate these improvements in their own job situations. Dispensaries will provide experience in individual patient, family or group education. This will include topics on nutrition, and child rearing. Schools will demonstrate how teaching health to children can tie together the health services and environmental aspects with health instruction.

The educational approaches used in the project will place responsibility for learning on the student, and on the local community organizers, and promote self-reliance and a capability for solving problems in a team situation. Villagers will learn how to bring about change to improve health conditions and to assume responsibility for maintaining such change.

(2) Who is going to organize and carry out activities

Under the leadership of the Cameroon Ministry of Health (MOH/C) cooperative arrangements have been developed which makes it possible to mobilize diverse educational efforts and concentrate attention to improve health conditions in Méfou and Kadey districts during the

four years of the project. The institutions and agencies providing education and training resources are WHO/CUSS, OCEAC, ENISFAY, and the Peace Corps. The manpower to be trained will come from Cameroon and other francophone countries through government and private sponsorship. Employment following training will come from the governments and private (i. e. missions, cooperatives) sponsors.

Unique relationships have been worked out in extensive precedent setting individual and group meetings with AID, WHO, MOH/C, UNICEF, CRS, Peace Corps, University Center for Health Sciences/Cameroon (CUSS), Organization for the Coordination of the Fight Against Endemic diseases (OCEAC), and Canadian International Development Assistance (CIDA). Other Ministries of GURC, i. e. Education, Finance, Social Affairs, Agriculture, Youth and Sports have participated in the planning meetings for this project paper and their field staffs will be a welcome addition to the training programs as indicated in the Detailed Description section.

(3) Relationship of inputs to outputs to achieve purpose

Project technicians will have the expertise required to develop the administration, planning and training functions necessary for the practical training system in health education. The continued cooperation and support of the collaborating agencies will supply both the training capabilities, as well as the manpower to be trained. The cooperation and support of other ministries at the village level will broaden the base of health education services and increase the rate of expansion of village health committees.

Scholarships will enable health and other workers to participate in training programs and thereby increase their effectiveness in the health care delivery system.

Regional health education conferences will serve as a motivating force to continue village health education efforts and to provide feedback on ways of improving the organization and supervision of technical assistance to village health education efforts.

Health education will be included as a regular part of the in-service training program for primary school teachers, and hopefully during the life of this project, attention can be directed toward including health education in the curricula of teacher training institutions. In this way a continuous positive influence can be exerted for future citizens.

Transportation will make it possible to carry out the organization and supervision necessary for village health committees. Construction materials will make it possible to institute the needed sanitation improvements. Not all the materials needed will be provided by the project but demonstration models will greatly aid the effort.

Peace Corps Volunteers will expand the manpower needed on the village level for the organization and supervision of village health committees and will be able to augment the faculty for the recyclage and in-service training programs to the extent that their academic backgrounds are appropriate. Teaching aids prepared by PCV/Audio-Visual specialists will be important in localizing messages for the villages and in expanding the library of materials at OCEAC, CUSS, and ENISFAY. It is anticipated that the school health education program will be the largest recipients of the audio-visual aids prepared by PCV/Audio-visual specialists.

By increasing the knowledge, skills and teaching abilities in health education of the ENISFAY faculty or faculties of other institutions they will be able to reorient some of their curricula to the health problems of the country and thereby prepare their students to more adequately serve the needs of the people in the rural areas.

Although the largest output from this project is at the village level, it is of critical importance to provide the widest range of practical training possible for health educators and other health professional students at the baccalaureate and Master's degree level. These are the people who are trained to assume positions of national and regional responsibility at the policy and administrative management levels. Only as they become sensitive and knowledgeable as to how-self-help can be developed at the village level can they evolve the kind of policies and programs at the national level which supports the whole concept of prevention through self-action.

(4) End of Project Status

The conditions which will exist at the end of the project will be:

An actively functioning practical training system as follows:

- Integration of health education into other socio-economic programs.
- Village Health Committees actively functioning and routinely using services of field-level workers,

having developed local village expertise which monitors and improves total environmental and family health in collaboration with dispensary services.

Health Education curriculum taught in village schools linked to new health practices in the village environment.

Active recyclage of all health workers in Mefou and Kadey districts.

Integration of practical training of health education in academic programs of WHO/CUSS, OCEAC, and ENISFAY.

The existence of the end-of-project status conditions will indicate that the project purpose:

To develop and implement a nationally coordinated practical training system of health education activities responding to the needs of rural populations and other underprivileged groups in Africa. Initial project activities will take place in the Mefou and Kadey district of Cameroon.

has been achieved.

D. SUMMARY FINDINGS

This project has been designed to suit the technical, social, and economic realities of the African countries. The involvement of several bilateral and international assistance agencies in a project administered by the host country Ministry of Health implies the integration of donor assistance. The success of the project will be depend upon the ability of the project administrators to efficiently utilize the material resources and institutional support provided by the different participant agencies. Projected manpower needs should be adequate to support the project and with proper time-phasing and intergration of the inputs of participants the system can become an efficient model for replication elsewhere.

The target of project activity is the small rural African village, emphasizing the participation of rural villagers in activities designed to improve their welfare. Equally important is the bringing of future health personnel at all levels to grips with rural health problems. The PTHE does not intend to create new village organizational structures except when absolutely necessary. The approach is to utilize existing structures to solve village health problems. Insofar as possible, materials for project activities will be procured locally. At the institutional level, teaching materials such as audio-visual aids, posters, models, charts, graphs, etc. will be developed to suit the cultural milieu building upon the small library of available materials at the educational institutions.

The coordination by the Ministry of Health of these various practical training programs in the Mefou and Kadeu districts will provide future health workers with a viable real life experience demonstrating how members of the health team can work together at all levels. This approach represents a radical departure from the classical curriculum in medicine in countries which adhere to the hierarchical traditional which was part of their colonial heritage. Today this approach is inefficient and inappropriate for dealing effectively with many health needs with limited resources in developing countries. The active participation approach to the delivery of health services contains the greatest hope for developing programs which meet the needs of the rural populations in Africa.

The Project meets all applicable statutory criteria.

## E. PROJECT ISSUES

The Executive Committee Review of the PRP on November 26, 1975 requested additional information on the following points:

1. The need for a strengthened evaluation plan
2. A statement regarding the role of women in the project.
3. A more detailed social and economic analysis
4. The relationship of the project to past projects and studies.
5. An indication of what health education materials would be available.
6. A statement regarding the types of research anticipated

The additional information is presented below:

### Evaluation Plan

The evaluation plan has been strengthened and is discussed in more detail in the Implementation Planning Section. An attempt has been made to design a more quantifiable approach to the project evaluation.

### Women in Development

The Social Analysis Section discusses the role of women and the relationship of this project to the women of Cameroon. There will be meaningful involvement of women in the teaching and training aspects of this project. Women are also expected to benefit from the educational services of the project.

### Social Analysis

Visitations to the project areas have been made by the project design team and discussions have been held with villagers who will be involved in this project. Some of the opinions of the villagers and informations obtained from professionals and others experienced in village work are discussed in the Social Analysis Section.

### Economic Analysis

A detailed economic analysis is included in Part III., Section D.

### Prior Related Activities

Throughout the Project Paper, references have been made to the relationship of this project to past activities. Essentially, this project will expand upon work which was conducted in the Regional Public Health Training Project (625-519). The key positive elements of the past project have been incorporated into this current project.

### Health Education Materials

Many of the health education materials developed by OCEAC during the past few years will be useful to this project. Additional audio-visual aids will be developed through the services of audio-visual specialists including two volunteers who will be recruited by Peace Corps for this project. Included as an Annex is a list of the materials currently available at OCEAC.

### Research Activities

This project has been designed as a service-oriented program and not as a research project. Any research conducted will be considered a "spin-off" of on-going project activities and in no way should interfere with the service priorities. Some baseline data at the village level will be collected as part of student training activities.

### POTENTIAL PROBLEMS

In addition to the issues raised by the Executive Committee consideration should be given the following potential problems which have been raised during the development of the project paper.

#### 1. Contractor Personnel Selection

The quality of the contractor personnel will be a key factor in the success of this program. It will be essential that the contractor have the necessary qualifications to work effectively within the Cameroonian system (see Annex for qualifications). The essential requirements are a strong community service orientation with extensive experience in the training of field level workers in developing countries and fluency in French.

Because of the organizational and administrative nature of this project a representative of the Ministry of Health/Cameroon should be invited to Washington to participate in the selection

process. The success of the collaborative effort depends upon complete understanding of the opportunities and constraints on the part of GURC and the contractor.

2. Number of Project Participants

Due to the large number of project participants, there is potential for breakdowns in coordination and communication. A new set of relationships will be established among all participants which is intended to minimize this potential communication problem. The project organization structure through the coordinating Committee has been designed to facilitate effective coordination.

3. Number of Project Students

During the design of this project paper, considerable enthusiasm and interest was expressed by the participants to have students trained by the project. Some of the participants have indicated a need to have field training occur in villages close to Yeoundé and main transportation arteries. The question arises therefore, that some of the villages may be "worn out" by having too many students. The project staff will need to be sensitive to this potential difficulty and make special efforts to assure that villages are not over-used for training purposes.

4. Number of Committees

The projected number of health committees to be formed may be too ambitious. This question was discussed with host country personnel who felt that it was possible to establish the number of committees indicated in the PP.

The success and accountability of committee effort should consider that some committees will be in different stages of development by the end of the project. Some may be fully effective, while others may be struggling in early stages of development.

5. Difficulty in the Kadey District

The migratory and mobility pattern of the Baya in the northern Kadey raises some questions regarding whether the experiences gained and methods developed in the Méfou can be transferred to the Kadey region. Any effort at broadening the project to the northern Kadey should be done only on an experimental basis. Special attention should be given to the fact that the majority of the population are not in villages for nine months out of the year. A reassessment of Peace Corps involvement in the northern Kadey should take place.

## PART II. PROJECT BACKGROUND AND DETAILED DESCRIPTION

### A. BACKGROUND

Although considerable progress has been made to improve the health status of the population in Cameroon, the need is crucial to take positive action on a broader scale in rural areas. For example, according to the 1975 World Population Reference Bureau, the life expectancy in Cameroon today is 41 years; in North American it is 71 years, a difference of 30 years, or more than one generation. The infant mortality rate in Cameroon is 137 per 1,000 live births while in North American it is 13, making the rate almost 7 1/2 times higher in Cameroon. The dietary energy supply for Cameroon varies greatly according to availability of food supply within different geographic regions and according to cultural food habits. For Cameroon the kilocalories per person per day is 2,410; in North American it is 3,320. The rate of population growth in Cameroon is 1.8% per year while in North American it is 0.9%.

Recognizing the governing realities of limited material resources and scarce trained health personnel, the health strategies of the governments of the Central African Republic, Gabon, Chad, and Cameroon all direct their attention to preventive health programs aimed at rural populations:

- the Cameroon Government's plans and priorities in the health sector, Central West Region Development Assistance Plan, 1975, p. J-86; (CWR DAP) stresses the need to "direct the focus of services to preventive medicine directed at the rural population, to increase both the quality and quantity of health manpower development and to promote medical research and data collection";
- the Government of the Central African Republic expressed the development of "basic health services throughout the country and the training of qualified health workers at all levels", specifically through "preventive programs directed at rural populations" as a priority in its Second Plan (CWR DAP 1975, p.K-65);

Gabon's Fifteen-Year Plan for the Development of Health Services: 1966-1980 (CWR DAP 1975, p. L-13) established "the training of health workers at all levels" and "the development of a national health education program" as two of five priorities;

Chad's Ministry of Health, in an address to the recent Regional WHO Annual Conference in Yaoundé, reiterated its recently adopted three-pronged approach for developing a comprehensive, integrated rural health delivery system, on being "re-establishment of the operation of the present system, involving a program for the 'recyclage' of all levels of existing health workers at regular intervals".

It has been further estimated that while Cameroon's current health budget cannot reasonably be expected to provide adequate curative care for the rural population, it would take only 75% of this budget to provide adequate preventive care. While it may not be feasible to devote a full 75% of the budget to preventive care, it is recognized, as a sounder long-range investment of the health dollar, and accordingly, the Ministry of Health has emphasized the priority of health education (and specifically this project), in the Health Sector of the Fourth-Five-Year Plan (1976-1980).

The strategy which both the CWR DAP 1975 and the Chad DAP 1976 recommended for the development of AID programs in the health sector follows closely the government priorities cited above. Specifying a need for Cameroon, one which could be said to apply to all of the African developing countries, the DAP also states that "Perhaps the key to improvement of the health sector in Cameroon lies in human resources development broadly defined. That is, via projects designed to meet the first goal mentioned earlier, 'to increase the ability of the people of Cameroon to participate in development activities by providing comprehensive curative, preventive, and health education services', and via conventional training programs aimed at increasing the quality and quantity of available health personnel". (CWR DAP 1975, J-82).

This need for the Africa Region has been recognized and given the priority it deserves by international organization such as the World Health Organization, which has identified "education, training, and national health planning" among its priority objectives for

Africa. Accordingly, WHO has designed a regional program to train Africans in health education at upper levels (baccalaureate and Master's degree levels) with the goal of providing much-needed trained health manpower who can, among other things, ably participate in national health planning. (This program, which will be based in Yacundé, and is scheduled to begin in September 1976, is discussed in the Annex).

Recognizing that health planning at the highest levels must be in conjunction with motivation of the rural sectors, USAID, in the Congressional Mandate document, is directed to give attention to programs in which "decisions about development programs are made in cooperation with the poor to the fullest extent possible and "programs in which implementing development programs becomes a learning experience for participants, yielding lasting improvements in their skills". In order to accomplish this, Africa Health Strategy "Health in Africa", AID-January 1976, suggests certain priorities:

- a phased approach to the development of an integrated rural health delivery system which includes elements of disease control, planning, sanitation and nutrition
- The strengthening of the health system infrastructure including administration, planning, information system, health education, and manpower development
- Coordination of the activities of the various donors in the health sector.

These two WHO and USAID approaches underline the need, as stated by the African governments cited above, for health manpower development at all levels, and the need for bringing these levels together in a common effort to meet the needs of the great mass of the population -- the rural populations and other underprivileged groups. Common to all of these priority statements are the need to direct the health effort to the rural populations, the need to involve the rural populations in preventive self-help programs, and the need to improve the quality and quantity of existing health personnel.

It is precisely these national and regional needs which this project, Practical Training in Health Education, addresses. The project is part of a phased approach to the development of an integrated rural health delivery system which strengthens the health system infrastructure and coordinates donor activities.

The attainment of the project purpose, or the development and active functioning of such a system of health education activities addresses the broader sectoral goal of "increasing the ability of the rural population and other underprivileged groups to participate in development activities by providing comprehensive health education services."

This project builds upon the success of the "Village Health Committee" approach to rural health problems implemented in Chad's Farcha Zone, Central African Republic's Biombo Zone, and Cameroon's Méfou Zone. The village Health Committee approach was developed in the course of the AID Regional Public Health Training Project (625-510) over the past three years.

The national significance of Village Health Committees was set forth in an official address by the Minister of Public Health on January 31, 1976 in Méfou. He said that the Cameroon government policy of public health "has as its major thrust the active participation of the rural masses in health matters through the medium of the village health committees".

The importance of the village health committee movement was also demonstrated at the recent OCEAC Second Annual Regional Health Education Conference held in Yaoundé, March 22 - 25, 1976. The theme of the conference was totally devoted to village health status and to village health committee development. The keynote address given by Dr. Atangana, Associate Director for Public Health and Preventive Medicine, JIRC was, "The Concept of Village Health Committees". An editorial in the April 6 issue of the Cameroon Tribune on the Ministry of Health Press Conference reflects the attitude of the mass media and public press toward the importance of preventive medicine.

"If this position fills us with legitimate pride, it should not, however, make us forget that we are far under the international standards in the field of health. A lot of efforts are still necessary. That is why we are all invited to take an active part in the promotion of health; mainly in the field of preventive medicine which presently takes up the first place in our public health system. This medicine aims at protecting healthy people against diseases. It is not an expensive one and it is within the reach of most people. Doesn't the well-known old proverb say: "an ounce of prevention is worth a pound of cure"? It is therefore important that each Cameroonian be the maker of this new strategy with a view to protecting our populations, a precious capital which is necessary to the building of a stronger nation".

Academic institutions are seeking ways of introducing practical training in health education in the curricula for the undergraduate program and of expanding whatever practical training may currently exist. In a sense, a social momentum is being generated to focus on problems of local relevance. The timing of this project is critical as a mechanism to implement these interests.

Two other AID Projects are related to this project:

The University Center for Health Sciences (CUSS) Project (625-531) provides (1) four technicians who serve on the CUSS faculty and work in maternal and child health at Yaoundé's Central Hospital and (2) funds for the construction of the MCH wing and outpatient center of the new CUSS teaching hospital. PTHE's health education activities in the Méfou and Kadey district will benefit, directly or indirectly, those members of the health team trained at CUSS. The PTHE activities will provide a field situation which contributes to the team approach to medicine, with members of the health team working together and reinforcing each other. This approach coincides with CUSS's philosophy of community projects.

Through an Operational Program Grant (OPG) to Catholic Relief Services for North Cameroon Rural Health Education, AID is assisting twelve rural mission dispensaries with training field and middle-level health workers and carrying out community outreach activities similar to those envisaged under PTHE. Should the Government of Cameroon decide to implement the system of health education activities developed under PTHE throughout the country (as has been indicated), these activities would provide an invaluable base for further expansion and development.

#### SUMMARY OF BACKGROUND

Primary and secondary preventive measures exist which can improve both the length of life and also the quality of life. Based upon the experience in Central Africa, health education, which is directed toward assisting villagers to carry out preventive measures themselves is the approach with the greatest potential value for the people of Cameroon.

B. DETAILED DESCRIPTION

Considering the problems of health and development in the Cameroon and the GURC's commitment to rural health services as presented in the DAP and GURC public decrees, the agencies involved in international assistance have committed their resources in support of this commitment.

This commitment takes the form of intervention through health education and community development.

