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IVERMECTIN DELIVERY PROGRAM

ONCHOCERCIASIS CONTROL PROJECT
IN THE DIVISION OF DJA ET LOBO
SOUTH PROVINCE, CAMEROON

WORK PLAN
FOR
YEAR TWO

THE INTERNATIONAL EYE FOUNDATION

OCTOBER 1992

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I EXECUTIVE SUMMARY

During the first year of the Ivermectin Delivery Project in the division of Dja et Lobo, South Province, Cameroon, a functional project infrastructure was established, and epidemiological and knowledge, attitude and practice (KAP) surveys were carried out. Furthermore, training, health education and distribution activities are well under way.

In Year Two, project activities will focus on: 1) finalizing the epidemiological characterization of the division of Dja et Lobo, 2) training of personnel involved in treatment activities, 3) health education and 4) distribution of ivermectin in all villages targeted for mass treatment.

The goal of the project remains the same as in Year One which is to introduce an ivermectin distribution system for high risk populations that can be sustained by the indigenous health institutions.

As in Year One, great care will be taken to strengthen the primary health care structure of the division. Therefore, local health unit staff will be trained for all activities concerning the distribution of ivermectin, including health education, handling of adverse reactions and record keeping. Furthermore, the rules of cost recovery, as established by the Cost Recovery Committee of the Project SESA (Santé de l'Enfant du Sud et de l'Adamaoua) will be respected at all times.

The division of Dja et Lobo has approximately 150,000 inhabitants of which no more than 60% (i.e. 90,000) are thought to be eligible for treatment at a given point in time. Villages with onchocerciasis prevalence levels of 40% or above, will be targeted for mass treatment, which will be carried out by CBDs or through mobile teams. Passive distribution, i.e. demand driven, health center based, will be employed for villages with prevalence levels below 40%.

II ABBREVIATIONS

BSP	-	Bureau de Santé Publique
CBD	-	Community Based Distributor
IEC	-	Information, Education and Communication
IEF	-	International Eye Foundation
KAP	-	Knowledge, Attitude and Practice
mf	-	microfilaria
MOH	-	Ministry of Health
PA	-	Project Assistant
PCV	-	Peace Corps Volunteer
PD	-	Project Director
PHC	-	Primary Health Care
PHCC	-	Primary Health Care Coordinator
SESA	-	Santé de l'Enfant du Sud et de l'Adamaoua

III SUMMARY OF POPULATION AND HEALTH CARE STATISTICS OF THE DIVISION OF DJA ET LOBO

SUB-DIVISION	# VILLAGES	# PEOPLE	# HEALTH ZONES	# HEALTH CENTERS
BENGBIS	63	9,521	N.D.	4
DJOUM	82	21,118	8	5
MEYOMESSALA	77	30,652	N.D.	7
SANGMELIMA	106	58,498	11	20
ZOETELE	49	23,112	N.D.	8
TOTAL	377	142,901	-	44

Figures are based on census data taken in 1986.

IV OBJECTIVES FOR YEAR TWO

1. To determine a rapid assessment method to be used for the epidemiological mapping by March, 1993.
2. To map the entire project area using a rapid assessment method by June, 1993.
3. To provide one cycle of mass treatment to all villages with onchocerciasis prevalence levels of 40%, or higher, by the end of Year Two.
4. To capacitate at least one person in all 44 health centers of the division to handle distribution activities, including health education, handling of adverse reactions, and record keeping by April, 1993.
5. To train all five Primary Health Care Coordinators, and their Peace Corps Volunteer counterparts, to function as TOTs, handle distribution activities where necessary, and supervise distribution activities in their subdivision, by the end of 1992.
6. To train at least 200 Community-Based Distributors (CBDs) in villages with prevalence levels of 40% or above by the end of Year Two.
7. To develop and produce appropriate health education materials by April, 1993.

V EPIDEMIOLOGY

The results from the two in-depth surveys (performed in the sub-divisions of Djoum and Sangmelima) will be carefully analyzed in the period between November'92 and February'93. The current Project Director, Dr. Basile Kollo, will spend three to four months at Tulane University to establish the most reliable and appropriate rapid assessment technique for the epidemiological classification of all villages of the division of Dja et Lobo.

Upon the Project Director's return, scheduled for March 1993, or earlier, all villages of the entire division will be epidemiologically classified, using the rapid assessment method established. This epidemiological mapping will be performed by teams consisting of the Primary Health Care Coordinator and one health center staff member of their assigned sub-divisions. Currently, there are five functional sub-divisions with regards to primary health care, i.e. there will be five teams mapping the division of Dja et Lobo. The Project Director will train the teams for this task and supervise them during the first days of survey activities. Therefore, mapping will start in a staggered fashion, with all five teams engaged in mapping activities three weeks after the training.

