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ASSISTANCE TO THE
NATIONAL CAMEROON CDD PROGRAM

Report Prepared By PRITECH Consultant:
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TECHNOLOGIES FOR PRIMARY HEALTH CARE (PRITECH) PROJECT
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Abbreviations used in this report

EPS	Education pour la Sante (Health Education Dept.)
CDD	Control of Diarrheal Diseases
HED	Health Education
IEC	Information, Education & Communication
MESRES	Ministere de l'Education Superieure et Recherche Scientifique
MINASCOF	Ministere des Affaires Sociales et de la Condition Feminine
MSP	Ministere de Sante Publique
OCEAC	Organisation de Coordination Pour la Lutte Contre les Endemies en Afrique Centrale

I. Overview of consultancy

This consultancy was carried out from July 7-Sept. 2 by PRITECH consultant, Judi Aibel, and was coordinated by Robin Steinwand, PRITECH Representative in Yaounde.

Purpose of consultancy:

To work with the National Cameroon CDD program of the Ministry of Public Health to organize a national focus group study and to supervise the first phase of that study

Scope of work: The scope of work was discussed and agreed upon prior to the consultant's arrival in Cameroon. (The following SOW items appear in the consultant's contract but have in several cases been reworded to increase clarity)

1. to meet with MSP, CDD and Health Education staff to review the CDD Program and plans to date
2. to work with MSP CDD and Health Education (HED) staff to outline the steps and the timetable for conducting the national focus group study
3. to work with the CDD/HED staff to choose the study sample and develop data collection instruments
4. to work with the CDD/HED staff to plan the interviewer training
5. to train the study interviewers
6. to supervise the study in the first region and train MSP staff who will supervise in the other 5 regions
7. to coordinate the analysis of the data collected in the first region and the preparation of the report for that region
8. to discuss the followup steps in the CDD health education/IEC strategy.
9. to debrief PRITECH/Cameroon and CDD team before departure
10. to prepare a final report to include:
 - the objectives and methodology of the study
 - copies of study discussion guides
 - summary of data analysis in first region
 - recommendations for study in other regions
 - recommendations relevant to CDD IEC strategy

Organization of 8-week consultancy:

The consultancy was organized as follows:

1. Initial contacts and briefings with USAID and MSP staff: July 7-8
2. Planning and organization of the focus group study: July 11-30
3. Planning and conducting interviewer training: Aug. 1-12
4. Supervision of data collection in first region: Aug. 15-26
5. Analysis of first region data and preparation of report of findings: Aug. 29-Sept. 2
6. Debriefing of USAID and MSP staff: Sept. 1 & 2

1. Initial contacts and briefings

PRITECH

The initial briefing was held with PRITECH Representative, Robin Steinwand, to review the terms of reference, to discuss the preliminary planning for the focus group study which she had done with MSP officials, and to plan the initial meetings to be held with MSP and USAID officials.

USAID

A meeting was held with the Mission Director to explain to him the content of the consultancy in the context of the PRITECH CDD project.

MSP

Several initial meetings were held with Dr. Owona, Assistant Dir. of Preventive Medicine and Director of the National CDD Program, and Mr. Ndeso, Manager of the national program. The consultant elicited their expectations of the study and outlined the steps and procedures involved in carrying out a qualitative study on CDD. From the outset and throughout the consultancy Dr. Owona and Mr. Ndeso demonstrated a strong interest in the study and provided maximum support for all of the related activities.

In the initial discussions with MSP officials, the consultant explained her belief that the study should serve two purposes. On the one hand, data should be generated which can be used in the development of the CDD health education program. Secondly, it should be an opportunity for certain MOH personnel to develop skills in the development and use of the focus group methodology, which could be of use in the future for the collection of information on other community health problems. Dr. Owona and Mr. Ndeso were in agreement with the consultant in this regard and stated that they wanted it to be a learning experience for their personnel.

A meeting was likewise held with the Director of the Health Education Dept. to assure that the dept. participate actively in the study. He was initially very supportive and expressed his wish that his staff be actively involved in this activity. Anne Domatab, Assistant Dir. of the Dept. was chosen to be involved in all stages of the planning and supervision of the study in the regions.

2. Planning and organization of the study

Initial discussions on the steps involved in organizing the study and the consultant's desire for ministry colleagues to be involved in all phases of developing and conducting the study, led to the identification of the different tasks to be accomplished and the need to identify persons who could collaborate on each of those tasks, namely: 1) the technical/ methodological planning of the study 2) logistics planning 3) planning and conducting the training of the interviewers 4) supervision of the interviewers and data collection in the regions 5) coordination of the data analysis and preparation of the report of the findings in each

region.