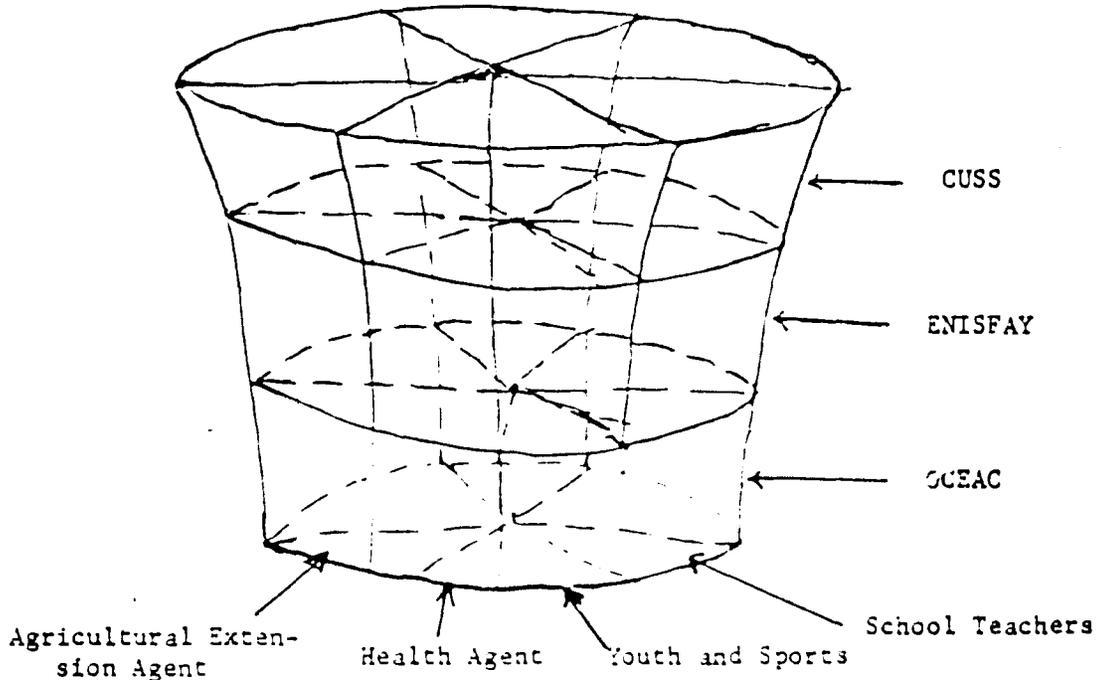
The PTHE project will address this commitment through the provision of five types of activities: (See pg. 3) for financing of these activities).

1. formal training of health personnel at the University level,
2. recycling of current field level health workers for refresher courses in health education,
3. introduction of health education into the formal primary school system through training in health education of existing primary school teachers,
4. assistance in the formation of village health committees for the purpose of disseminating health information and motivating villagers to take specific action to improve their health environment,
5. training in health education of existing personnel working in other areas of development. The project will provide three technicians who will work with counterparts at the MCH, D and will assist the MCH in implementing project activities.

The conceptual model of the project is presented below. For purposes of description, the parts of the model will be discussed separately although it should be borne in mind that the model represents an integrated whole, the parts of which have to be time-phased to achieve the project purpose.

CONCEPTUAL MODEL OF PROJECT

(Integration of Village Activities for Health Education)



The vertical lines represent the various government and private agencies which may be operational in any village or rural area.

The horizontal tiers of the conceptual model represent different levels of involvement of academic institutions. All of these institutions will use the project activities to provide practical experience for their students.

The vertical lines represent service agencies addressing the needs of the rural population of the Méfou and Kadey districts. The specific activities and their objectives are discussed in detail in this section.

The first layer of the model represents OCEAC, the institution providing training for agent itinerants and the recyclage of nurses into health specialists in a six months program. The second layer in the model represents ENISFAY, the institution preparing sanitarian technicians, nurses, and midwives. The third layer represents CUSS, the institution preparing students in health education at the baccalaureate and Master's level.

The general purpose is to develop the area in a socio-economic sense. Although the Ministry of Health is organizing and directing the PTHE, it does not have the resources and personnel to cover the entire project zone. One alternative to solve the personnel problem is to train enough new health workers to cover the entire area. However, the future employment status of a large number of such trainees after the project terminates is questionable. Therefore, the Ministry has decided to train only 120 new workers for which it will be able to provide employment.

The second alternative selected by the MCH/C is to retrain present workers in a recyclage program. The activities of dispensary personnel which have been largely curative and limited to the dispensary will be expanded to include the health education and preventive aspects in the villages surrounding the dispensaries.

In addition, the Ministry intends to "seed" health education activities into activities of the other governmental agencies represented by the vertical lines in the conceptual model. This effort will be carried out with the concurrence and cooperation of all the Ministries involved. This is a new development since the PRP was prepared. The purpose is to integrate and reinforce the efforts of the various extension agents working in the villages. It is conceivable (this has happened in the past) that private organizations or well organized and economically self-sufficient villages will appoint a candidate to be trained in the PTHE project. Such organizations/villages will ensure the employment of such an agent once he has been trained.

Peace Corps volunteers involved in the project will be administratively under the control of the Ministry of Health. The involvement of the Ministry of Education is through primary school teachers in the villages who will receive in-service training in health education. This aspect of the project is discussed in more detail later in this section.

The Peace Corps volunteers and Ministry of Health personnel will work directly with villagers, dispensary personnel, primary school teachers, and students from the academic institutions.

Specific education objectives for the students will be different depending on their academic standing. It will be possible, for instance, to have CUSS M.P.H. students and OCEAC students in the field at the same time and place. They will be studying the system from different perspectives which integrates with their theoretical courses.

The following kinds of learning experiences will be provided in the villages to:

(1) Motivate villagers to form Village Health Committees and assist these committees in dealing directly with improving the health environment of the village (through such activities as digging latrines, protecting water sources and building enclosures for animals) and give basic health education instructions (simple cleanliness, causes of illness, maternal and child health) to the villagers.

Approximately 20 MOH/C field-workers are already trained and working in the Méfou and have forty-three operational Village Health Committees. These employees will continue to function actively in the Méfou and, assisted by one of the project technicians, will organize, supervise, and provide technical assistance to approximately 350 new Village Health Committees.

PCV/Field-workers and newly trained field workers can reasonably be expected to organize, supervise, and provide technical assistance to approximately 738 village health committees in the Méfou and Kadey districts. Five hundred health committees in the Méfou zone will constitute a 100% coverage in addition to 43 already operating in the region. In Kadey 233 health committees at the end of 4 years will constitute a 100% coverage. There are no village health committees operating in this area at the present time (see Annex G: Magnitude of Output). Thus 260 field-workers trained under the program, assisted by other newly-formed health personnel and recycled health cadre, and encouraged by MOH/C recognition of the Village Health Education effort will be working actively in the field to continue and expand this phase of health education activity.

(2) Teach existing dispensary personnel how to give instruction to patients and teach families, actually giving some health education classes instruction to villagers at clinics when necessary, increasing the health education expertise of the dispensary personnel. The target will be a total recycling of 150 health workers in the Kadey and Méfou districts, i. e. 100% of the existing MOH/C health workers in these areas (see Annex G: Magnitude of Outputs).

(3) Develop and implement in-service training program in health education for 511 primary school teachers in the Méfou and Kadey districts. Under the direction of project technicians and in cooperation with the MOE/C and appropriate administrative authorities, seminars and workshops will be held for teachers at mutually convenient locations. Faculty for the in-service program will be drawn from appropriate resources so that teachers develop an integrated concept of health services, health instruction and health environment for their classroom teaching.

PCV/Audio-visual specialists will develop teaching materials which will be used during the in-service program so that teachers will be better prepared in knowing how to use the materials in the classroom. Teachers will also learn how to prepare their own teaching materials. One of the lasting benefits of this project will be the strengthening of the teacher's position, to participate and provide leadership in the village health committee effort as well as to use the results of the committee effort to demonstrate to the children how to improve village health conditions. During the four years of the project, 171 teachers in the Kadey district, and 340 teachers in the Méfou district, a total 511 teachers in 181 schools with approximately 33,548 pupils as well as administrative authorities, will be affected by the project. (See Annex for protocol uses in in-service training programs).

#### Health Training Institutions

WHO/CUSS, OCEAC, and ENISFAY training programs will be supplemented by a practical training program in Health Education reaching approximately 613 future health workers in the life of the project. (See Annex G: Magnitude of Outputs).

#### WHO/CUSS

There are not health education students enrolled for an academic degree in health education in CUSS at the present time. The degree to establish the B.Sc. (H.Ed.) and the M.Sc. (H.Ed.) has been presented through the appropriate University channels and is awaiting final approval (see Annex).

It is the intention of WHO/CUSS to augment the academic curriculum of baccalaureate and Master's candidates in health education with a practical training program to be developed by this project in the Méfou and Kadey districts. This field training program will provide learning experiences for the students at all levels of project activity in the Méfou and Kadey districts: organizing and implementing activity at the village level and motivating, supervising, and evaluating personnel at the village and provincial levels within the local health infrastructure.

Examples of specific areas of student activity include evaluating different health education models for effectiveness in various part of the country's carrying out portions of operational research for the PTHE appropriate to the levels of competency and ability of students and learning needs of students, i. e. research on village health committees; carrying out community organization work in the villages; training health workers in the use of educational methods and media; assisting school teachers in the teaching of health in the schools and organizing activities for students, teachers, and parents related to health problems in the area.

As part of its effort to reinforce the concept of the health team, CUSS will use the project facilities for its 4th year medical students, (about 45 students), 3rd year technician students (about 20), and 1st year nursing students (about 20) in addition to the health education specialists. In all, about 100 CUSS students will be expected to use project facilities each year.

CUSS will continue to conduct other field training programs so it should be noted that participation in this project represents an expansion of existing effort.

#### OCEAC

The Organization for the Coordination of the Fight Against Endemic Diseases (OCEAC) is a regional organization serving the health interests of five Central African countries (Cameroon, Gabon, Central African Republic, Chad, and Congo). OCEAC carries out basic medical research, provides epidemiological services and recycles health personnel from member countries. Recycling programs currently include a six-month course for state-registered nurses and a two-month course for itinerant health workers. OCEAC plans to expand the current six-month course into a two-year diploma course (in Tropical Public Health) to begin in September, 1977 at the request of the OCEAC Ministry of Health in order to increase employment opportunities for the students.

Personnel participating in these OCEAC recycling courses are identified from Ministry of Health cadres, remain on government payrolls during their training, and return to positions in their respective governments at the end of the training period. OCEAC has requested the PTHE project to provide a Health Education component for these two groups, including didactic instruction as well as practical training. During the life of the project, OCEAC will offer training for approximately 120 health workers and 100 nurses. Scholarships will be provided for 60 participants from other OCEAC countries.

Therefore, during the life of the project a total of 220 participants would be trained at OCEAC, 120 of whom would be from Cameroon and 100 from other Central African countries. The project technician directly responsible for training programs would work extensively with this phase of OCEAC participation.

#### ENISFAY

The National School of Nurses and Midwives/Yaoundé (MOH supervision) requested PTHE assistance in developing and carrying out practical field experience in health education for its sanitarian

technician, nurse, and midwife program. PTHE will provide a practical training program for a total of 313 ENISFAY students (of which approximately 78 are from Chad) over the life of the project. The plan is to have a group of 15 students every month acquire their field experience from project on a continuous basis throughout the academic year. Each group of students will comprise students from all the classes in the institution.

In addition, project technicians will serve as faculty to the ENISFAY staff providing one five day seminar each year, in addition to other consultive assistance. The director of the school has specifically requested that all her staff members be allowed to benefit from these health education seminars.

#### Summary of Detailed Description

There are numerous assumptions which are common to health projects in developing countries such as "continued government support of the health sector", availability of personnel for training, etc. (Annex A). Two major assumptions have been implied in the planning of this project. The first is that future health education personnel for Africa should acquire their practical experience along with health education theory in an environment in which they will eventually work. Given the fact that the health priorities of the Central African countries are rural-oriented, it makes sense for future personnel to have some experience working in such an environment.

The second important assumption made is that villagers will participate in the effort to improve their health. It is conceivable that at the beginning of the project and its relevance to their everyday problems. It is exactly this problem that the service objective of the project addresses itself, to educate the villagers to understand that morbidity is a limiting factor to their socio-economic advancement. Action to control disease is of course implied in the acquired knowledge.

This practical training system will develop teaching settings in which students representing all members of the health team can work together in learning how to provide health education services applicable to other francophone countries of Central Africa. It is also the intent of the PTHE to provide settings for health workers to learn how to function in the face of different challenges, how to make observations, analyze data, draw conclusions, understand concepts, understand how villagers make decisions for change, and how to teach people. The system will provide situations in which the students are expected to do these things, are helped to do them, and are rewarded if they do them well.

Through this project it will be possible to determine on a prospective basis where and how to provide the greatest impact for village improvement. Plans can be made in advance for the number and the types of workers and students to receive practical training as well as the number of teachers who should participate in the program simultaneously. Coordination of the training of these people in a selected geographical area makes it possible to achieve a cumulative effect in a short time with maximum benefits.

### PART III - PROJECT ANALYSIS

#### A. Technical Analysis including Environmental Assessment

The appropriateness of this project for immediate implementation in Cameroon is examined from two viewpoints: the cooperative arrangements organized to administer and implement the project, the quality of the training program provided by the project. Environmental assessment is included at the conclusion of this section of the Project Analysis.

This project has several features for African countries which means that the data to validate the soundness are based upon past experiences in other programs and projects, assessment of current needs, and the commitment shown by the MOH/C and other participating groups in the development of this project.

These features are:

the establishment of a collaborative mechanism for service agencies, academic institutions and international groups to participate together in a practical training effort to solve rural health problems,

the MOH/C central role in coordinating the effort of different institutions in practical training in health education,

the utilization of workers from other sectors in solving health problems,

the re-orientation of undergraduate preparation of health professionals to the relevant rural health problems of their country,

the opportunity to provide teaching settings where village, mid-level and upper level health workers can learn how to work together to solve health problems,

the opportunity to define more precisely the kinds of operational research needed to improve the self-help effort in the villages.

Details of the technical analysis follow:

Cooperative Arrangements for administration and implementation

The problems of the relevance of the training of health professionals and other workers to meet community needs is a universal one. Although this particular kind of cooperative arrangement to solve the problems is new to Cameroon and Central Africa, experience in programs elsewhere shows the validity and reliability of the approach. For example, in the USA, the Carnegie Commission on Higher Education recommended such a collaborative arrangement in this study on higher education of health professionals published in 1970. As a result, different kinds of administrative structures have been established, linking community health services and educational programs. Some of these programs are called Area Health Education Centers, some are called Health Service Education Activities, and some are called Community Health Education Service Cooperations. The thrust is to re-orient health professional training to meet community health service needs based upon current problems rather than on elite intellectual subjects, remote from the needs of the people. Over one hundred programs have been established with government and private funding all over the United States during the past five years.

The purpose of citing this example is to indicate that a body of management and professional educational experience is available which demonstrates how the many linked units of a program of this kind can be molded into a cohesive effective force for local health improvement.

The current needs in Cameroon to coordinate practical training are evident from the different approaches already in existence and the emergence of a broad-based recycle program also directed toward practical training in health education. The alternatives to a coordinated approach are for each group to conduct its own program, independently, or by having one institution or agency conduct all of the training.

The first alternative of independent action tends to isolate students from interaction with other disciplines and from the other levels of administration and program development. It also results in duplication of services for some villages and uneven distribution of resources, with some villages receiving no assistance. The second alternative of one institution conducting all the training

restricts the spectrum of training to that particular institution, diminishing the learning potential inherent in a mix of students of different levels and backgrounds. It also curtails the creative innovative training designs so essential to solve the current village health problems within the existing culture. Although both of these advantages of the coordinated approach appear to outweigh its more complicated amangement.

A coordinated approach, the one described for this project, reduces fragmentation of effort, provides the interrelationships of health with socio-economic development activities, and makes optimal use of manpower and resources.

In analysing this project for Cameroon, a major strength exists in the favorable and encouraging support by the MOH/C and the participating agencies. The level of involvement within the administrative hierarchy of the MOH/C, the amount of executive time devoted to the development of the project, and the official addresses describing the village health committee approach speak strongly of the commitment to the coordinated approach presented in this project.

#### Quality of Training Programs

The training program conducted by OCEAC for the village level worker is the model which will most likely be applicable for expansion for the recyclage program and for training new village level workers. The training program is of two months duration with one month of didactic instruction and one month in an apprenticeship in a village with a trained field worker. Supervision is provided by trained experienced field workers.

The identification of the appropriate control measures and preventive procedures to be taught in the training program was made initially by a group of OCEAC and MOH/C specialists in preventive medicine and health care. Task analysis was not applied systematically for the design of this training program but after workers had been on the job for several months or a year, they were asked to write a list of their job tasks, problems encountered, and resources used to cope with the problems. So a task analysis approach is not new in Cameroon although it has had limited application.

The present field training at CUSS does not include students in health education since that program has not yet been established. However, there is a very active program to introduce medical students, nursing and technician students to health education concepts in the field. Objectives, process, and outcomes are detailed and applicable to the urban/rural areas around Yaoundé. This project will expand existing efforts and provide a wider range of inter-disciplinary experience.

No practical field work training exists at ENISFAY at this time. The enthusiasm and interest of the Director of the Program at ENISFAY for this project indicated that a high level of cooperation can be expected once the PTHE gets underway. The training in health education for ENISFAY faculty assures incorporation of educational principles in the curriculum on a long range basis and is additional evidence of the commitment of ENISFAY to the purposes of the project.

The recyclage program of the MOH is on a limited scale at the present time and undoubtedly will expand to meet different program needs of the Ministry. This project can contribute a great deal not only in content but in over-all program organization, design, and evaluation.

Although a comprehensive analysis of the existing training programs could not be undertaken in the context of preparation for the project paper, an assessment of the quality of the training effort shows a strong capability for the expansion and coordination planned in this project. The Chief of Project and the technicians for the project will need to have the closest collaboration with the academic and recyclage faculties to achieve the objectives of service/student learning.

#### Community Organization

The community organization methodology adopted by the Regional Public Health Education project consists of four interrelated stages. The first two stages consist of community contact and problem analysis and education. The first stage as it has been applied in the Méfou district emphasizes that the worker gains the acceptance of the community. The worker's responsibility is to analyze the community structure, i. e. power relationship, communication activities and leadership patterns.

The next step of communication and education follows as integral part of the dialogue with members of community. The worker's role is to assist in the education of the community through problem identification, problem analysis and exploring different means of intervention.

The third and natural extension from individual and small group education is the committee which identifies the problem, the means of intervention and resolves it through a project activity.

The frame work of the community organization approach has proven effective in the Méfou region. The implicit recognition is that change can only be valid when it is accepted by the individuals of the group.

The method developed is sound and there is no reason to believe that it will not succeed.

Environment Assessment

The goal of the PTHE is to improve the health environment of the rural populations of the Méfou and Kadey districts through broad based education at the village level. Since the thrust of this project is basic health education combined with the very limited construction activities necessary for building latrines and safe water sources, this project poses no danger to the environment.

B. Financial Analysis and Plan

The project presently has eight participants with the possibility that additional participants could become involved at a later date. The present financial participation is projected in the following chart.

<u>Participant</u>	<u>Total Project Contribution (\$000)</u>
GURC	1,236
USAID	1,954
USPC	596
OCEAC	413
WHO	316
CIDA	164
UNICEF	240
TOTAL	<u>4,918</u>

The financial participation of GURC of \$ 1,236,000 (276,074 million CFA) comprises 25% of the total project costs. The MOH/C plans to meet these obligations from the allocations expected in the 1976-77 and future budgets. The 1976-77 budget which begins July 1, 1976 has been submitted to the legislature for approval. Approval is expected in May or June 1976. The past total GURC budget and the allocations for Public Health and Social Welfare are shown in the following chart.