It is expected, that one team can survey three to five villages per day, depending on the size and the spread of the villages. A smaller sub-division, such as Zoetele with 49 villages, can thus be mapped in 15 working days, i.e. three weeks. Mapping of Sangmelima, the largest sub-division with 106 villages (20 of which were surveyed already in June 1992) will take approximately 5 weeks. Thus, training for mapping, and mapping of the project area, are expected to take a maximum of 9 weeks total, i.e. will be finished by May 15, 1993, the latest.

To enable the teams to visit all villages for mapping activities, adequate transportation needs to be assured. One motorcycle per team of two people is considered adequate transportation. Currently, there are no motorcycles in the health centers. Therefore, five motorcycles are required (one per sub-division) and this project has made provision for their purchase. These motorcycles are also required for supervision during community-based distribution.

VI TRAINING

There are five training sessions planned for Year Two:

1. Training of health center staff in the sub-division Sangmelima

In this sub-division, only staff members from the Central Hospital in Sangmelima Town were trained for distribution and record keeping activities in Year One. Therefore, at least one staff member per peripheral health center in the subdivision of Sangmelima needs to be trained. Included in this training session will be the PHCCs and PCVs of Bengbis, Meyomessala and Zoetele. With 17 health centers outside Sangmelima Town, and two staff members of the Central Hospital who did not participate in the training session for their hospital, the total number of trainees amounts to 24. The training session will take place in Sangmelima Town and will last for 2 days. One person from the project (either the Project Director or the Project Assistant) and one official from the "Bureau de Santé Publique" will conduct the training which will be followed by a written evaluation.

In preparation of this training session, a circular letter, announcing the training, will have to be sent to all health centers of the sub-division of Sangmelima. This activity will take approximately 4 days. The health center staff is expected to have received training by December 15, 1992, the latest.

2. Training for epidemiological mapping, using a rapid assessment method

To train the personnel for the mapping, one one-day session is scheduled for March 1993, possibly earlier. Training will take place in Sangmelima Town. The trainees will be the PHCC plus one health center staff member from the five sub-divisions (i.e. 10 persons). The Project Director, and an official from the BSP, will conduct the training which will be exclusively focused on teaching how to use the rapid assessment method.

3. Training for health center staff from the sub-divisions of Bengbis, Meyomessala and Zoetele

At least one staff member per health center will be capacitated for distribution activities, including health education, handling of adverse reactions and record keeping. With four health centers in Bengbis, seven in Meyomessala, and eight in Zoetele, at least 19 persons will be trained in total. One two-day training session will be held in each of the three sub-divisions. The PHCC and PCV of the sub-division will teach the training sessions, with one project staff member (PD or PA) and an official from the BSP providing supervision during the training sessions.

These three training sessions can take place as soon as the PHCCs and PCVs have been trained during the two-day training session held in Sangmelima, and as soon as the health education material has been developed. Both activities are expected to have been completed by the end of February 1993. Therefore, the capacitation of the health center staff of Bengbis, Meyomessala and Zoetele is scheduled for March, 1993, if not earlier.

4. Training of Community-Based Distributors (CBDs)

According to the Detailed Implementation Plan, all villages with an onchocerciasis prevalence level above 40% should receive mass treatment through a community-based method. For this, Community-Based Distributors (CBDs) have to be trained. The final number of villages with prevalence levels above 40% will only be available after the epidemiological mapping has taken place. Therefore, the precise number of CBDs to be trained can not be determined. Based on preliminary data, which showed that the majority of villages has prevalence levels above 40%, it can be assumed that for the entire division at least 50% of all villages need to be treated through a community-based mechanism. Therefore, approximately 200 CBDs are targeted for training in Year Two.

Training sessions will take place on the sub-divisional level, and will be taught by the PHCCs and PCVs of their assigned sub-divisions. The CBDs will be trained in groups of 20, i.e. there will be 10 training sessions which will take five days. Supervision will be provided by a project staff member (PD or PA) and a member of the BSP.

Training of CBDs can start immediately after the mapping has been finished, i.e. after May 15, 1993, or earlier. As the training sessions will be followed by supervised distribution of ivermectin by the CBDs, training sessions for CBDs will take place throughout the remainder of Year Two, i.e. until September 1993.

5. Training for Health Education

Training for health education will be an integral part of all training sessions scheduled for Year Two. However, the personnel cannot be trained before the health education materials have been developed. Health education materials are expected to be available by March, 1993. As the health center staff of Sangmelima and Djoum were trained in Year One, or are scheduled to be trained before the end of 1992, this staff has to receive specific training for health education. For this, a two-day training session in Sangmelima Town is planned for April, 1993, possibly earlier, depending on the availability of the health education materials. The five PHCCs, four PCVs, one person from Meyomessala as this sub-division does not have a PCV, and two more persons from Sangmelima Central Hospital (i.e. total of 12 trainees) will be attending the training. The training session will be conducted by the Project Director or the Project Assistant, and the divisional PHCC, who is SESA's representative for IEC.

VII HEALTH EDUCATION

In Year Two, health education will consist of five major steps:

1. Developing the Health Education Messages

Health education messages will be developed in collaboration with AMA (Atelier Materiel Audio-Visuel), a local PVO. These messages will be based on the findings of the KAP survey. The Project Assistant and SESA's representative for IEC will be in regular contact with AMA's staff. This first phase is expected to be finished by the end of 1992.