1) technical/methodological planning of the study:

Prior to the consultant's arrival in Cameroon, discussions had been held between the MOH and the Dept. of Projects and Studies of the Ministry of Social and Women's Affairs (MINASCOF) regarding the participation of the this dept. in the technical design and supervision of the study. The Dept. of Projects and Studies was previously involved in a large focus group study on "The Cameroonian Family" and they had proposed to the MSP that responsibility for conducting the study be delegated to them, to include use of the MINASCOF interviewers.

This proposal was discussed with the consultant but it was decided that the MSP should have the main responsibility for carrying out the study in order to build skills in the use of the methodology in the MSP. Nevertheless, there was a commitment to involving the MINASCOF personnel in the study as members of the technical planning work group, and to use a number of their trained interviewers for the data collection.

An additional human resource which was identified in Yaounde was a young Cameroonian anthropologist, Flavien Ndonko, who already had some experience in health and who expressed interest in working on the study. The consultant felt that his skills, in terms of qualitative research methods, were very relevant, and that his involvement in the planning and initial data collection phases would be beneficial. The MSP agreed that his collaboration on the study would be valuable and while the ministry did not have the means to hire him, they were in favor of him working on the study and agreed that PRITECH recruit him as a short-term consultant.

A working group responsible for the technical planning of the study was constituted by Dr. Owona and included several people from the Health Education Dept., Robin Steinwand, Mr. Ndeso, 2 persons from MINSCOF and Flavien.

2) logistics planning:

There was the need to identify someone in the ministry who could work on the logistics planning for the study, initially with Mr. Ndeso and Robin Steinwand, and later take full responsibility for logistics planning on his/her own. Mr. Dan Ebah from the Health Ed. Dept. was identified.

3) planning and conducting the training of the interviewers:

The need to identify one or two persons, ideally from the CDD national training team, who could work with the consultant on the planning and facilitation of the interviewer training was discussed. Given the busy schedules of the CDD trainers in the ministry, it was difficult to identify these persons. Ultimately, one of the training team members, Anne Domatab, and Mr. Ngouana, responsible for ministry professional training programs were chosen.

4) supervision of the interviewers and data collection in the regions:
Given the importance of the supervision function in a focus group study,

it was important that several individuals from the MSP be identified who could learn how to supervise the data collection in the field. Ultimately, two persons from Health Education, Anne Domatab and Tah Shadrak, Mr. Ngouana and the consultant anthropologist were chosen.

5) coordination of the data analysis and preparation of the report of the findings in each region:

This task will be the responsibility of the one or more supervisors who follow the data collection in each of the regions, in collaboration with the consultant anthropologist.

2.1 Defining the goals of the study:

The primary focus of the study was on data collection at the community level, but it was decided to also collect data from health personnel. The working group charged with the technical planning and organization of the study defined the goals of the study as follows:

- 1) to assess the knowledge, beliefs and practices of the community related to the management of diarrheal disease as the basis for development of a CDD information, education and communications strategy and for the development of training activities for health personnel
- 2) to assess the knowledge and attitudes of health personnel regarding the management of diarrheal diseases by the community and in the health structures
- 3) to strengthen the competence of MSP personnel and of persons in other agencies which are collaborating in the national CDD program in the use of qualitative research methodologies for the study of community health problems