<u>Fiscal Year</u>	<u>Total GURC Budget (\$ Million)</u>		<u>Public Health + S. W. (B.CFA) (\$Million)</u>		<u>% of Total</u>
1974	74.5	319	3.952	16.9	5.3
1975	34.0	360	4.504	19.4	5.4
1976 <sup>o</sup>	100.0	429	5.249	22.4	5.2
1977 <sup>o</sup>	100.0	429	5.190	22.3	5.2

The GURC has maintained the level of support to Public Health at approximately the same level for the last four years. It is present policy to continue this support or, if possible, to increase it in upcoming budgets. The GURC has stated its support of rural health services officially.

Approximately \$936,000 or 76% of the GURC contribution of \$1,236,000 represents direct personnel costs. Of these workers 80% are already on the government payroll. The remainder represents planned expansion in rural health workers via direct hire or transfer from other sections of GURC. The remaining \$300,000 (24%) represents the in-service training costs and scholarships.

<sup>o</sup>projected budgets

Because the GURC contribution represents low recurrent costs the contribution of project related activities should not constitute an unreasonable burden on GURC resources.

OCEAC has been organized by five African states to address common problems in health. One of its goals is to provide education and research in the field of health for its member states. It has successfully managed a budget of \$250,000 over the last three years and has provided considerable inputs into this project. OCEAC has also worked with USAID in previous health projects.

The remaining participants (WHO, UNICEF, Peace Corps, CIDA) have also had considerable experience in managing sizeable budgets in programs in Cameroon.

SUMMARY COST ESTIMATE AND FINANCIAL PLAN

Source	AID		Host Country		Peace Corps		UNICEF		WHO		CIDA		OCEAC		TOTAL
	FX	LC	FX	LC	FX	LC	FX	LC	FX	LC	FX	LC	FX	LC	
Technical Assistance	1263		800		510				270		140		165		3148
Recyclage		80	28				30						85		223
OCEAC Scholarships		30											80		110
CUSS Scholarships		185	160												345
Participant Training	45														45
Four Annual Health Confs.		40													40
Mid-Project Evaluation	25														25
Commodities	55						170								222
<b>Sub-Total</b>	<b>1388</b>	<b>335</b>	<b>988</b>		<b>510</b>		<b>200</b>		<b>270</b>		<b>140</b>		<b>330</b>		<b>4161</b>
Inflation	90	50	148		36		20		19		10		50		423
Contingency	72	19	100		50		20		27		14		33		335
<b>TOTAL</b>	<b>1550</b>	<b>404</b>	<b>1236</b>		<b>596</b>		<b>240</b>		<b>316</b>		<b>164</b>		<b>413</b>		<b>4919</b>

COSTING OF PROJECT OUTPUTS/INPUTS PP (\$000)

Project #/ 631-0009

Title: Practical Training in Health Education

Project Inputs

Project Outputs

	1. Village H.C.	2. Curriculum Dev. +Teacher Training	3. Field Health Workers Trained in Service	4. Academic Training	TOTAL
AID appropriated	600	420	448	255	1723
Host Country	400	200	220	160	980
Other Donors:					
UNICEF	50	30	120		200
WHO				270	270
OCEAC				330	330
CIDA				140	140
Other U.S. Peace Corps	200	310			510
<b>SUB-TOTAL</b>	<b>1250</b>	<b>960</b>	<b>796</b>	<b>1155</b>	<b>4161</b>
<b>INFLATION ALLOWANCES</b>	<b>127</b>	<b>98</b>	<b>81</b>	<b>117</b>	<b>423</b>
<b>CONTINGENCY ALLOWANCES</b>	<b>101</b>	<b>101</b>	<b>65</b>	<b>88</b>	<b>335</b>
<b>GRAND TOTAL</b>	<b>1478</b>	<b>1159</b>	<b>942</b>	<b>1360</b>	<b>4919</b>

AID Financial Analysis (By Fiscal Year October 1 to September 30)

Expenditures	FY 77	FY 78	FY 79	FY 80	TOTAL
	Year I	Year II	Year III	Year IV	
<b>1. Personnel</b>	554	315	315	79	1263
a) long term (ten months)	(36)	(36)	(36)	(36)	(144)
b) consultants (ten months)			25 (3)		25 (3)
<b>2. Participant Training</b>					
Host Country	144 (372)	113 (372)	113 (372)		340
<b>3. Commodities</b>					
Vehicles (3)	127	3	3	3	139
FOI. FOR FOI IC	4	4	4	4	16
<b>4. Other Costs</b>					
Annual Health Education Conference	10	10	10	10	40
<b>SUB-TOTALS</b>	<u>712</u>	<u>445</u>	<u>470</u>	<u>96</u>	<u>1723</u>
INFLATION FACTOR	20%	(47)	60	13	(140)
CONTINGENCY FACTOR	(18)	(28)	(37)	(6)	(91)
<b>GRAND TOTAL</b>	<u>(750)</u>	<u>(520)</u>	<u>(567)</u>	<u>(117)</u>	<u>(1954)</u>

### C. SOCIAL ANALYSIS

The social analysis is presented according to the guidelines required by AID for the Project Paper. There are three distinct but related aspects: (1) the compatibility of the project with the socio-cultural feasibility; (2) the likelihood that the new practices or institutions introduced among the initial target population will be diffused among other groups; and (3) the social impact or distribution of benefits and burdens among different groups, both within the initial project population and beyond.

In Cameroon where the economic development is so closely linked to the resources of the land, the socio-cultural patterns of man directly correlate with the physical conditions. The PTHE project will be established in two districts of the GURC, the Méfou and Kadey. A brief geographical and physical description of these two districts provides the picture of the environment in which the project will operate.

#### MEFOU

The Méfou district is the second most densely populated rural area of Cameroon with an approximate density of 40 persons to square kilometer based on 1968 statistics. Yaoundé, the capital and second largest city is in the Méfou district. Located on the Adamaoua Plateau with elevations ranging from 900 meters to 1,500 meters of gently rolling hills, the area is covered by tropical rain forest. Méfou is 255 kilometers from the Atlantic Ocean and 175 kilometers from Gabon, one of Cameroon's three neighbors to the South.

The district has an average of 125 days of rain per year in two rainy seasons, with peaks in May and October; the drier months are July and December. The abundant, though not excessive, rain provides the climatic conditions for its main agricultural cash crops of coffee and cocoa, as well as staple crops of manioc, plantains, cassava, maize, and bananas.

This project will involve the major ethnic grouping in rural Méfou, the Ewondo. Other smaller groupings are the Evouzok, Mvélé, and Ntoumou. The local language spoken in the Méfou is Ewondo, although a large percentage of the population speak French as well.

## K A D E Y

The Kadey district is east of the Méfou and borders the Central African Republic, one of Cameroon's two eastern neighbors. The Kadey district differs markedly from the Méfou district in geography and has a population density of only 5 persons per square kilometer (approx. estimate, 1968 statistics). The climate of the Kadey district is similar to the Méfou except that there are variations in the rain fall resulting in a transition between the tropical rain forest of the Méfou to the savannah of the North.

Batouri, the district capital and the largest town, is easily accessible by road year-round. Ndélélé, the second largest town is in the south/eastern corner of the district and is inaccessible at times during the rainy season. A bridge construction projects currently underway will alleviate this problem.

Concentration of populations follows very closely the main transportation arteries and the banks of the Kadey river and its tributary, the Doumé.

There are differences in the population distributions between northern and southern Kadey. The northern Kadey consists primarily of savannah and includes approximately three-fifth of the population. The southern Kadey consists mostly of rain forest and contains the remainder of the population.

In the North, the most important ethnic group is the Baya. Additionally, there are several villages of sedentary Bororo. The Bororo and Fulani also migrate through the area from North to South with their herds of cattle following established grazing patterns. In the southern forest region the Kakas are the dominant ethnic group.

The distinction between the northern and southern region is also reflected in the economy of the area. In the South the cash economy revolves around cocoa and coffee and lumber.

Because of the increasing demand for tobacco since the '40's, the northern savannah has witnessed an important change in its economy. Tobacco has dominated the economy of the Baya people. The Cameroon Tobacco Company (Société Camerounais du Tabac) plays a very important role in the economy of the area. According to a Kadey government official, Cameroon, in particular the Kadey region, has surpassed Indonesia as the World's first producer of cap tobacco (tabc de cap).

There are important socio-economic effects experienced by the people of Kadey because of Tobacco cultivation. These effects have serious implication for the project and are discussed in the PHE.

The compatability of the project with the socio-cultural environment is discussed in the next section.

## (1) Socio-Cultural Feasibility

The first aspect of determining the socio-cultural feasibility is understanding the social mapping of the area, knowing where villages are located, the social family structure, roles of authority and responsibility, division of labor between men and women, and patterns of influence in health and education.

The people in the Mefou are primarily farmers who live in loose hamlet groupings located along the roads of communication. Generally, there is a dispersion of houses along main transportation arteries, without a large grouping of villages around a central point. In the Kadey district, villages are widely scattered and there are few "main transportation arteries".

The family unit is headed by the man and property is passed on through the men. There is a highly structured division of labor within the family, with the women responsible for the majority of the tasks that are life giving, raising and caring for the children, growing the food, cooking and tending the house. The men are responsible for the cash crops, coffee, cocoa. The predominant religion in the area is christianity, although many traditional beliefs still remain and play a major role in the life of the people. Of special significance to this project are the tabcos and traditional medicine men. A study conducted by Louis Mullant of a Evouzok village revealed forty medicine men for a population of two thousand. His study shows that the role of the medicine man may be apprenticed, inherited, or acquired. Women, as well as men could be medicine men. Success is determined by the number of people who ask for his services. The importance of the medicine man is further underlined by the division of the hierarchy of tasks performed by sorcerers, diviners and big medicine men.

In some villages savings and social associations may exist consisting of either men and women meeting regularly. At each meeting dues are collected and turned over to one of the association members. At the next meeting the collected dues will be given to another member. This process continues until all members have received collected dues and then the cycle is started again. These groups may also play an important social role in the village.

In African villages today, and especially Cameroonian villages, the government effort to improve the socio-economic status of the people is represented by development committees. These committees represent the various ministries of government. In the Mefou and Kadey districts in Cameroon, some villages have rural animation committees, youth and committees, etc. The political party plays an active role in village life with a party cell in every village with an elected chairman. In addition, these government supported structures attempt to solve the every day problems of the villagers and to stimulate general socio-economic development.

The problems of socio-economic development from the point of view of the villagers are single identifiable problems. However, a single problem may fall administratively under the auspices of two or more government ministries. If each Ministry tries to create a committee in each village to solve villager's problems in a sectorial and parallel approach, confusion and conflict can result. For instance, a rural agricultural committee sponsored by the Ministry of Agriculture may be well built into the traditional power structure of the village, therefore, it would reinforce the existing village effort and reduce dilution of effort to introduce health education activities as part of the already existing structure. Coordinated and intergrated efforts between the Ministry of Health and Agriculture would provide an opportunity for villagers to appreciate the necessity for intergrated and coherent effort in the work for socio-economic development.

In a village where no development effort has started, a new structure will be tailored to suit the traditional power structure as much as is possible. In another village where the Ministries of Agriculture, Youth and Sports have initiated an effort, the village health committee could be sub-committee at the same level as the efforts represented by the Ministries of Agriculture, Youth and Sports, etc.

The important point to be made in this section of the Social Analysis is the high degree of compatibility of this project with the socio-cultural environment. The selection of the mechanism for participation of the rural population in solving health problems is based upon the desirability of maximum integration within the existing socio-cultural environment, using existing village structures to implement change.

The thrust of the project is to integrate and use the leadership of the villages and have the initial development execution and diffusion of improved health conditions come from understanding and acceptance of the village leaders.

The term, "village leader" is used in the broadest sense and includes the traditional leaders, party leaders, youth leaders, active women, and dynamic farmers. Through the utilization of already existing structures, it is planned that the leadership will not be over-extended and that the established power relationship will not be disturbed, thereby increasing the likelihood that the impact, as well as spread will be greater.

Conversely, any change brings a degree of social disruption. For example, the creation of health committees will undoubtedly cause some realignment of the present village power relationships and be perceived by some as a threat to their present position. However, the project has developed its initial approach to the villages in a manner designed to minimize the potential for disruption. The first stage of development consists of gaining confidence and acceptance of the villagers through a dialogue with the majority. This stage is also used to explore each individual's awareness of the community health problems and plant the idea that by working together they can bring about a positive change in their current health conditions.

The second stage is gaining official sanction and recognition of the committee's efforts to organize through the local administration generally the sous-prefect. Only after the community has felt the need for the health committee will there be broad representation of all the important political, traditional, and concerned members of the community.

This approach is designed to emphasize the individual's understanding of the need before he is asked to work on a problem.

With each individual's understanding and acceptance the potential for resistance and distrustion is minimized and the potential for acceptance and success maximized.

(2) Likelihood that new practices will be diffused among other groups

The Regional Public Health Education Project showed that the village committee approach to health education can and does work in the Meïou. The Kadey district is much more isolated with less exposure to new ideas. There, the rate of response and acceptance may be slower than in the Meïou district.

Several examples of village acceptance are cited. The village of Ekalie now has a complete and permanently covered water source and eighty families have latrines out of a total population of one hundred-twenty families. Of the forty three committees started in the Meïou area, thirty-six are considered by OCEAO to have had some degree of success and are continuing their effort. Some committees which initially devoted their effort to improving the sanitary conditions of the village have moved into other program areas such as agricultural development. Health committee chairmen would be among the first to point out that for each of their successes they have had their share of bad starts, frustration and opposition. One village health committee chairman who talked with the design team felt that its efforts only scratched the surface and that opposition still existed, but he was proud of the fact that he had been called upon by neighboring villages to give assistance in the development of their health committee.

When asked if the villagers really felt their efforts brought about an improvement in their life, they answered that they most appreciated their new living conditions after a visit to a village which did not have privies or safe water. They realized the differences between the two villages and were quite proud of the development work done in their own village.

In another example, when asked if gathering forage for animals took too much time and trouble, the villager replied by pointing to a row of maize near his house and said that before the animals were penned, it was not possible to grow food so close to home. The new inconvenience was overcome by the benefits of a home garden nearby. This kind of improvement may run counter to tradition under other circumstances, however. Traditionally the care of the animals has been the responsibility of the man. If it is decided that fencing is to be done, the man will have to add to his task the gathering of forage for the enclosed animals. For the women, the enclosure of the pigs and goats will enable her to have garden plots near and around the house (currently fields are far from the village). When there is a lack of forage, the man may let the animals loose with the consequence that animals may destroy the women's garden, causing conflict between the man and the women. The implication of this example points out the importance of examining all the consequences of changes.

The field level worker will be trained to develop community projects in such a way that the changes will not make the villagers' lives much more difficult. Part of the educational process is developing awareness of the trade-offs required in order to receive the benefits of the new health practice.

The efforts in health education at the village level will seek to reach everyone. The development of the health committee will seek to involve village leaders, traditional and political leaders, men as well as women who have shown a concern for their community. The procedure to be used is to have the field level worker do a community analysis, to study the village communication system and the pattern of leadership and influence within the village. Upon completion of this initial survey, the field level worker will be better able to involve the key leaders representing all facets of village life. The purpose of this approach is to improve communication through participation at all levels and segments of the village structure.

The emphasis on broad-based involvement of the village leaders should minimize the potential for disruption of established power relationships; however, experience has shown in one village that a village chief who initially supported the work of the health committee withdrew his support because he felt individual committee members began to threaten the power base he had established. It should be noted that this incident does not appear to be representative of most of the health committee activity.

Since leaders frequently serve as role models within the community, there is a high potential for a spread effect. An example of this spread effect can be found in the village of Ekalie, an earlier "development" village which now has latrines for over half of the families, and a clean, sanitary water source as a result of health committee activities. This success spread to other villages such as Cocca II which, before being approached from the outside, developed its own health committee when it heard that neighboring village, Ekalie, had formed a committee. The health education emphasis in the schools will provide a strong reinforcement for the work of the local village committees and will assist them in their education efforts. The teacher, especially if the teacher is an older person, often serves as a respected leader.

The success of the spread effect will become apparent through the number of successful committees in operation and the types of projects that they develop, i.e. latrines, safe water sources, housing improvements, enclosures for animals, garbage disposal, etc.

The most basic local materials are used as much as possible in the construction of latrines and water sources. This enables the villagers to make improvements at an easily affordable cost.

Similarly health education teaching aids should be made of local materials, involving the teachers in their construction of the learning experience. A greater likelihood of use occurs when the individual has helped produce the material.

One of the ways UNICEF will be involved in the project is to supply cement and reinforcing steel to the villagers for the construction of safe water sources and latrines. Several field workers have indicated that there would be some difficulties involved with providing such supplies to villagers on an individual basis. The field workers also felt that villagers should be encouraged to use available local materials for their own latrines and that cement and other UNICEF material should be used exclusively for communal efforts such as school latrines and water sources.

The village committee segment of the project will have no impact on employment in the Kadey or Mefou district; however, an underlying assumption of this project is that a healthy population is economically more self-sufficient.

### (3) Social Consequences and Benefits

The consequence of the committee effort is improvement in the physical environment and an increased ability to take appropriate action to improve personal health status. One of the outcomes of such effort is a better understanding of how to use local dispensaries early enough to enable easy prevention and likewise, training of dispensary personnel simultaneously to know how to instruct the villagers.

The incentives and reward of the project will come from the improvement of village environment and the improved health conditions that result. The close participation and involvement of the local administration will give recognition and support for those who are directly involved as well as the community at large. There is long-range potential for economic benefits through increased productivity by healthy manpower.

Although patterns of mobility are not a major factor in the Mefou district, women are usually in the fields during the day, returning home in time to prepare the evening meal. The men may likewise be tending crops during the day so that the village may be practically deserted of people of productive manpower age during the daytime. Scheduling of field training experience will need to take this into account.

As stated earlier the economy of the Kadey district poses some major problems for the P.T.H.E., particularly the Peace Corps involvement in the area. The main cash crop in the area is "Cap" tobacco a very high quality outer leaf that is used to make cigars. For nine months out of the year families in the Kadey district leave their homes to cultivate tobacco. They will be in the fields from November through July. Some efforts have been made to convince villagers and young people of school age to remain in the villages and be cared for by a wife or other family

members who are too old to work in the fields; however, this effort has not been very successful.

Field workers who visited several villages in the north during the month of April (the middle of the growing season) have indicated that many villages were almost entirely abandoned and resembled ghost towns. Only a few persons who were too old or too young to work in the fields remained in the villages. In the village of Kiete, for example, over 90% of the population was out in the fields and would not return until August 5th which is when the tobacco company pays the villagers.