2. Field Testing of the Health Education Messages

The health education messages developed in phase one, will be field tested in four villages of the sub-division of Djoum. As there are four major language groups in the project area, one village per language group will be asked to participate in the test. Field activities are expected to take place in January, 1993. The results will be analyzed in collaboration with AMA during the month of February, 1993.

3. Production of Health Education Material

Once the results from the field testing are available, health education materials will be produced in large enough numbers to be distributed to all health centers and all villages treated by CBDs.

4. Training

All health center staff and CBDs will receive training to enable them to deliver the health education messages. While in some cases, this training will be part of a general training session for ivermectin distribution, there will be also one training session focusing on health education only. For details concerning health education training, see chapter "VI. Training".

5. Implementation

In March, 1993, distribution of the health education materials to the health centers will take place. For the remaining months (i.e. March to September, 1993), slide shows and educational films will be shown at least once in the towns of Sangmelima, Djoum, Meyomessala and Zoetele. As there is no electricity in Bengbis, other means of health education will be used in this sub-division. During the same time, messages to encourage treatment seeking behavior will be broadcasted from the national radio station in Yaounde.

On Youth Day (February 11) and Independence Day (May 20), there will be educational games using messages from the ivermectin distribution project, in which people can win prizes.

As CBDs will start treatment, they will deliver the health education messages in their villages.

VIII DISTRIBUTION

In Year Two, there will be two main modes of distribution: passive, i.e health-center based, and through CBDs. However, the 20 villages of Sangmelima sub-division which were surveyed in June 1992, will be treated by a mobile team. It is important, that the people who participated in the survey, i.e. accepted to be skin snipped, will receive ivermectin as quickly as possible to maintain their trust in the program.

Therefore, a mobile team, consisting of the Project Director, who is an MD, an official from BSP, and the PHCC and PCV from Sangmelima, will treat the 20 survey villages during November and December 1992. Before the team will visit the villages, a circular letter will be sent to each of the 20 village chiefs, asking for their collaboration in the upcoming treatment campaign. The village chiefs will also be asked to sell the treatment cards (for CFA200 each), as the treatment team should not be involved in this activity required by the cost recovery system of SESA. Treatment will take place in a central place in the village, there will be no house-to-house visits and no household census will be taken. Each village will be revisited for two days after treatment to assure proper handling of adverse reactions.

In villages with levels of prevalence of 40%, or above, treatment will be carried out by CBDs, provided the villages can be reached by supervisory staff on motorcycles. The CBDs were trained for this task as described above (see "Training"). They will be supervised by staff from the nearest health center, usually the PHCC and the PCV. While all distribution related activities will be carried out by the CBDs, they will not sell the treatment cards. For this task, the village chiefs will be asked for their assistance. They will sell the cards and then hand the collected money and the remaining cards to the supervisor who will visit the village after the distribution has taken place.

Should the result of the epidemiological mapping reveal that the majority of all villages has to be mass treated, the villages without trained CBDs will be mass treated by mobile team (as only 200 CBDs will be trained in Year Two). In Year Three, all villages requiring mass treatment are scheduled to have a trained CBD in place.

For villages with onchocerciasis prevalence levels below 40%, and those that cannot be reached by motorcycle due to the poor quality of the road, treatment will occur passively, i.e. the people will have to come to their nearest health center to be treated with ivermectin. As all health centers of the division should be capacitated for distribution by March, 1993, passive distribution will be able to start in all health centers by the beginning of April, 1993, if not earlier.

IX H/MIS

The computerized H/MIS developed by Dr.Eckard Kleinau for AID/VBC is expected to be available by the end of 1992. Until then, forms are being used that were developed for an onchocerciasis control project in Nigeria, Kwara State, and that were adapted to the local situation and translated into French.

X SUPERVISION

Special care will be given to maintain and expand the supervisory structure established by SESA. This structure operates on three levels: divisional, sub-divisional, and on health center and village level. Project staff, either the PD or the PA, will accompany the supervisor from the divisional level, i.e. an official from the BSP, on his monthly visit to the central health units of each sub-division where the PHCCs and the PCVs are stationed (=supervision on the sub-divisional level).

In regular intervals, the divisional team will join the PHCCs and PCVs on their supervisory visits to the peripheral health centers and the villages where CBDs are performing distribution activities (joint supervision). It is expected, that a member of the project staff will have visited all health centers and villages, in which CBDs are working, at least once during Year Two.

XI EVALUATION

In April, 1993, the first 18 months of the project will have been completed. It is therefore expected, and desired, that USAID will carry out the mid-term evaluation in April 1993.

Informal evaluations of project activities will be performed on an ongoing basis. The impact of the training sessions will be evaluated through a written test which was developed and successfully used during the training sessions of the first year. The quality of administering ivermectin, handling of adverse reactions, and record keeping will be assessed during the regular supervisory visits by the project staff.