Villagers may travel as far as 30 kilometers away from their village to cultivate tobacco, and there seems to be no specific pattern of movement. A villager who may have gone North last year may go South next year. Villagers may return to the same area for no more than two consecutive years because after that period of time the land may be exhausted. In the fields, the villagers construct shelters near their tobacco plots, so there is no concentration of the population. Any health education efforts will be severely handicapped because of such a mobile populations.

Dispensary and clinic personnel are eager to receive recyclage training based upon information received from a variety of sources, therefore motivation of the participants appears to be present. Encouraging dispensary personnel to talk to patients instead of pointing a finger to show where to go next in obtaining help, to assume responsibility for interpreting instruction so that villagers understand them, and explaining preventive measures should increase appropriate use of dispensary facilities.

In-service training of teachers will create a mutually reinforcing environment for health education for both parents and students. The CMSS program offers great benefit in providing experience in a multi-faceted field training setting for administrators, program directors, supervisors and other positions in health education of a management level.

#### Potential Obstacles

The single most difficult obstacle to overcome will be that of trying to create an awareness among the villagers that certain health problems exist and provide the information and motivation which will enable them to change some of their most basic habits such as nutrition, elimination of human waste and child rearing practices.

Potential conflict exists between village traditions and good health practices particularly in the area of nutrition and child rearing. For example some Baya of the Kadey region believe that if a young child is permitted to eat eggs he will become dumb. Another health practice of the Baya is to treat burns by using a bandage of red dirt or salt.

Conflict may develop between the traditional medicine men and the health worker. The traditional medicine man may see the health worker as a threat to his status. To minimize this threat, the health workers must be extremely sensitive to the role of the traditional doctor and where possible should attempt to gain his support. This support will be quite important because the power of the traditional medicine man cannot be discounted. In many cases it appears to have a certain degree of success in the treatment of some illnesses.

As discussed earlier in relation to scheduling, the project may encounter difficulties in the Kadey district and possibly to a lesser extent in Mefou as well. Since agriculture is the primary means of livelihood, villagers spend an important amount of time in their fields located considerable distance away from their village. In the Mefou the amount of time spent in the field is the major part of a work day whereas in the Kadey region the family spend extended periods of time in their fields. Under these circumstances, the health improvement (latrines, water supply, etc.) which have been made and accepted in the village will not be available in their fields. Not only will the potential for improvement of the health conditions be jeopardized but the reinforcement of these improvements is next to impossible in the fields.

The Kadey region present a language problem for persons who are not from the area. This will be a particular challenge for the U.S. Peace Corps volunteers and limit their effectiveness in working with village committees.

Although these obstacles are formidable, the knowledge of their existence is the first step in the preparation of overcoming them. The success to date in the health committee approach reinforces the importance of the villagers themselves playing the key role in deciding how to cope with the problem raised.

#### Role of Women

Women have participated in the planning, designing, and implementation of this project from its beginning, using several women representatives from GURC, CIDA, and AED throughout the design of the project. The conceptual aspects of the project were developed with the assistance of women and it is anticipated that women will continue to play an important role throughout the life of the project in its implementation and as beneficiaries.

The faculty for the practical training program at CCEAC as well as the academic faculty at CUSC is well represented by women. The director of the ENISFAY program is a woman who actively participated in the development of this project.

The Ministry of Health is encouraging a greater participation by women in its operations, endeavoring to increase the number of women employees. Women serve in administrative positions at the M.H, although the majority of such posts are held by men. Women are considered for new positions, for promotions, and as candidates for training programs.

On the consumer side, women play a key role in the family life in the village, responsible for child-rearing, nutrition and share responsibility in handling the finances of the family. Consequently major changes in health behavior within the family structure will come about through the acceptance, interest, and commitment of women.

The picture is not a glowing one in all respects, however. The power, authority, and respect at the village level reflect a man's world, and here is where change is likely to be slowest in moving women into a stronger role. There are two implications of the role of women at the village level crucial to this project. The community organization work for a village health committee requires trust, respect, and authority and these attributes are more likely accorded men than women. The second implication of the role of women is the physical demands of the field worker position for construction work, travel, and need for mobility to visit different villages requiring absence from home for periods of time.

Nevertheless, in the course of the life of this project it is anticipated that an increasing number of women will be trained and able to function effectively in the villages. The rate of acceptance may accelerate as women become involved to a greater extent in cooperatives and other aspects of socio-economic development.

#### D Economic Analysis

Cameroon is faced with the formidable task of overall economic development while attempting to improve the health and social welfare of its approximately 6.1 million peoples. There is considerable competition for scarce resources among the sectors of government involved in development activities.

As discussed in the Financial Plan, the policy of the GURC towards allocation of resources for the health sector has been constant for the last five years. There has also been attempts to increase the health allocations but declining government revenues and increasing deficits in FY 74-76 has made this impossible. In view of the current budgetary constraints resulting from these declining government revenues, the projected FY 77 health budget of 5.1 billion CFA (21.7 million dollars U.S.) represents continued commitment to the health sector. The per capita expenditure for health of 227.15 CFA ( 3.55 U.S.) compares favorably with that of its neighbor states in Central and West Africa.

The major question now is how can the GURC best utilize extremely scarce resources in dealing with the health needs of its citizens. Given the resources available the government is dealing with the major health problems of gastroenteritis, dysentery, and intestinal parasites on an increasing preventive basis. This is a very reasonable approach in view of the fact that a curative approach would entail prohibitive costs and would not affect either the behavior or the environment, often the source of the problem.

The question now arises concerning the cost-effectiveness of health education as the medium to influence rural areas and establish better health conditions. Various studies in developing countries tend to support the theory that cultural practices, life style, and socio-economic factors contribute to poor health. One specific analysis by the World Bank Policy Paper, dated March 1975, identifies the major problems for health as fecally transmitted diseases, air-borne diseases and malnutrition which interact cumulatively and synergistically. While public health education can have varying impacts on incidence of these diseases, the Policy Paper states that all health approaches are inappropriate and ineffective unless backed up by outreach and preventive services.

The issue now must be revised as to how can preventative health practices be introduced through health education to the population in need. Since Cameroon does not yet have an extensive mass-media coverage, the approach must be through existing structures with wide exposure with minimal recurrent costs. The immediate need for GURC to initiate an effective health education effort is for skilled manpower. A cost effective approach is to utilize those elements of the present personnel structure that can be given additional training to meet the extra manpower needs.

The GURC/MCH presently operates a system of 45 dispensaries staffed with 131 salaried health workers in Mefou and Kadey districts. These workers are either nurses or aides and have had some training in curative care and work only in dispensaries. There is no outreach work and workers are often underutilized (25% of the time) because of light patient loads.

The project will address this problem of underutilization and will meet the need for skilled manpower by providing retraining of these dispensary personnel. In addition these workers will be taught how to use visual aides. They will also be encouraged and expected to provide health education outreach to villagers in their area in addition to their regular curative function at the dispensary. They will receive their regular salary with no increase for health education activity.

At the end of this project the MCH/C will have added the resources of 160 health workers trained in delivery of health education services.

In this way the GURC/MCH will be able to increase its efficiency in providing both curative and preventive services with no additional recurrent costs.

In addition to training in health education for existing health employees, the project will assist the GURC in expanding its health manpower base. The GURC has budgeted to add 120 new field level workers to its present rural health effort. The project will also provide training for these workers thereby permitting an immediate return to the GURC on their investments in salaries for these workers.

In addition to providing training for new employees and re-training of present employees at the field level, the costs of the project include expanding the GURC's own training ability. This is accomplished through the use of health educators trained at CUSS at the baccalaureate and Master's level. These upper level trainers, once trained, can provide continuous in-service training for all MOH personnel.

The training aspect of the project is also cost effective from the administrative point of view since it utilizes the existing structures of participant agencies. This eliminates the need to set up a costly administrative structure.

The project also makes cost effective use of the existing system of formal education. This previously untapped resource has 181 primary schools staffed by 511 teachers serving 33,548 students. At present health education is not taught in any of the schools. By expending \$654,000 US the project will develop a curriculum in health education and will train existing primary teachers in basic health education subjects. The teachers are presently on salary and will continue on salary while training. The only project expenditures will be for travel and per diem (where necessary), teacher training time, curriculum development and visual aid costs.

As a result of this training, it is planned that, at least one classroom period (45 minutes) per day will be devoted to health education topics. These will include personal hygiene, nutrition, food preparation, nutrition and basic disease etiology. Through this approach, the project will produce 110,376 hours of classroom instruction per year, every year with no recurrent costs.

The project will also utilize through health education, the available no cost resources of labor and materials in the villages. This will be done by making the villagers aware of the dangers of diseases through certain behaviors and will motivate them to take steps to eliminate these dangers. The project will show the villagers how to construct latrines and safe water sources themselves using local materials. All that will be required from the villagers is their interest and labor.

Measurement of the specific economic benefits of this project involves measurement of the improvement in health and quality of life which is difficult because of the variables over which there is no control. Previous studies have shown however, that similar intervention in the health milieu have decreased days of work lost due to sickness. These studies have also

shown that reduction of parasite infestations has enabled workers to increase caloric expenditure in their daily work with comparable increased productivity.

Lastly, the project is designed on a regional basis in order to affect health policies and practices on as broad a scale as possible. It is anticipated that this project will result in similar health training projects in other zones and possibly the other member states of OCEAC.

## PART IV. IMPLEMENTATION PLANNING

### A. Administrative Arrangements

*input*

#### Overview

As indicated in Figure 1, Project Organigram, the primary responsibility for the PTHE Project will be assumed by the Minister of Health/Cameroon through a coordinating committee consisting of representatives of those agencies or other ministerial departments involved with the PTHE Project. Additionally, the Minister of Health/Cameroon will assign a Project Director who will have responsibility for direct supervision of project staff and related project activities. The RDO/Y will participate as a member of the Coordinating Committee.

The Project will be staffed full-time by three AID-sponsored technicians, one of whom will be designated Chief of Project. The AID-sponsored technicians will be provided through a contract with a U.S. based university or other contract institution. The Chief of Project will be responsible to AID for the on-going daily management of all project activities and will report directly to the Project Director. The MCH will provide three technicians to the project. All project technicians will assist the Chief of Project. The WHO will provide one technician who will have teaching responsibility at CUSS. The entire Public Health Department of CUSS including one CIDA technician will participate in the project.

The primary implementing agencies for this project are OCEAC, CUSS, Peace Corps, and ENISFAY. Each will have a significant responsibility for providing training and personnel resources for the project. Each agency, through a designated project representative, will work directly with the Project Director to coordinate PTHE project activities.

### B. Specific Project Administrative Responsibilities

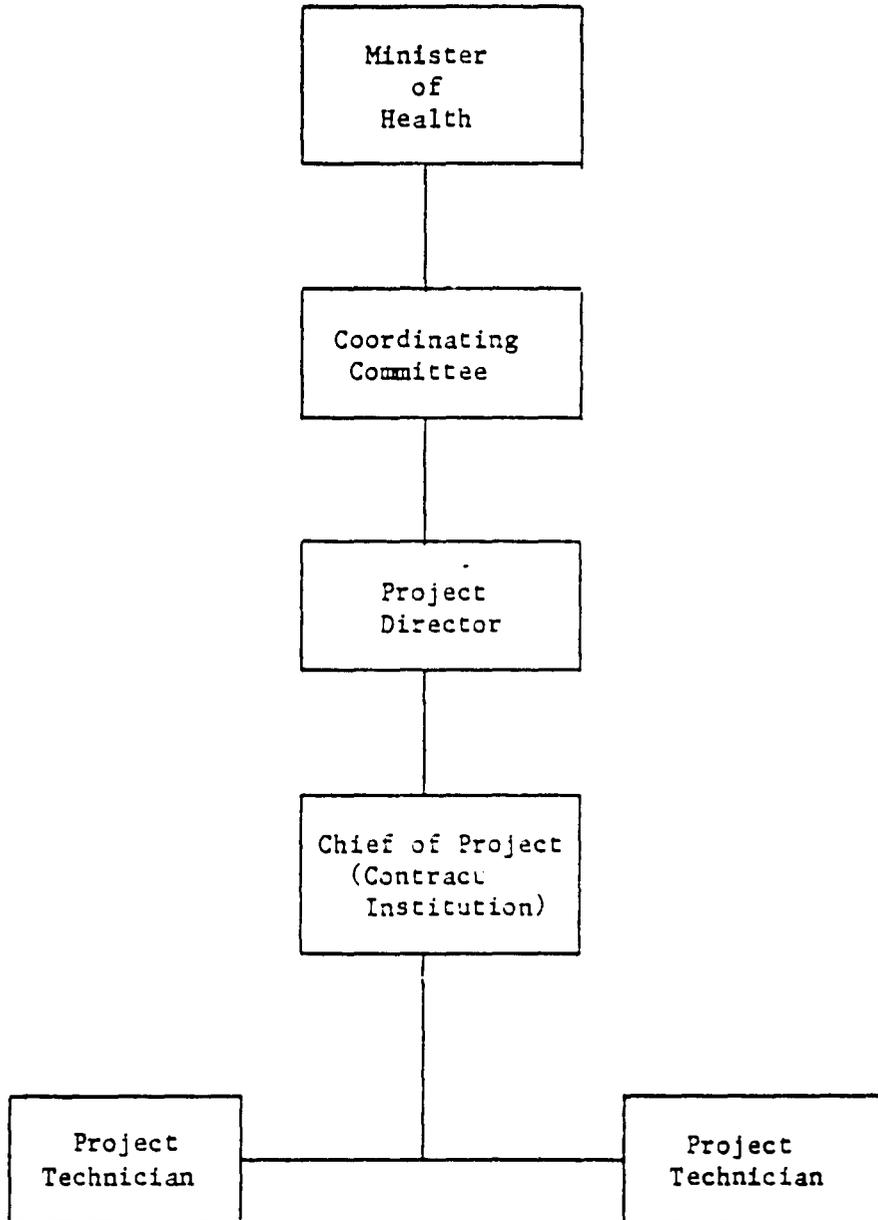
#### Minister of Health

The Minister of Health or his designate representative will assume overall responsibility for establishing policies regarding project activity. Specific responsibilities include:

1. Assuring the coordination and liaison among project participants, including other Cameroonian Ministries.
2. Planning, convening meetings of the coordinating committee and serve as staff to the coordinating committee.

IV - A Figure I.

PROJECT ORGANIGRAM



3. Assigning a representative of the Ministry of Health as Project Director to the PTHE Project.
4. Negotiating Project Agreements with relevant participants.
5. Arranging for periodic MOH/C Project Progress Reports.

#### Coordinating Committee

The Coordinating Committee will have the major responsibility for advising the Minister of Health on policy matters regarding aspects of the PTHE Project. The Coordinating Committee, through its President, a representative of the Ministry of Health, reports directly to the Minister of Health. Specific responsibilities include:

1. Meeting periodically to assure the continual coordination of the PTHE Project activities.
2. Recommending needed PTHE Policies to the Minister of Health.
3. Reviewing and evaluating PTHE Project progress.
4. Providing input for the development of PTHE project plans.
5. Assuring that individual committee members are fully informed regarding PTHE Project activities.
6. Organize sub-committees as needed for the project.

#### Project Director

The Project Director will be a staff person designated by the Minister of Health to implement and coordinate the project, and will have direct supervisory responsibility for the project technician staff. Specific responsibilities include:

1. Supervising the implementation of the PTHE Project activities in a manner consistent with policies established by the Minister of Health.
2. Providing leadership to the project staff in planning, designing, and evaluating project activities.
3. Assuring that required MOH administrative procedures are followed.
4. Providing administrative liaison between the PTHE Project and the existing administrative structure in the pilot zones.
5. Assuring that required MOH Project records are maintained and that needed project reports are prepared.
6. Acting as President of the Coordinating Committee

Chief of Project

The Chief of Project will be one of the three AID-financed technicians. His nomination must be approved by the Ministry of Health and AID. Under the Project Director, the Chief of Project will be responsible for the execution of the project in accordance with the objectives of the PTHE project as stated in the Project Paper. Specific responsibilities include:

1. Assisting the Project Director with the planning, design, evaluation of project activities.(See pps. 17-21 for description of project activities)
2. Implementing project activities in accordance with policies established by the Minister of Health and Coordinating Committee.
3. Contributing substantial technical expertise to the teaching and research activities of the project.
4. Providing supervision and administrative support to other project technicians.
5. Providing liaison between the contracting organization and the project.
6. Preparing necessary project reports including those documents required as part of the AID contract process.
7. Assisting the Project Director with liaison activities regarding the Coordinating Committee, by serving as the non-voting committee executive director.

U.S. Contract Institution

The U.S. contract institution in cooperation with the MOH will assume administrative responsibility for the logistics and support of the AID-sponsored technicians staff and related project training activities. Specific responsibilities include:

1. Recruiting, selection, and dismissal of project technician staff.
2. Providing logistical and technical backstopping for the technician staff.
3. Providing short-term technical assistance to the project when required.
4. Handling the logistical support for participant training activities including payment of travel, per diem and tuition.

#### Other Project Technicians

The other PTHE project technicians will be directly responsible to the Chief of Project and will provide general administrative support as required by the Chief of Project. They will function primarily in a technical capacity as described in Section II.B.

#### Participating Agencies

The participating agencies, OCEAC, CUSS, Peace Corps, and ENISFAY will function primarily in a technical capacity as described in Section II.B. Administratively they will coordinate activities with the Project Director.

#### C. Management Capacity of Project Organization

This project will bring together several organizations to work towards achieving common program objectives. Inherent in such an approach is the need for successful experience in management and coordination. It has been clearly emphasized by participants that this project requires the clearest possible lines of authority and communication. The assumption of primary responsibility by MOH/C for this project is looked upon as a very positive indication of success. The Ministry of Health has given ample evidence of its interest and management capacity for this project.

Since other project participants, OCEAC, CUSS, Peace Corps, and ENISFAY are already involved in related project activities, these participants have also given evidence of the management skills required to effectively participate in this project.

An additional consideration regarding the management of this project is the capability of the U.S. institution selected for contract. It is essential that the institution or firm have demonstrated management skills in the international health programs specifically in developing countries. Because of the large number of organizations to be involved with this project, the contract organization must have staff with the ability to ~~effectively~~ manage the various levels of project activity.

#### D. AID Involvement

Although there are several elements of this project, the current organization structure will not require additional AID staff commitments. It is expected that AID through the RDO/Y, will participate in the coordination of this project as a member of the Coordinating Committee. Additional details regarding AID's role in evaluating this project are discussed in the "Evaluation Plan" (Section 4.C.).

JOB DESCRIPTIONS

I. CHIEF OF PROJECT:

A. General

The relationships that the Chief of Project maintains with the Ministry of Public Health, the other project technicians, the contracting organization and AID are described in the previous section. In general, the Chief of Project will manage, under the authority of the Project Director, the daily operational aspects of the PTHE project.

B. Specific:

The Chief of Project will be the senior technician on the PTHE project staff. As such he will monitor the technical aspects of all project activities. It is expected that the Chief of Project will serve as a member of the faculty of CUSS teaching in the Department of Public Health and giving special attention to the WHO/CUSS Health Education program. His teaching responsibilities will be in the area of rural, service-oriented operational research, and he will be expected to supervise research activities of undergraduate and graduate health education students. CUSS will award a faculty appointment which is consistent with the Chief of Project's credentials and experience. Specific responsibilities include, but are not limited to:

1. Provides administrative and technical supervision of the project staff.
2. Assumes major responsibilities for the planning, and evaluation of project activities.
3. Assists the Director with liaison among coordinating committee members.
4. Provides technical assistance with the development of project research activities.
5. Provides teaching assistance in health education for project participants, where appropriate.
6. Provides technical assistance with project community development activities.
7. Prepares required program reports particularly reports required by AID and the Contract Organization.
8. Provides other related program assistance as required.

C. Qualifications:

More important than the credentials cited below, the Chief of Project should have a record of dynamic leadership and should be recognized as a "man of action". He should have a doctoral degree with specialization in health education and a minimum of five years of related administrative experience. An alternative health speciality may be considered. The candidate should have strong backgroup in community health development particularly in international health programs, ideally in Africa. Additional skills in program planning, evaluation and research are necessary. The candidate should also possess a faculty appointment at a U.S. University. Verbal fluency in French is essential at a minimum Foreign Service Institute level of 3 and facility in writing at a minimum professional level.

## II. HEALTH EDUCATOR: TRAINING PROGRAMS

### A. General:

Under the supervision of the Chief of Project, this project technician will be responsible for the development of the PTHE input into the formal training programs of middle and lower level health workers (including nurses, midwives, and itinerant agents) and primary school teachers. He will also be responsible for the health education components of the PTHE project's in-service training for all the health workers in the project zones. During the life of the project health workers from additional areas of Cameroon will be included in PTHE in-service training.

### B. Specific:

1. Is responsible for the design and evaluation of health education curriculum for the project's training activities.
2. Assumes responsibilities for all project continuing education (re-cyclage) activities.
3. Provides direct teaching assistance in project-related programs when required.
4. Supervises practice teaching by upper level health education students.
5. Provides technical assistance with the development of audio-visual aids as necessary.
6. Assists the Chief of Party with program planning, evaluation and research activities.
7. Prepares necessary project reports when required.
8. Provides other related program assistance as required.

### C. Qualifications

The candidate should have a MPH in health education with a minimum of three years of related experience. Specialization in the areas of school health and curriculum development is desirable. Candidate should also have teaching experience in health education and have a firm background in teaching methodology. Experience in international health programs is desirable along with knowledge of other community oriented health education programs such as the Indian Health Service, Alaskan Health Service and the United Farm Workers Health Service. Fluency in French is essential at a minimum Foreign Service Institute level of 3.

III. HEALTH EDUCATOR: COMMUNITY ORGANIZATION

A. General:

Under the supervision of the Chief of Project, the project technician will be responsible for the community out-reach activities of the PTHE project. This will include coordination of the development and continued support of village health committees throughout the project zones.

B. Specific:

1. Responsible for the coordination of all project field training and research activities.
2. Responsible for the supervision and coordination of all project village health committee activities.
3. Supervises itinerant agents and Peace Corps volunteers engaged in PTHE project activities.
4. Provides teaching assistance as required for project field training programs.
5. Prepares necessary project reports when required.
5. Provides other related program assistance as required.

C. Qualifications

The candidate should possess MPH in health education with a minimum of three years of related experience. Specialization in the area of community organization is required. Background in international health programs with emphasis on environmental health and sanitation is desirable. A graduate degree in a related health or social science would be considered if demonstrated competence in health education and community organization is shown. Fluency in French is essential at a minimum Foreign Service Institute level of 3.

PROJECT DEVELOPMENT SCHEDULE

The project development schedule shows the relationships and time phasing of the significant actions important for successful completion of the PTHE Project. The schedule should be reviewed in conjunction with the Planned Performance Tracking Network Chart included in the Appendix. The time schedule is an estimated projection and should show how coordination occurs rather than be accepted as a firm time-table of operation.

	<u>OUTPUT</u>	<u>RESPONSIBILITY</u>	<u>DATE</u>
1	P.P. Approval	AID	10/76
2	Project Agreement Finalized and signed	AID/MOH	10/76
3	RFP for Contract Developed	AID	11/76
4	UNICEF Contract for Motor-cycles/Supplies	MOH	11/76
5	Potential Contractor Proposal Review	AID	11/76
6	Contractor Orals	AID/MOH	12/76
7	Contractor Selection	AID/MOH	12/76
8	Recruitment and Orientation of Project Staff	Contractor	12/76
9	Reporting of Project Staff to Cameroon	Contractor	1/77
10	Project begins UNICEF MOTORCYCLES ARRIVE	AID/MOH/Contractor UNICEF/STAFF	1/77
11	Finalize Plans for first operating phase	MOH/Contractor	2/77
12	a.Monthly Progress Report	Contractor	2/77
13	Selections of Initial Field Training Site	MOH/Contractor	2/77
14	a.Monthly Progress Report	Project Staff	2/77
15	First Class of field workers in Mefou District	Staff	3/77
16	First Class of Teachers in Training in Mefou District	Ministry of Education/ CCEAC/MOH/Project Staff	3/77
17	Quarterly Progress Report	Project Staff	3/77
18	WHO Technician on-site	WHO/CUSS	3/77
19	First Group of Peace Corps volunteers begin training for Kadey District	Peace Corps	3/77
20	Monthly Progress Report	Project Staff	3/77

	<u>OUTPUT</u>	<u>RESPONSIBILITY</u>	<u>DATE</u>
21	1st Class of ENISFAY students in field	ENISFAY/Staff	3/77
22	First Class of mid-level workers in Mefou district for Field Training	OCEAC/MOH/Project Staff	3/1/77
23	Monthly Progress Report	Project Staff	3/1/77
24	First Class of CUSS students (non-health education) for Field Training in Mefou District	OCEAC/Staff/CUSS/MOH	4/77
25	Quarterly Progress Report	Staff	4/1/77
26a.	First Group of PCV's in field	Peace Corps/Staff	4/77
27	First Class of CUSS baccalaureate degree students in health education in field training	CUSS/MOH/Staff/OCEAC	5/77
28	2nd Class of ENISFAY Students in field	ENISFAY/Staff	5/77
29	Reports from first class and revision initiated of first phase of field worker training	MOH/CCEAC/Staff	5/77
30	Monthly Progress Report	Staff	5/1/77
31	Reports from first class and revision of first phase of training for teachers 34th Class of ENISFAY students in field	Ministry of Education/MOH/OCEAC/ENISFAY/Staff	6/77
32	Monthly Progress Report	Staff	6/1/77
33	Reports from first class and revision of first phase of training for mid-level workers	MOH/OCEAC/STAFF	7/77

<u>OUTPUT</u>	<u>RESPONSIBILITY</u>	<u>DATE</u>
34 Quarterly Progress Report	Staff	7/1/77
35 Feedback from Baccalaureate students field training in health education	CUSS/MOH/OCEAC/Staff	7/77
36 Evaluation initiated correlating all reports from all levels	MOH/STAFF	8/77
37 Monthly Progress Reports	Staff	8/1/77
38 Evaluation completed on reports from all levels - Plan modification	MOH/Staff	9/1/77
39 Monthly Progress Report	Staff	9/1/77
40 4th Class of ENISFAY students in field	ENISFAY/Staff	9/77
41 Concurrence on new plans	MOH/Coordinating Committee	9/77
42 Initiation of second round of training based in revised plans	Coordinating Committee/Staff	10/1/77
43 Begin Annual Program Evaluation	AID/Staff	10/1/77
44 Quarterly Progress Reports	Staff	10/1/77
45 5th Class of ENISFAY students in field	ENISFAY/Staff	10/1/77
46 Second Class of field workers go to Mefou and Kadey	OCEAC/MOH/Staff	10/77
47 Complete Annual Program Evaluation	AID/Staff	11/77
48 6th Class of ENISFAY students in field; monthly progress reports	ENISFAY/Staff	11/77
49 Second Class of Teacher in field training in Mefou and Kadey	Ministry of Education/ OCEAC/MOH/Staff	12/77
50 Monthly Progress Report	Staff	12/1/77

<u>OUTPUT</u>	<u>RESPONSIBILITY</u>	<u>DATE</u>
51 Second class of baccalaureate degree students in Health Education in Mefou District	CUSS/Staff	1/78
52 Quarterly Progress Reports	Staff	1/1/78
53 7th Class of ENISFAY students in field	ENISFAY/Staff	1/78
54 Monthly Progress Report	Staff	2/78
55 8th Class of ENISFAY students in field	ENISFAY/Staff	2/78
56 Reports from all levels of training	ENISFAY/CUSS/OCEAC/Staff	3/78
57 First Class of Master's level health education students in field	CUSS/Staff	4/78
58 Monthly Progress Report	Staff	4/1/78
59 Quarterly Progress Report	Staff	5/1/78
60 9th Class of ENISFAY students in field	ENISFAY/Staff	5/78
61 Feedback from Master's Program	CUSS/MOH/Staff	7/78
62 Monthly Progress Report	Staff	7/78
63 Interim Evaluation to improve planning and training	MOH/Staff/All Agencies	8/78
64 Monthly Progress Report	Staff	8/78
65 10th Class of ENISFAY students in field	ENISFAY/Staff	8/78
66 Third Class of field workers in Mefou and Kadey districts	OCEAC/Staff	9/78
67 Third Class of Teachers in training for Mefou and Kadey	Ministry of Education/ MOH/Staff	9/78

<u>OUTPUT</u>	<u>RESPONSIBILITY</u>	<u>DATE</u>
68 Quarterly Progress Report	Staff	9/1/78
69 First Group of Mid-level workers return to Mefou and Kadey	OCEAC/MOH/Staff	9/78
70 Third Class of B.S. students in field (CUSS)	CUSS/MOH/Staff	10/78
71 Second Year Masters students in field training	CUSS/MOH/Staff	10/78
72 Monthly Progress Reports	Staff	10/1/78
73 Begin Mid. Project Evaluation	AID/Staff	10/78
74 11th Class of ENISFAY students in field; monthly progress reports	ENISFAY/Staff	10/78
75 Complete Mid-Project Evaluation	AID/Staff	11/78
76 12th Class of ENISFAY students in field	ENISFAY/Staff	11/78
77 Quarterly Revision as Indicated	MOH/Coordinating Committee/Staff	12/78
78 Quarterly Progress Report	Staff	12/78
79 Initiation of Fourth Round of Training based on Revised Plan	Coordinating Committee/Staff	1/79
80 Monthly Progress Report	Staff	1/79
81 13th Class of ENISFAY students in field	ENISFAY/Staff	1/79
82 Fourth Class of field workers in Mefou and Kadey	OCEAC/MOH/Staff	1/79
83 Fourth Class of mid-level workers in Mefou and Kadey	OCEAC/MOH/Staff	1/79
84 Fourth Class of Teachers in training in Mefou and Kadey	Ministry of Education/MOH	1/79
85 Second Group of Peace Corps Volunteers in training	Peace Corps/MOH/Staff	2/79

<u>OUTEUT</u>	<u>RESPONSIBILITY</u>	<u>DATE</u>
86 Monthly Progress Report	Staff	2/1/79
87 14th Class of ENISFAY students in field	ENISFAY/Staff	2/79
88 Quarterly Progress Report	Staff	3/79
89 15th Class of ENISFAY students in field	ENISFAY/Staff	3/79
90 Monthly Progress Report First Group of PCV's leave field	Staff Peace Corps/Staff	4/1/79 4/79
91 Second Groups of PCV's in field	Peace Corps/Staff	4/79
92 Fourth Class of B.S. students in field	CUSS/MCH/Staff	5/79
93 16th Class of ENISFAY students in field	ENISFAY/Staff	5/79
94 Monthly Progress Report	Staff	5/1/79
95 Second Group for Master's students (CUSS) *	CUSS/MOH/Staff	5/79
96 Begin Interim Evaluation Reports, Analysis; new plans	Coordinating Committee/ Staff	6/79
97 17th Class of ENISFAY students in field	ENISFAY/Staff	6/79
98 Quarterly Progress Reports	Staff	6/1/79
99 Monthly Progress Report	Staff	9/1/79
100 Monthly Progress Report	Staff	8/1/79
101 18th Class of ENISFAY students in field	ENISFAY/Staff	9/1/79
102 Quarterly Progress Report	Staff	9/1/79
103 Begin Third Year Evaluation	AID/Staff	10/1/79
104 19th Class of ENISFAY students in field	ENISFAY/Staff	10/79

	<u>OUTPUT</u>	<u>RESPONSIBILITY</u>	<u>DATE</u>
105	Begin Fifth Round of Training at all levels	OCEAC/CUSS/MOH/ENISFAY/Staff	10/79
106	Monthly Progress Report	Staff	10/79
107	20th Class of ENISFAY students in field	ENISFAY/Staff	11/79
108	Complete Third Year Evaluation	AID/Staff	11/79
109	Monthly Progress Report	Staff	12/79
110	Program Revisions based on yearly Evaluation	Coordinating Committee/Staff	12/79
111	Continue Training and Evaluation Activities		1/80 - 6/80
112	Sixth Round of students at all levels	OCEAC/CUSS/MOH/ENISFAY/Staff	3/80
113	Reports and Evaluation	Coordinating Committee/Staff	5/80
114	Seventh Round of Students	OCEAC/CUSS/MOH/ENISFAY/Staff	6/80
115	Reports, Analysis, Final Project Evaluating and Operating Plans continued by MOH	Coordinating Committee/Staff	6-9/30/80

\* Much of the academic schedule for CUSS has not yet been finalized. The time periods indicated in the schedule are estimates.

IMPLEMENTATION PLAN - VEHICLE WAIVER

Request for Procurement Source/Origin Waiver

Problem: Request for Procurement Source/Origin Waiver from Geographic Code 000 (U.S. only) to Geographic Code 935 (Special Free World) for Practical Training in Health Education Project: 631-0009.

- (a) Cooperating Country: Cameroon
- (b) Nature of Funding: Project 631-0009
- (c) Description of Goods: 3 Toyota Landcruisers
- (d) Time Limitation: Four years, after which a reassessment will be made
- (e) Approximate Value: \$27,000
- (f) Probable Source: Japan

Discussion:

Section 636 (i) of the Foreign Assistance Act of 1961, as amended, prohibits A.I.D. from the purchase of long term lease of motor vehicles unless such vehicles are manufactured in the United States. Section 636 (i) does provide, however, that "...where special circumstances exist, the President is authorized to waive the provision of this section in order to carry out the purposes of this act". We are of the opinion that the mobility of our field staff and local personnel engaged in the implementation of the A.I.D. programs in the Mefou and Kadey Districts of Cameroon present special circumstances that justify waiving the origin requirement of Section 636 (i) and to source requirements set forth in Chapter 2 of the A.I.D. Handbook 15.

In order to provide continuous direct supervision of the PTHE projects' service, training and research activities in the remote regions of the Mefou and Kadey Districts of Cameroon, it is necessary that project technicians have full time use of vehicles particularly suited to the rugged terrain, local repair and maintenance facilities. This project will provide three vehicles which will be used by eight or more project technicians, including those assigned by the Ministry of Public Health and the Peace Corps.

Much of the travel by local project staff will be in areas where there are no roads at all. It is to be expected, therefore, that the project vehicles will be subjected to considerable wear and tear, and will have to be well-maintained on a rigorously regular basis in order to assure necessary longevity. An American vehicle could not be maintained in the project area and would quickly become useless. In case of the breakdown of any vehicle and subsequent need for emergency repair in most of the project area, the only repair and parts facilities available are for Japanese, British and French-made vehicles. It is reasonable to assume that the area mechanics have greater familiarity with these vehicles than other makes and would be more likely to keep them running.

The Regional Public Health Training project (RPHT : 625-11-540-510) has recently provided the RDO with the experience of trying to maintain five American vehicles operational in Central Africa. There has never been a time during the past two years when all vehicles were operational and frequently all five were sidelined at once. The project was severely compromised by vehicle failure and tremendous expenses incurred ordering spare parts.

For this project, the Toyota Landcruiser has been selected as being most suitable for the off-road type travel which will be required. One of the largest firms in the country is Toyota which also has one of the largest repair and spare parts facilities in Cameroon. For these reasons RDO/Y has decided to standardize its field vehicles using Toyota Landcruisers. Four such vehicles have already been purchased for project activities in North Cameroon.

The RDO/Yaounde has certified that neither the RDO nor the United States Embassy has independent maintenance/repair and that other United States agencies in Cameroon possess non-U.S. vehicles for travel to the field. These vehicles are not available to the Regional Development Office (Yaounde 1348).

Primary Justification:

It is essential for the effective implementation of the A.I.D. PHE Project (631-0009) to have foreign-made vehicles which can be operated, serviced and repaired locally.

Recommendations:

For the reasons stated above, that you determine that special circumstances exist at this time to warrant the procurement of non-U.S. made vehicles.

B. Implementation Plan

The Ministry of Health of Cameroon will be the agency directing this project as outlined in Figure 1 of the previous section of this paper. The AID technical assistance input will be provided primarily through contract with an American institution such as a university School of Public Health or a private contractor. Additional project input will be provided by other participants through the Coordinating Committee established by the Ministry of Health for that purpose.

The U.S. based contracting institution will be responsible for the on-going daily management of the project including the recruitment of personnel, maintenance of logistical support and participant training expenses, such as travel, per diem, and tuition. It is essential that the project be managed by one institution with full agreement and commitment to work within the organization structure already developed for the project.

OCEAC will provide office space for the project team at headquarters in Yaounde. PTHE project will provide secretarial assistance to the Project Director, their regular monitoring of the project, and will participate on the coordinating Committee.

One of the unique aspects of this project is the interest and participation being shown by a significantly large number of agencies. See Appendix for a complete list of all agencies. The project organization structure (see Figure 1) has been designed to clarify the lines of responsibility and authority among the more than nine groups involved. The roles of each of the principal project participants can be summarized as follows:

Ministry of Health

Overall project direction and the provision of MOH personnel for training.

A.I.D.

Primary resource for long and short term technical assistance.

W.R.O.

Training assistance provided to CUSS.

UNICEF

Resource for transportation (motor-cycles), other construction and audio-visual materials, and some student stipends.

OCEAC

Training resource for field level workers.

C.U.S.S.

Training for university level personnel.

ENISFAY

Training resource for nursing personnel.

Peace Corps

Resource for volunteer field workers.

C.I.D.A.

Training assistance provided to CUSS.

Other Ministries of Cameroon

Technical assistance for ministry related aspects of the project.

A more detailed description of each participant's role has been included in Section 1. Project Description.

C. EVALUATION

The emphasis of the PTHE project focuses on health education within Cameroonian villages. Consequently, the evaluation will address the association between the educational activities and observed health behavior change. The evaluation plan for this project will rely primarily on indirect measures of project success by documenting project inputs and outputs in relationship to stated project goals. Implicit in the design of this project is the assumption that increased training in health education and increased health education among the villagers will result in improved health behavior.

Because of the multiplicity of influences occurring within a village which are beyond the control and scope of this project, the evaluation will not examine nor attempt to infer a direct cause and effect relationship between project activities and any changes in health behavior which may occur in the project villages. It is too costly in money and manpower to establish an accurate data base and the adequate controls for comparison necessary in order to investigate a direct cause and effect relationship.

Since a precise, quantifiable evaluation is desirable for its technical accuracy, a detailed explanation of why this project is not pursuing this approach follows:

1. The need to have an accurate initial data base. If an accurate data base does not exist, it must be established. This is not possible in this project because of the high cost and also because of the lack of available trained manpower to collect the needed data.
2. The second problem concerns the effective utilization of the trained project manpower which is available. A decision on the allocation of scarce resources of a project takes into account the amount of resources assigned to data collection and processing for measurement of goal attainment. Because of the service orientation of this project, there are very few resources available to conduct project research.

Therefore this project does not have now nor will it be able to develop the baseline data on behavior change nor the system to readily collect such data. The initiation of such a system would be unrealistic in terms of the immediate resources available. Because of these inherent difficulties, maximum use will be made of indirect measures of changes in health knowledge, attitudes and practices of the project village populations.

### Evaluation Plan

The PTHE project will be evaluated both internally and externally at different intervals throughout the life of the project. Internal evaluation will be conducted by the project staff, the project director and the coordinating committee. External evaluation will be conducted by AID at mid-term, in collaboration with the other participants involved. Other AID evaluations will be consistent with AID policy.

It is planned that the project staff will be responsible for preparing monthly and quarterly progress reports which will be submitted to the project director. The monthly reports will be brief discussions of any problems encountered, plans to meet problems, and a projection of the next months' activities. The quarterly progress report will contain similar information, but in summary form. Additionally, the quarterly reports will contain a financial summary.

Information about the village sanitary environment, observation of villagers, use of preventive and curative health services, village structure, interest in preventive health by teachers, and competence in teaching health will be obtained by students and Peace Corps volunteers as the first step in their learning how to plan a health education program. Therefore, information gathering becomes a process in learning for students as well as providing information for PTHE evaluation.

After students have had time to carry out educational activities in the villages, faculty and supervisors of field training will be able to observe changes by making direct field observation, and random sample surveys of villages for attitude and behavior changes which could influence continued use of the village as a training site.

Measures of institutional involvement may include provision of rewards at annual Health Committee Conferences, certificates of achievement to villages, material incentives considered necessary to carry out desired changes, and recognition through photographs, newspaper and national publicity.

In order to evaluate the effectiveness and efficiency of the proposed PTHE project, certain evaluation indicators are recommended. Reference should be made to the Logical Framework for summary of the specific goals and objectives of the project.

## Evaluation Indicators

### Village Health Committees

The project intends to establish 788 village health committees in four years. The evaluation indicator for this activity is determined by the formula:

$$\frac{\# \text{ of committees formed}}{788} \times 100 = \% \text{ of goal achieved}$$

Although it may be possible to establish the projected number of health committees, it is unrealistic to assume that all committees will be effective. For the purposes of this project, an effective health committee is one which (1) meets regularly (at least once a month); (2) has begun at least one health project within the first six months of formation; and (3) has completed one health project and has begun another during the first year of formation. Utilizing such a definition, it is possible to suggest an additional evaluation indicator for village health committees to determine the overall effectiveness of committees.

The recommended measure is:

$$\frac{\# \text{ of effective committees formed}}{\text{Total number of committees formed}} \times 100 = \% \text{ effectiveness.}$$

The evaluation of the village health committee component of this project should also consider the following questions:

1. What level of community involvement is being shown by the committee? Are other community members aware of the committee? How many committee members? How often do they meet? Is it representative of the community?
2. What is the activity level of the committee? How many projects have been considered? How many planned? How many implemented? How many completed within a specified period of time?
3. What is the relationship of the committee to project field workers and project trainees? Does the committee seek out or accept technical advice and suggestions regarding health activities?

The amount of time that students spend in the village may not be long enough to count the number of projects completed by health committees. In such cases, counting the number of committees organized may be all that is possible, although it is understood that it is the end result or the output of community organization effort which is important, not solely the process or technique of organizing a committee.

### Project Training Activities

The PTHE project will be training several different categories of students and at several different levels. Each student will be evaluated by testing according to existing institutional procedures. Academic testing and field testing will be the responsibilities of the participating agencies. For the purpose of this project successful training will be considered to be the achievement of a minimal score of 65% of whatever numerical rating system is utilized, (i.e. 65 out of 100, 12 out of 20, etc.). An evaluation indicator for all students trained by this project would be:

$$\frac{\text{Total \# students obtaining a score of 65\% or above}}{\text{Total \# of students trained}} \times 100 = \% \text{ effectiveness of training}$$

The project plans to train 1,614 persons in various specialities. The evaluation indicator for this activity is:

$$\frac{\text{Total \# of students trained}}{1,614} \times 100 = \% \text{ goal achieved}$$

Additional evaluation information regarding the project training activity should include:

#### Primary School Teachers

1. How many primary school teachers have attended training sessions?
2. How many training sessions were held?
3. How many teachers attained an acceptable level of competence?
4. How many teachers have incorporated health education into the primary school curriculum?
5. Have there been any plans developed to incorporate health education curriculum into the formal primary teacher training college curriculum?

#### Field Worker Training

1. How many workers have been trained?
2. How many in-service training sessions have been held?
3. Has an increased level of competence in health education been demonstrated among the workers?

4. Have the workers been able to integrate health education concepts into their daily work?
5. How many workers have jobs after training?

#### Other Personnel Categories

A similar format for evaluation could be utilized for the students trained at CUSS, ENISFAY and other participants. Where possible, the PTHE project should utilize the existing evaluation system established for these students as long as it is consistent with the goals of the project.

This project differs from traditional training projects in its emphasis on problem-solving, using results in the community as criteria for success rather than individual student achievement. It is recognized that conditions and circumstances outside the purview of the PTHE may delay or even prohibit changes from occurring in the village despite well-directed student effort. In all cases of success and failure in village change, students will be taught how to record their educational efforts, and in this way they will learn how to objectively analyze events as they occur. From the students' point of view, the learning goal is analysis and synthesis of the experience, but from the service point of view, the goal is village improvement.

This emphasis does not negate or overlook the importance of individual learnings, but rather places the teaching objectives in a problem-solving context with observable community results rather than traditional testing or examination of individual students. Individual testing and measurement of learning will be used in the training program, but it is not intended to be the major thrust of achievement.

#### Other Evaluation Activities

Each evaluation activity should attempt to measure in quantifiable and qualitative terms the actual health impact of a particular project activity. Health activities which are included in this project such as water source development, latrine construction, animal shelter construction, garbage disposal, etc. should be well-documented, so that some measure of project effectiveness can be obtained.

#### Evaluation of Project Costs

The evaluation of the PTHE project would not be complete without some attention being directed at project costs. Because of limited financial resources, it is essential that the project be conducted in as cost effective a manner as possible. Examples of the kinds of evaluation indicators which could be considered are:

$$\frac{\text{Total Project Cost}}{\text{Total \# Committees formed}} = \text{Cost per committee}$$

$$\frac{\text{Total Project Cost}}{\text{Total \# of Persons Trained, all categories}} = \text{Cost per trainee, all categories}$$

$$\frac{\text{Total Training Cost by Category}}{\text{Total \# of Persons Trained by Category}} = \text{Cost per Trainee, by Training Category}$$

$$\frac{\text{Total Cost for All Training Sessions, All Categories}}{\text{Total \# of Training Sessions, all Categories}} = \text{Cost per Training Session, all Categories}$$

$$\frac{\text{Total cost for All Training Sessions, by Category}}{\text{Total \# of Training Sessions, by Category}} = \text{Cost per Training Session, by Category}$$

$$\frac{\text{Total Cost for All Training Days, all Categories}}{\text{Total \# of Training Days, all Categories}} = \text{Cost per Training Day, all Categories}$$

$$\frac{\text{Total Cost for All Training Days, by Category}}{\text{Total \# of Training Days, by Category}} = \text{Cost per Training Day, by Category}$$

$$\frac{\text{Total Cost of Technical Assistance Man-Months}}{\text{Total \# of TA Man-Months}} = \text{Cost per Man-Month of TA}$$

The preceding formulas are included as examples of the ways costs can be evaluated for the PTHE Project. Additional formulas can be developed; however, it is the responsibility of the project staff, the project director and the Coordinating Committee to determine the formulas which will accurately reflect the efficiency of this project. Costs should be considered in the evaluation effort along with the project outputs.

Clinical criteria to judge the effectiveness of a health education program after several years of work can only be applied if the same clinical criteria were used at the beginning of the project to establish the objectives. There has to be consistency in using the same data base for criteria in order to measure change and retain consistency and validity in the conclusions.

D. CONDITIONS, COVENANTS AND NEGOTIATING STATUS

There are no special host country actions which must be taken prior to the execution of the Project Agreement. Additionally, there are no special conditions or covenants proposed for the Project Agreement.

# TELEGRAM

PTHE/PR:ANNEX

431-0009

676-0002

ACTION AID --HMPO / APRM UNCLASSIFIED

05 FEB 76 1325

INFO AMB Chron  
DCM/RF  
CHRON

Classification

ACTION	Handwritten initials
TO	Handwritten initials
FROM	Handwritten initials
DATE	Handwritten initials
TIME	Handwritten initials

EE RUEHC 9022 0370352  
ZNR UUUUU ZZH  
R 060224Z FEB 76  
FM SECSTATE WASHDC  
TO AMEMBASSY YAOUNDE 6413  
BT  
UNCLAS STATE 029022

AIDAC

I.O. 11652: N/A

TAGS:

SUBJECT: HEALTH PRP REVIEWS

1. PRP'S SUBMITTED BY RDO/Y FOR PRACTICAL TRAINING IN HEALTH EDUCATION AND OUNAM PROVINCE RURAL HEALTH APPROVED BY DOPR FOR INCLUSION IN CONGRESSIONAL PRESENTATION AND TO PROCEED WITH DEVELOPMENT PROJECT PAPERS.

2. MESSAGE CLEARED BY ALL OFFICES FOLLOWS SEPTTEL CONTAINING SUBSTANCE REVIEW COMMENTS AND RECOMMENDATIONS FOR CONSIDERATION DURING FINAL DESIGN. KISSINGER

UNCLASSIFIED

Classification

Project Title: **PRACTICAL TRAINING IN HEALTH EDUCATION 631-009**

OBJECTIVE	INDICATORS	MEASUREMENT	ASSUMPTIONS																				
<p>To increase the ability of the rural populations and other underprivileged groups to participate in development activities</p>	<p>1. Organization of Village Leadership to address village priorities.                  2. Knowledge and Utilization by villagers of multiple government services.                  3. Participation by villagers in planning of CURC service programs.</p>	<p>1. Annual Reports of Committees, activities and project from government and other field workers                  2. Annual Reports from government and private agencies on volume of services provided villagers                  3. Annual Reports from project participants (Agencies and Institutions) on village participation in program planning and use of services.</p>	<p>1. Poor health is a limiting factor to socio-economic development                  2. Villagers will take advantage of increased opportunities to participate in program planning                  3. CURC continues to encourage village participation in general socio-economic development</p>																				
<p>To develop and implement a nationally coordinated practical training system of health education activities responding to the needs of the rural populations and other underprivileged groups in Africa. Initial project activities will take place in the Mefou and Kadey districts of Cameroon.</p>	<p>1. Coordination by WHO/CUSS OCTAC and EHSFAY                  2. Integration of health into other socio-economic programs in villages                  3. Modification of educational objectives by institutions involved to match reality of village life.                  4. Continuous reassessment of project impact on villagers of service provided.</p>	<p>1. System of reporting and planning between participating bodies                  2. Health and other sector workers planning village projects together                  3. Village committee and field worker reports                  4. Review of WHO/CUSS, OCTAC, and EHSFAY curricula for practical training                  5. Periodic feedback of villagers perception of project value.</p>	<p>1. Coordinated and integrated action is more efficient than independent and isolated action.                  2. Impact on villagers is more positive and effective through coordination                  3. Villagers will understand the relationship among various development activities                  4. CURC will continue to support project and will incorporate findings and results of project in national planning                  5. Future health personnel for Africa should acquire practical experience in the environment in which they will eventually work</p>																				
<p>1. Program of village health committees                  2. Program of teacher in-service training                  3. Program of recycling for health and other workers                  4. Program for OCTAC mid-level workers                  5. Program for CUSS students                  6. Program for EHSFAY students and faculty.</p>	<p>1. 768 village health committees                  2. 120 field level workers trained and working                  3. 511 Primary School Teachers trained                  4. 160 Health Workers recycled                  5. 100 Mid-level nurses trained                  6. 400 Professional level CUSS students trained                  7. 313 EHSFAY students trained                  8. 10 EHSFAY faculty trained                  Total persons trained 1,614; Total villages served: 788; total population served: 220,016</p>	<p>1. Coordinating committee reports                  2. Training program reports                  3. On-site observation                  4. Review of Plans, documents, and schedules                  5. Periodic conferences.</p>	<p>1. Inputs implemented in a timely manner                  2. Continued cooperation and support                  3. Project technicians will have relevant expertise</p>																				
<p><b>A.I.D.</b>                  -Technical Assistance Team: 144 M/M                  -Recycling Program: 10,000 M/Days                  -Scholarships: 250 M/M                  -Health Education Conferences (4)                  -Mid Project Evaluation                  -Commodities: 3 vehicles + PDL  <b>Peace Corps:</b> 24 Volunteers  <b>WHO:</b> One Professor, Scholarship, Consultant Service, Supplies  <b>UNICEF:</b> 200 Motorcycles, construction &amp; audio-visual materials  <b>CUSS/CIDA:</b> Faculty Support  <b>GEAC:</b> Consultant Services, Training Program and Facilities  <b>MOH/C:</b> Personnel and Budget Support</p>	<p><b>Implementation Target (Type and Quantity)</b></p> <table border="1"> <tr><td>1. Technical Assistance Contract</td><td>31,263,000</td></tr> <tr><td>2. Recycling Program</td><td>80,000</td></tr> <tr><td>3. Scholarships</td><td>360,000</td></tr> <tr><td>4. Commodities</td><td>52,000</td></tr> <tr><td>5. H.Ed. Conferences</td><td>40,000</td></tr> <tr><td>6. Mid-Project Evaluation</td><td>25,000</td></tr> <tr><td>Initial: 18 Mos. after project technicians report in Cameroon</td><td></td></tr> <tr><td>7. Contingency</td><td>197,000</td></tr> <tr><td>8. Inflation</td><td>147,000</td></tr> <tr><td><b>TOTAL AID</b></td><td><b>3 2,060,000</b></td></tr> </table>	1. Technical Assistance Contract	31,263,000	2. Recycling Program	80,000	3. Scholarships	360,000	4. Commodities	52,000	5. H.Ed. Conferences	40,000	6. Mid-Project Evaluation	25,000	Initial: 18 Mos. after project technicians report in Cameroon		7. Contingency	197,000	8. Inflation	147,000	<b>TOTAL AID</b>	<b>3 2,060,000</b>	<p><b>AID PROJECT BUDGET</b>  <b>AID CONTRACT OFFICE</b>                  File, etc.</p>	<p>1. Continued availability of funds                  2. Current training programs continued                  3. Suitable candidates identified for training</p>
1. Technical Assistance Contract	31,263,000																						
2. Recycling Program	80,000																						
3. Scholarships	360,000																						
4. Commodities	52,000																						
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8. Inflation	147,000																						
<b>TOTAL AID</b>	<b>3 2,060,000</b>																						

OCEAC HEALTH EDUCATION MATERIALS

A selected bibliography of health education materials shows a well-balanced collection of books, journals, posters, charts, flannelgraphs, slides, and a film provided by the Regional Health Education Project. A small library of the materials on the attached list is maintained at OCEAC and is available for demonstration purposes. The Manual on the OCEAC agent itinerant training program entitled Practical Health Education in the Rural Village, (L'Educaton Pour La Santé Appliquée aux Communautés Rurales) is in the process of being published. It will provide a full detailed description on the development, pre-testing procedures and results, and use of health education teaching materials.

Considerable attention has been given to the appropriateness of the materials for Cameroon and the majority of the materials have been purchase commercially from four sources:

1. Desmet, Daniel  
Ann, Box 807  
Yaoundé, Cameroon
2. Bureau of Study and Research for the Promotion of Health  
Republic of Zaïre
3. Foundation for Teaching Aids of Child Health  
30 Guilford Street,  
London, WC1N 2E
4. Institut Africain pour le developpement economique et  
social (INADES)  
B. P. 8008  
Abidjan, Ivory Coast

Comments about visual aids:

1. Film charts carried in a self contained easel/case are the most practical type of aid because they are more easily transported on a bicycle, require no electricity or machine, and can be easily seen and handled by the audience. A teaching guide accompanies each of the sets of charts with small pictures of the images contained in the guide.

2. Flannelboards offer a better quality of teaching but require a trained teacher and are often lost because they are various sizes of individual pieces requiring assembly to be used appropriately.

3. Movies, film strips and slides require electricity or car-operated batteries and projectors neither of which may be readily available in Kadey and in more remote parts of Méfou. They may be useful in villages where a technical school or mission is located.

4. Cost is a major problem. One set of charts in a case costs 7,000 CFA or approximately \$35 for a minimum quantity of 500. The charts need to be appropriate to the part of the country visualized, for example protection of water sources in the desert area is quite different than the rain forest or swamp area.

Reproduction of existing slides (about 100 or more are in the OCZAC Library) could be reproduced at Antwerp Institute (connected in the Regional Health Education Project) for \$ 15 for one set of 24 slides.

5. The dispensary is the location where the teaching aids have been used up to this time. Very little if any use has been made of the aids by the primary schools although the aids would appear to be of equal if not greater value in that setting.

6. Whatever aids are developed by this project, the durability should take into consideration rough transport conditions, rain, dryness, and inept handling.

ATELIER DE MATERIEL POUR L'ANIMATION

YAOUNDE (Cameroun)  
B.P. 267 Tél. 22-32-08

CATALOGUE DE NOTRE MATERIEL AUDIO-VISUEL

A - EDUCATION POUR LA SANTE

BOITES A IMAGES

- 75 - HYGIENE DE L'EAU :  
Eau potable, non potable. Comment se procurer une bonne eau à boire, en brousse, en ville. Solutions familiales et communautaires.
- 76 - COMMENT SOIGNER LES PLAIES :  
Conséquences des négligences dans le soin des plaies. Exemples à l'appui et conseils pratiques.
- 77 - HYGIENE DU CORPS :  
Maladies dues au manque d'hygiène. Différents soins d'hygiène du corps.
- 78 - L'ALCOOLISME :  
Après sa guérison un père de famille fait le récit des conséquences de ce fléau.
- 79 - LE PALUDISME :  
Causes et moyens de combattre cette maladie.
- 80 - LES VERS INTESTINAUX :  
(ankylostomiase, ascariidose; construction du cabinet)  
Causes et moyens de combattre ces maladies.  
(Colis avec affiches murales sur contreplaqué)
- 81 - NUTRITION :  
Colis standard : Boîte à images - Livret - Flanellographe - affiches murales sur contreplaqué.  
  
Une bonne nutrition est une des conditions essentielles de la santé. - Eléments de base de la nutrition : Aliments de construction, de protection, de force - Alimentation rationnelle de l'enfant.
- DIAPOSITIVES : (mêmes thèmes, Nutrition excepté)
- 82 - Hygiène de l'eau. = 27 diapos
- 83 - Comment soigner les plaies. = 20 diapos
- 84 - Hygiène du corps. = 27 diapos
- 85 - L'alcoolisme. = 27 diapos
- 86 - Le paludisme. = 61 diapos
- 87 - L'ascariidose. = 27 diapos
- 88 - L'ankylostomiase. = 24 diapos
- 89 - NU : Education nutritionnelle des enfants de 0 à 5 ans. Causeries simples ; aliments du pays ; recettes. = 39 diapos
- 90 - S : Education sexuelle pour adolescents et adultes = 91 diapos
- 91 - La bilharziose. = 20 diapos
- 92 - Construction d'un cabinet : = 17 diapos  
Nécessité d'un bon cabinet pour combattre les verminoses.

## PLANCHES LOGRAPHES

- 93 - L'ALIMENTATION : ( 3 affiches + livret )  
Les 3 catégories d'aliments, adaptés au Cameroun.
- 94 - LA ROUGEOLE ( 3 affiches + livret )  
Symptômes, développement et soins de la maladie - les complications. Le vaccin.
- 95 - LE CYCLE FEMININ : ( 3 affiches - livret )  
Le cycle : ovulation, fécondation - Le développement de la grossesse. L'accouchement.
- 96 - L'APPAREIL GENITAL MASCULIN.
- 97 - LA BILHARZIOSE.  
Symptômes. Cycle de transmission de la maladie. Lutte contre la bilharziose.

## LIVRES

- 98 - LES VERS INTESCTINAUX.
- 99 - LA MALARIA
- 100 - NUTRITION
- 101 - PETITS PROBLEMES DE PHARMACOLOGIE
- 102 - PETIT AIDE-MEMOIRE POUR LE DISPENSAIRE
- 103 - NOTIONS DE PHARMACOLOGIE

## B - AUTRES THEMES

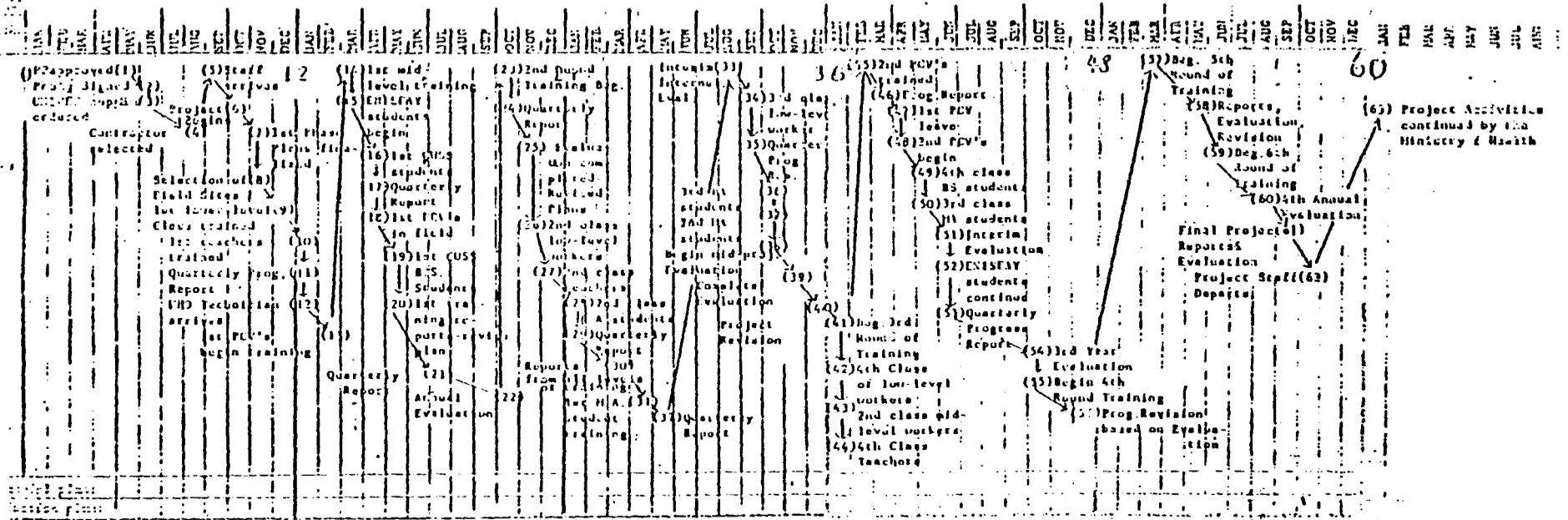
- 104 - L'ARGENT DANS LA FAMILLE, en Boîte à images = 27 images
- 105 - " " " " en diapositives = 27 dias
- Une bonne et une mauvaise utilisation de l'argent mettent en parallèle deux familles ayant les mêmes moyens de subsistance, mais l'une les utilisant au mieux et l'autre les gaspillant. Discussion possible sur le budget familial. L'épargne, les techniques agricoles, la nourriture, l'hygiène, etc.
- 106 - METHODE D'ALLIEMENTATION POUR LE NORD-CAMEROUN : en Boîte à images.
- 107 - AFFICHE INDEPENDANCE SUR L'EST ROUE (grand format, deux exemplaires)
- 108 - 3 PETITES AFFICHES SUR L'EPARGNE :  
Épargne, bonheur familial - épargne, scolarité - avenir du pays.

## C - REALISATIONS ARTISTIQUES

- 109 - TABLEAUX artistiques. sur toile graybaft, style KOROHO (65/80)
- 110 = (125/80)
- 111 = (180/80)
- 112 - NAPPES de table, imprimées de motifs artistiques = (120/160)
- 113 = (120/180)

SECRET

Contract No.	Project No.	Project Title	Date	Original / Revised	PPF app.
631-009		Practical Training in Health Education	4-7-76	/ revised	



PROJECT PERFORMANCE NETWORK

CT PERFORMANCE NETWORK

(65) Project Activities continued by the Ministry of Health

Final Project Report & Evaluation Project Staff Departed

(56) 3rd Year Evaluation (57) Begin 4th Round Training (58) Prog. Revision based on Evaluation

country:	project no:	project title:	date:	/x / original / / revision #	apprvd:
Cameroon	631-0009	Practical Training in Health Education	4-7-76		
<b>CPI NARRATIVE</b>					
( 1)	5/76	Project Paper Approved	(29)	1/78	Quarterly Report
( 2)	6/76	Project Agreement Signed	(30)	3/78	Reports from all training levels
( 3)	6/76	UNICEF Supplies Ordered	(31)	4/78	First Class of M.A. students begin training
( 4)	8/76	Contractor Selected	(32)	4/78	Quarterly Report
( 5)	9/76	Project Staff Arrives in Cameroon	(33)	8/78	Interim-Internal Evaluations
( 6)	10/76	Project Begin	(34)	9/78	Third Class of lower-level workers begin training
( 7)	11/76	First Phase Plans are finalized	(35)	9/78	Quarterly Report
( 8)	11/76	Initial field sites are selected	(36)	10/78	Third Class of B.S. students begin training
( 9)	12/76	1-st Class of lower level workers beg. training	(37)	10/78	Second Class of M.A. students begin training
(10)	1/77	1-st Class of Teachers are trained	(38)	10/78	Begin Mid-Project Evaluation
(11)	1/77	1-st Quarterly Progress Report	(39)	11/78	End Mid-Project Evaluation
(12)	1/77	WHO Technician arrives	(40)	12/78	Project Revisions Based on evaluation
(13)	2/77	1-st Group PCV's begin training	(41)	1/79	Begin Third Round of Training
(14)	3/77	1-st Group Mid-level workers begin training	(42)	1/79	Fourth Class of lower level worker begin training
(15)	3/77	1-st Group of ENISFAY students beg. training. Additional groups will be trained on a monthly basis. (See Project Development schedule).	(43)	1/79	Second Class of mid-level workers begin training
(16)	4/77	1-st Class CUSS students	(44)	1/79	Fourth Class of Teachers begin training
(17)	4/77	Quarterly Report	(45)	2/79	Second Group of PCV's begin training
(18)	4/77	1-st PCV's begin work	(46)	3/79	Progress Reports from all levels
(19)	5/77	1-st Class of CUSS B.S. students begin training	(47)	4/79	First Group of PCV's leave
(20)	5/77	1-st Training Reports due - Plan Revised	(48)	4/79	Second Group of PCV's begin work.
(21)	7/77	Quarterly Report	(49)	5/79	Fourth Class of B.S. students begin training
(22)	10/77	1-st Annual Evaluation	(50)	5/79	Third Class of M.A. students begin training
(23)	10/77	Round of Training Begins	(51)	6/79	Interim-Internal Evaluation
(24)	10/77	Quarterly Report	(52)	6/79	ENISFAY students continue
(25)	11/77	Evaluation Completed - Plans Revised	(53)	6/79	Quarterly Progress Report
(26)	11/77	Second Class of low-level workers begin training	(54)	10/79	Third Annual Evaluation
(27)	12/77	Second class of Teachers begin training	(55)	10/79	Begin Fourth Round of Training
(28)	1/78	Second Class of B.S. students begin training	(56)	12/79	Program Revision Based on Evaluation
			(57)	3/80	Begin Fifth Round of Training
			(58)	5/80	Program Reports, Evaluation, Revision

country:	project no:	project title:	date:	/X/ original	apprvd:
Cameroon	631-0009	Practical Training in Health Education	4-7-76	/ / revision #:	

GPI NARRATIVE ( continued )

- (59) 6/80 Begin 6th Round of Training
- (60) 8/80 Begin Fourth Annual Evaluation
- (61) 9/80 Final Project Reports and Evaluation
- (62) 10/80 Project Staff Departs
- (63) Project Activities Continued By the Ministry of Health

GRANTEE'S APPLICATION FOR ASSISTANCE

République Unie du Cameroun

Ministère de la Santé Publique

s/c du Ministère de l'Economie et du Plan

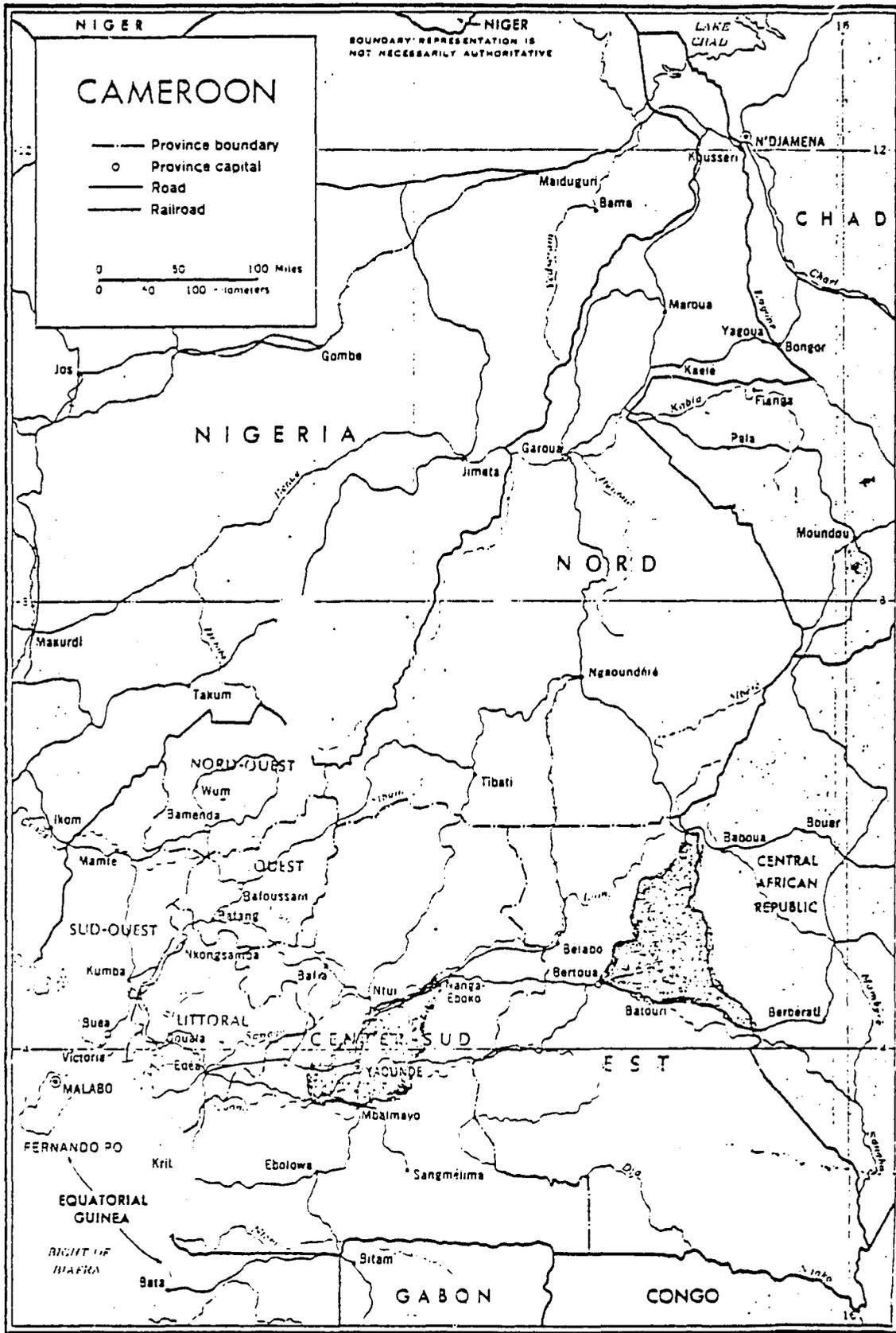
Monsieur le Directeur du  
Bureau Régional de l'U.S.A.I.D. pour l'Afrique Centrale  
Yaoundé

Monsieur le Directeur,

Le Gouvernement de la République Unie du Cameroun, par l'intermédiaire du Ministère de la Santé Publique, a l'intention d'étendre les services d'éducation pour la santé aux populations rurales et autres groupes déshérités.

Le Gouvernement de la République Unie du Cameroun a l'honneur de demander au Gouvernement des Etats-Unis de lui fournir son assistance pour ce développement des services d'éducation pour la santé.

The above letter has been forwarded from the Ministry of Public Health and the official copy is en route to the RDO via official channels including the Ministry of Economy and Plan and the Presidency.



LETTERS OF SUPPORT

This annex includes the written expression of the support of most of the agencies and institutions which have participated in the project design to this point. They show the unique degree to which the collaborative model of program design to which AID aspires has been attained. This collaboration, cited in the UNICEF letter in particular, is effective and can be expected to continue throughout the implementation and evaluation phases of the project. However, there are serious implications to the involvement of so many groups in a project before it has received AID/W approval.

It is reasonable to expect that few of the collaborating groups will be operating according to the same programming cycle as AID and that some of these groups will have to commit themselves to action before AID/W project approval is secured. With respect to this project, at the initiative of the Ministry of Health and WHO, the basic agreement between WHO and Cameroon for the CUSS graduate level program has been re-written to formally integrate the elements of this project into the CUSS training program.

A certain degree of commitment is implicit with early collaboration on such projects, and AID/W will need to delegate a level of project approval authority to the field to permit this type of cooperation to occur without a strong risk of AID embarrassment following project disapproval after other groups had preceded us down the project development road.

PTHE/PP : ANNEX F

ORGANIZATION DE COORDINATION  
POUR LA LUTTE CONTRE LES ENDEMIES  
EN AFRIQUE CENTRALE  
(O.C.E.A.C.)

YAOUNDE, le 21 Octobre 1975

B. P. 288 - YAOUNDE  
Tel: 22.22.32

Le Docteur Bernard DURAND  
Secrétaire Général

No. 906/OCEAC/SG

Dear Mr. Koehring:

Since the creation of OCEAC, the five-member states of our organization have been able to benefit from the extremely important assistance from USAID in smallpox and measles eradication, research in health education, fundamental research in ways of approaching rural populations, applied research in the field, and making of teaching aides adapted to the realities of the countries.

The projects (and that is a general rule for USAID) are unfortunately limited in time. In most cases, however, USAID seeks for possibilities of extending its activities by proposing new projects.

The USAID/OCEAC research project in health education will end by June 1976, and on the AID/RDO's proposition, we have studied a practical training project for health educators that would enable utilization, with maximum efficiency and profitability, the structures established during the USAID/OCEAC project and profit from the already acquired results.

In order to resolve the shortage crisis of health educators in Africa, the WHO Regional Office has designed a project creating two regional health education training centers, one of them located in Lagos for English-speaking countries, and the other in Yaounde (CUSS) for the French-speaking countries.

Training at the CUSS level will involve preparation of high-level personnel recruited either from a pre-university level among secondary school graduates, or the post-university level with a curriculum leading to a Master's degree.

I am pleased to confirm my agreement in principle of possibilities to use the OCEAC demonstration zone for the practical training of the OMS/CUSS Project.

These training and research operations which should be continued could take place in the OCEAC demonstration zone where within the context of the USAID/OCEAC Project, we started an active program in health education at the village level and a program for the training of middle level and low level personnel.

With the assistance of the project, OCEAC has been able to undertake the training of middle level and low level personnel and to make a series of educational materials adapted to the realities of the zone, but the WHO/CUSS Project goes beyond the level of the training offered by OCEAC and some assistance in specialized personnel will be necessary.

Also, it should not be forgotten that the success of a health education operation requires, particularly in the rural zone, not only high-level personnel but middle and low-level personnel who come into contact with the population and the daily realities; these people should also be well trained and regularly recycled.

The Practical Training for Health Educators Project presented by the AID Regional Office responds perfectly to our desire to continue the work initiated in the context of the AID/OCEAC Project, the results of which are considered to be a real success.

Lastly, we should mention the desire expressed by the five Health Ministries of the OCEAC Member States to have, in the near future at the OCEAC Headquarters, a good Public Health School for State registered nurses to attend.

The curriculum of such a school will include a large part of health education and we think that OCEAC might have to ask USAID for assistance for developing this project in the context of the project now being studied by the Regional Office.

Consequently, I am pleased to confirm my agreement in principle to the implementation of the Practical Training for Health Education Project which you have proposed for our consideration.

Sincerely yours,

Dr. B. DURAND

PTHE/PP: ANNEX F

ORGANIZATION MONDIALE  
DE LA SANTE  
-----

B.P. 155 YAOUNDE

publique Unie du Cameroun  
égr.: UNISANTE, Yaoundé

Téléphone: 22.29.20

WORLD HEALTH  
ORGANIZATION  
-----

P.O.B. 155 YAOUNDE

United Republic of Cameroon  
Telegr.: UNISANTE, Yaounde

ère de rappeler la référence :  
reply please refer to

ICP/HMD 017

STATEMENT BY WHO REPRESENTATIVE, YAOUNDE IN RELATION  
TO A PROPOSED USAID ASSISTANCE PROGRAMME IN CAMEROON

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In October 1975, the Ministry of Health of the United Republic of Cameroon convened 3 joint meetings in which all interested parties participated.

The purpose of such meetings was to discuss baseline of proposed USAID health education programme the narrative summary of which is as follows:

"To increase the ability of the rural population and other under-privileged communities to participate in development activities by providing comprehensive curative, preventive and health education services".

The overall objective of the proposed programme is "to develop a practical training system of health education activities responding to the needs of the rural population in the Mefou and Batouri DASP zones (Cameroon), for use by the CUSS/OCEAC upper level and OCEAC village training programme".

On behalf of the Organization, the WHO Representative, Yaounde, having participated in all discussions,

- endorsed the concept of practical training demonstration zones, that could be of regional value and complementary to WHO/UCHS joint Health Education intercountry project designed with a view to training national professional staff at both graduate and postgraduate levels;
- recommends that the future students in health education take advantage of such field training opportunity offered to the University Centre for Health Sciences, Yaounde.

PTHE/PP: ANNEX F

CORPS DE LA PAIX DES ETATS-UNIS  
UNITED STATES PEACE CORPS

Main Office:  
Siege Principal:  
YAOUNDE, Cameroun

Parc Repiquet  
Boite Postale 817  
Telephone: 22.25.34

Branch Office:  
BAMENDA, Cameroon

P.M.B. 45  
Telephone: 36.12.97

October 18, 1975

STATEMENT OF SUPPORT

TO WHOM IT MAY CONCERN

I, the undersigned, Norman Rifkin, Director of the United States Peace Corps, certify that our organization agrees in principle to assign 13 expert volunteers to work under the supervision of the Ministry of Health in a Sanitation/Health Education program.

These volunteers will work in close collaboration with other experts from several international organizations.

cc: Dr. Albert Henn, AID  
Dr. N. Atangana, Ministry of Health

/s/

Norman L. Rifkin  
Director

Formal relationship between the two projects will be established as required, through the Ministry of Health that will coordinate all other contributions to the programme expected from OCEAC, CIDA, UNICEF and Peace Corps.

The legal document (Plan of operations) with respect to the inter-country project in health education : ICP/HMD 017 will be amended to include this new specific area of cooperation.

YAOUNDE, 27 October 1975

(Sgd) Dr. R. Dackey.



UNICEF

UNITED NATIONS CHILDREN'S FUND  
 AFRICA OFFICE FOR CENTRAL AFRICA  
 P.O. Box 2300, Yaoundé 23

FONDS DES NATIONS UNIES POUR L'ENFANCE  
 BUREAU POUR L'AFRIQUE CENTRALE  
 Sous-Bureau de Yaoundé B.P. 1121

Your Ref.

Our Ref. 76/102/FR/omn

Yaoundé, le 7 Avril 1976

Dear Dr. Henn,

I had the pleasure of receiving on the first of April your colleagues who are in Yaoundé to prepare the project paper for Health Education in Méfou and Batouri.

I wish to confirm by this letter the willingness of our organization to participate in this project.

Following the discussions I had with your colleagues I would also like to further explain the terms of our eventual collaboration in this project.

As you may know, assistance from our organization is mainly in the form of materials and equipment and eventually in the financing of the organization of training and in-service training within the country.

- 1) This assistance is based on concrete "physical targets"
  - of persons to receive in-service training
  - of rural health centers to be equipped
  - of water sources
  - of latrines
  - of "leaders" trained
  - of village committees formed, etc.

Once we have the figures we can commit the material equipment or funds.

- 2) I said that the possible figure for our financial commitment to Cameroon would be between \$150 and \$170,000. This figure will represent our participation in the recyclage, financing of equipment and of rural health centers, as well as our financing of water projects in small rural villages.

Therefore, if Méfou and Batouri regions will serve as training centers for para-medical personnel for Cameroon you can consider our annual participation in the financing of recyclage, if the Ministry of Health accepts sending all of the para-medical staff to be "recycled" (to the Méfou and Kadey region).

We have started to equip three health centers this year in the Méfou and Kadey region in the towns of Ketté, Mbang, and Ndélélé and you can count on the continuation of our effort in this domaine in the two districts.

As for our concern about sanitation and potable water, our long-term plan is the realization of project in hundreds of Cameroonian villages (including the Méfou and Kadey region), after a technical analysis and organization of the villagers has been done.

Our problems is that we need a plan of action which indicates approximately the number of projects that will be undertaken in each district each year in order to make our fiancial commitment.

Some commitments for the financing of para-profession training, water systems; and sanitation in the DASP zones which were equipped by UNICEF in the past, remain.

(3) Objectively speaking, I think that even the highest figure I mentioned could not be absorbed exclusively by the activities in the Méfou and Kadey zones alone.

As a matter of fact, I think that the masimum number of persons to be "recycled" or trained coming from the two districts would not exceed 200.

On the other hand I don't think that the two regions could absorb all the equipment for the construction of latrines and materials originally planned for all Cameroon.

Therefore, we have to quantify precisely the commitment of our organization in terms of our involvement as it is exclusively related to the two districts. It appears necessary that I know the exact plan of action for the coming years of the project.

This plan of action will then enable us to know exactly the demands placed on us in terms of cement or reinforcing steel necessary for the Méfou and Kadey zones for the sanitation efforts, as well as the amount of funds to be set aside for the recyclage, training, the health centers, and other didactic (audio-visual) materials.

Estimated figures used by UNICEF:

a) Construction d'une dalle de latrine familiale

-Cement	50kgs	1,60 dollars
-Reinforcing Iron	3,10 kgs	0,65 dollars
-Iron wire	0,10 kgs	0,13 dollars
		<hr/>
		2,38 dollars

The cost of equipping the outpost garage will be approximately \$6,000. We will also provide the needed spareparts for the repairs of the vehicles delivered by UNICEF. I do not think that the vehicles needed in your project would present any real problems. All we would need is the agreement of the Minister of Public Health.

At the time of our discussion with the UNICEF Regional Transportation Officer we agreed in principle that we will deliver 200 motorcycles for the agent itinerants as a part of our contribution to this project.

We are talking about Suzuki 120 cc., Model 120. These motorcycles are well suited for the rough terrain; their cost is \$350 per bike, delivered to Douala.

As in the problems I raised in points 1, 3, and 4 above, it appears necessary that from your plan of action we would be able to find out the exact number to be delivered annually in relation to the number of agent itinerant that enter the service.

Concerning what I have stated above it appears to me that it is necessary for your colleagues to establish the annual goals of the PTHE.

7) At each of the physical goals, if it applies to the domaine of UNICEF intervention as I have listed above, we could apply the outlined norms in point No. 4. This would permit us more precise approximation of the annual financial contribution of UNICEF for this project.

Of course we would want to avoid any conflict with any other contributor to the project, or that UNICEF not duplicate any financing by other agencies.

I think, dear Dr. Henn, that the above information will permit your colleagues to prepare the project paper.

If you accept my suggestion in point 7 and if I had figures and physical target goals, I could make a time table available well before our meeting on the 14th.

F. DEBONNAY  
Ministère de la Santé des Programmes  
Ministère de la Santé



b) Construction d'une latrine collective

-Cement	3T118	99,78 dollars
-Reinforcing Iron	OT272	56,58 dollars
-Galvanized Iron	OT262	<u>104,80 dollars</u>
		261,16 dollars

c) Construction d'un puits dans la région de l'Est

-Cement	4T534	145,09 dollars
-Reinforcing Iron	OT418	<u>86,96 dollars</u>
		232,05 dollars

d) Construction d'un puits dans la région du Centre-Sud

-Cement	2T852	91,26 dollars
-Reinforcing Iron	OT276	<u>57,51 dollars</u>
		148,77 dollars

e) our cost for equipping a health center is about \$ 2,000

f) The cost of development of water supplies are extremely variable according to the work to be undertaken.

For this kind of work UNICEF engages itself for a maximum cost of \$1,500 and to a minimum cost of \$300.

Some very precise cost estimate studies have been done in the field by the Swiss Association for Technical Assistance - SATA- which enabled us to make an accurate estimate of each job to be undertaken.

To support the recyclage and training sessions we will follow the government figure of 6,000 CFA/month per person and 10,000 CFA/month for training.

4) The categories of personnel that our policy allows us to reimburse for training are: para-professional medical personnel, all categories of health organizers, any other development agents interested in health education services (teacher, rural engineer, midwives) and other health related personnel.

In other words if we want to quantify precisely the future participation of UNICEF on an annual basis in the Méfou and Kadey zones we must apply these to the detailed plan of action your colleagues are preparing.

As transportations is concerned I have already mentioned to you that before the end of 1975 the government of Cameroon in collaboration with UNICEF will establish in the Eastern part of the country for Batouri and Bertoua an outpost garage which will enable us to service and repair all the vehicles of the Ministry of Health (belonging to the Government or donated by UNICEF).

UNIVERSITE DE YAOUNDE

THE UNIVERSITY OF YAOUNDE

CENTRE UNIVERSITAIRE DES SCIENCES DE LA SANTE

N°           /CUSS/USP/UY

Yaoundé, le 16th April, 1976

Référence

à M. U.S.AID  
Yaounde

Objet :

PROJECT FOR PRACTICAL TRAINING IN HEALTH EDUCATION (USAID)

It is widely recognized that education for health is an integral part of all health care. Therefore, in the preparation of health personnel, it is the responsibility of the teaching institution not only to expose students to the principles and concepts of health education but to provide for their practical application under the guidance of professional personnel.

At the University Centre for Health Sciences in Yaounde (CUSS) the members of the staff have, and are continuing to exploit every possible facility to increase the students' practical experience. A project such as the one proposed by USAID would fill a critical need. As a professor of health education, I would welcome such a project where the students would be provided with a greater opportunity to practice and exercise their skills in health education.

*Ethel G. Martens*

Ethel G. Martens, Ph.D, MPH(Ed.)  
Prof. Health Education (CUSS)

EM/et

MAGNITUDE OF OUTPUTS

The following is a work schedule for all levels of persons to be involved in the project during the life of the project (four years).

- 1.1 75 villages in Mefou to be covered in the first year  
75 = 25% of total number of villages
- 1.2 150 villages in Mefou to be covered during the second year  
225 = 50% of the total number of villages
- 1.3 150 villages in Mefou to be covered in the third year  
375 = 75% of total number of villages
- 1.4 125 villages in Mefou to be covered in the fourth year  
500 = 100% of the total number of villages
- 1.5 50 villages in Batouri to be covered in the first year  
50 = 17.36% of the total villages in Batouri
- 1.6 83 villages in Batouri to be covered in the second year  
133 = 46.13% of villages in Batouri
- 1.7 94 villages in Batouri to be covered in the third year  
277 = 78.31% of villages in Batouri
- 1.8 61 villages in Batouri to be covered in the fourth year  
288 = 100% of villages in Batouri
- 2.1 30 itinerant aides trained per year in two annual training sessions
- 2.2 Total in four years - 120
- 3.1 50 school teachers in Mefou per one training session in first year  
50 = 14.70% of total number of teachers in Mefou
- 3.2 100 school teachers in Mefou per one training session in second year  
150 = 44.1% of total number of teachers
- 3.3 100 school teachers in Mefou per one training session in third year  
250 = 73.5% of Mefou school teachers

- 3.4 95 teachers per one training session in the fourth year  
345 = 100% total number of teachers in the Meïou
- 3.5 30 teachers in Batouri per one training session for first year  
30 = 17.54% of total number of teachers in Batouri
- 3.6 50 teachers in Batouri per one training session for second year  
80 = 46.7% of total school teachers in Batouri
- 3.7 50 school teachers in Batouri per one training session for third year  
130 = 76% of total number of teachers in Batouri
- 3.8 41 school teachers in Batouri per one training session in fourth year  
171 = 100% of total number of school teachers in Batouri
- 4.0 160 health personnel to be recycled in four years
- 5.1 25 mid-level nurses trained per year in one annual training session
- 5.2 Total in four years - 100
- 6.1 10 students from CUSS for training session during the first year
- 6.2 20 students from CUSS for one training session during the second year
- 6.3 30 students from CUSS for one training session during the third year
- 6.4 30 students from CUSS for one training session during the fourth year
- 7.1 313 ENISFAY students and staff to be trained in four years
- 7.2 10 ENISFAY Faculty trained
- 8.1 Total Health Personnel Trained: 1,614
- 8.2 Total Villages Served: 788
- 8.3 Total Population Served: 220,896.

UNITED REPUBLIC OF CAMEROON

PEACE - WORK - PROGRESS

P R O J E C TD E C R E E NO.....To Create Courses for the Training of  
Health Educators at the University  
Centre for Health Sciences (U.C.H.S.).

- Mindful of the Constitution of 2nd June 1972;
- Mindful of Decree No. 72/281 of 18th June 1972 to organize the Government of the United Republic of Cameroon;
- Mindful of Decree 72/304 of 3rd July 1972 to appoint Members of the Government of the United Republic of Cameroon;
- Mindful of Law No. 63/LF/23 of 19th June 1963 relating to the financial institutions of the Federal University of Cameroon;
- Mindful of Decree No. 62/LF/289 of 26th July 1962 to institute and organize the Federal University of Cameroon, as amended by Decree No. 67/LF/666 of 28th December 1967 to terminate the transitional period provided for the installation of the Federal University of Cameroon, by Decree No. 69/LF/504 of 21st November 1969, by Decree No. 71/LF/423 of 26th August 1971 as amended by Decree No. 72/376 of 2nd August and by Decree No. 73/477 of 24th August 1973;
- Mindful of Decree No. 72/LF/381 of 7th August 1972 to reorganize the Ministry of National Education;
- Mindful of Decree No. 62/LF/372 of 8th October 1962 to list the higher education establishments comprising the Federal University of Cameroon, as amended by Decree No. 72/LF/200 of 15th April 1972;
- Mindful of Decree No. 73/326 of 2nd June 1973 to alter the names of the Federal University of Cameroon, the Federal Advanced School of Agriculture and the Federal Advanced Polytechnical School;
- Mindful of Decree No. 73/478 of 24th August 1973 to set up a special duty allowance in favour of the administrative personnel of the University of Yaoundé;

Mindful of Decree No. 69/LE/256 of 14th June 1969 to establish the University Centre for Health Sciences; amended by Decree No. 73/796 of 20th December 1973 to reorganize the University Centre for Health Sciences;

Considering the opinion of the Board of Professors, UCEH of .....

Considering the opinion of the Board of Governors.....

Considering the Decision of the Senate of the University of Yaoundé :

..... of.....

HEREBY DECREES AS FOLLOWS

CHAPTER I

GENERAL PROVISIONS

Article 1 : A Regional Centre for the Training of Health Education Specialists shall be created at the University Centre for Health Sciences;

Article 2 : The training provided by the centre shall consist of two programmes as follows:

- (a) an undergraduate programme of at least two years of studies leading to a bachelor's degree in health sciences (B.Sc. in Health Education);
- (b) a post-graduate programme of at least one year of studies leading to a master's degree in health sciences (M.Sc. in Health Education);

CHAPTER II

ADMINISTRATION

Article 3 : The regional centre for the training of health education specialists shall be placed under the administrative rule and regulations provided for by articles 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 18 of Decree No. 73/796 of 20th December 1973 to reorganize the University Centre for Health Sciences;

Article 4 : The Regional Centre for the Training of Health Education Specialists shall constitute a section within the Public Health Unit of the University Centre for Health Sciences

CHAPTER III

TEACHING STAFF

- Article 5 : The hierarchy of the teaching staff for the Regional Centre for the Training of Health Education Specialists shall be as laid down under Article 40 of Decree No. 6366 of 28th December 1967 to reorganize the Federal University of Cameroon;
- Article 6 : The Members of the teaching staff for the regional centre for the training of health education specialists shall be teachers of the University of Yaoundé and they shall be subject to the general provisions of Articles 41, to 47, 49, and 54 to 61, of Decree No. 67/LE/366 of 28th December 1967;

CHAPTER IV

STUDENTS

SECTION I - CONDITIONS OF ADMISSION

- Article 7 : (a) Admission to the programme of studies leading to the degree of Bachelor of Health Sciences (option Health Education - B.Sc.(H.Ed) shall be by competitive written and oral examinations open to candidates who have successfully completed at least two years in the Faculty of Letters and Human Sciences, Faculty of Sciences and Mathematics, and the other Faculties, Schools, and Institutes of the University of Yaoundé or other University Institutions in Africa. Candidates holding qualifications considered as equivalent will also be admitted to the entrance examination.
- (a)1 In addition candidates must have an attestation from some superior officers who are not relatives commenting on the candidate's academic ability and suitability to do the course.
- (b)1 Admission to the programme of studies leading to the degree of Master of Health Sciences in Health Education - M.Sc. (H.Ed) shall be interview open to candidates with the following qualifications:-
- B.A. (Education, Sociology, Psychology, Journalist)
  - B.Sc. (In Health Sciences or Social Sciences)
  - M.B.B.S. or M.D. (Doctor of Medicine) In addition they all shall have served for at least two years after their basic qualification.

Article 8 : An order of the Minister of National Education issued after consultation with the Minister of Public Health shall fix the number of places open for competition to different countries in the African Region of the World Health Organization. (WHO)

Article 9 : The tests of the competitive examination, the registration conditions and the composition of the examining boards shall be the subject of an order of the Minister of National Education;

Article 10: Candidates accepted for the course leading to the bachelor's degree shall be subject to the same studies allowance prescribed for the third and fourth years of medical studies of the University Centre for Health Sciences.

(b) Candidates accepted for the course leading to the Master's degree in Health Education shall be subject to studies allowance prescribed for the sixth year medical studies of the University Centre for Health Sciences.

#### CHAPTER V

#### DISCIPLINE

Article 11 The disciplinary rules and regulations governing the studies for the training of health education specialists shall be similar to those laid down in Articles 63 to 73 of Decree No. 67/LE/566 of 28th December 1967;

Article 12 The Minister of National Education and the Minister of Public Health shall be responsible for the implementation of this decree, which shall be registered, notified whenever necessary, and published in the Official Gazette of the United Republic of Cameroon in French and English.

Yaoundé ..... 1976

EL HADJ AHMEDOU AHEDJO