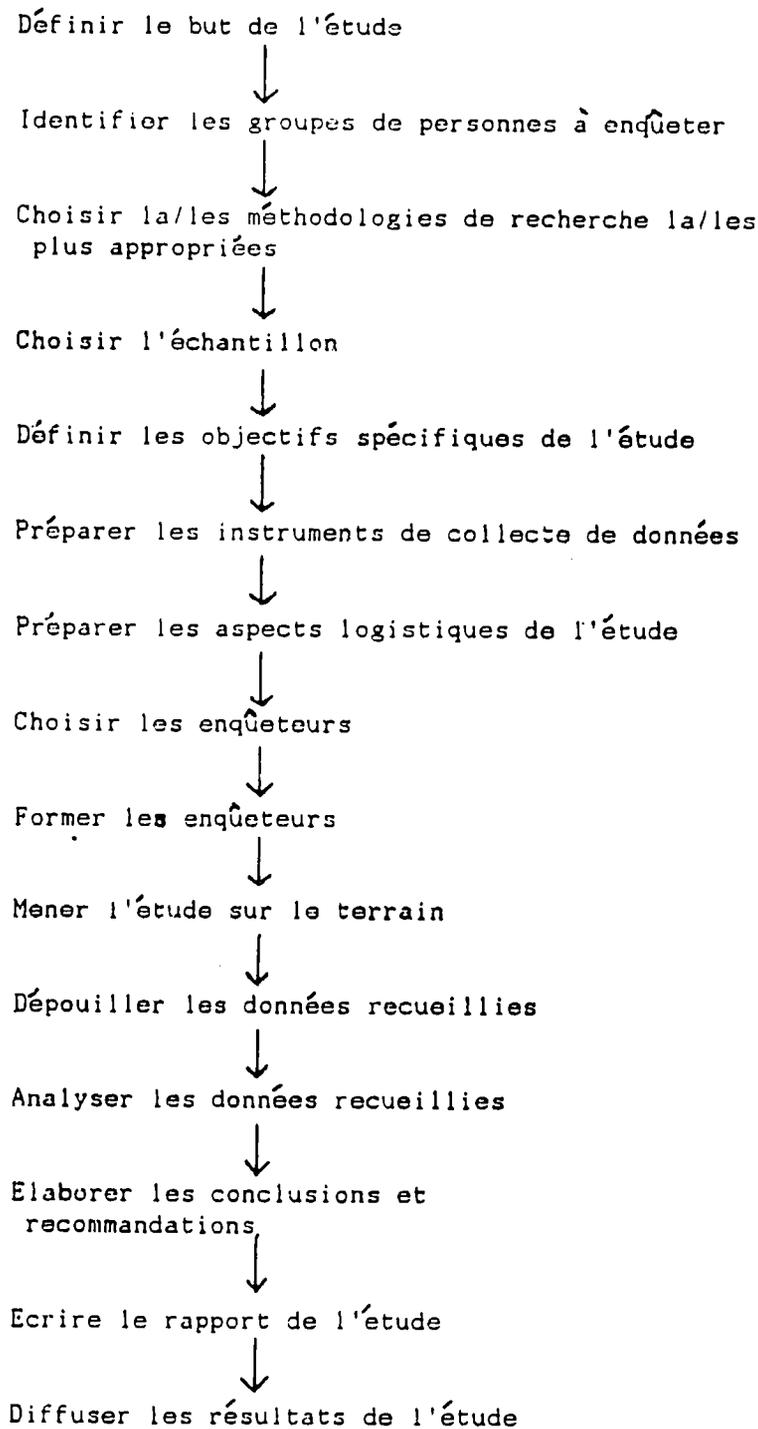
Community level data collection:

Relative to the first goal of the study, the next step was to identify the groups within the community from whom data would be collected. A "social influence analysis" was carried out by the technical working group to identify those individuals in the community who have information about or responsibility for the management of child diarrheal disease. The following list was generated: mothers of young children, fathers of young children, grand-mothers, young girls who are not yet married and who care for younger children in the family, traditional healers specialized in the treatment of diarrhea. Given the need to limit the total number of interviews and to have a minimum number of interviews in each of the sub-groups in the sample, it was decided that group discussions would be carried out with mothers, fathers and grandmothers; individual interviews with mothers and when possible with traditional healers.

Health personnel data collection:

10 individual interviews would be carried out in each region with health personnel responsible for consultations with diarrheal children.

Les étapes dans l'organisation d'une étude de base
en matière des maladies diarrhéiques



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2.2 Choice of methodologies:

The members of the technical working group had some experience with quantitative survey research but with the exception of the two people from MINASCOF, they had had no previous experience with qualitative methods. The consultant presented an overview of the differences between quantitative and qualitative methods and it was agreed that the methodologies to be used in the study would be essentially qualitative in nature.

Community data collection:

Two qualitative research techniques were to be used at the community level: the group discussion, or focus group; and the indepth interview. The two techniques were used in combination at each study site, with the group discussion to be carried out one day and one or more indepth interviews the following day, to complete the data set for that site.

Health personnel data collection:

Individual interviews with a combination of closed and open-ended questions were planned for the health personnel

2.3 Choice of the study sample:

2.3.1 Community study

The study was to be national in scope and a first step was to divide the country into regions which would be the basis for the choice of the sample. In an initial meeting of the technical working group, the Cameroonians presented a proposal to constitute such regions along administrative lines. Given the nature of the study and its focus on beliefs and practices tied to socio-cultural realities, the consultant and anthropologist insisted upon the importance of defining the regions rather along socio-cultural lines. Such an approach was new for all of the Cameroonians involved and while there was considerable initial resistance, the group did ultimately understand the rationale for choosing the sample in a "non-traditional" way.

The next step was to define such socio-cultural regions. This was an extremely difficult and time-consuming task given the ethnic and linguistic complexity of the country. In Cameroon there are approximately 200 different languages and close to 150 ethnic groups. Unlike many countries where ethnicity and linguistics are intimately related, this is not the case in Cameroon. Amongst the Bamileke ethnic group, for example, there are approximately 30 completely different languages.

2.3.1.1 Identification of socio-cultural regions:

While this was to be a national study, given limited time and resources it was obviously not possible to envision an exhaustive study of the beliefs and practices of all ethnic groups. For the purposes of choosing the sample, it was therefore necessary to simplify a very complex

situation. The assistance of the anthropologist was indispensable at this point and after several arduous meetings the group finally agreed on six regions based upon cultural, religious and ecological factors.

2.3.1.2 Choice of regional sites and languages:

The next step was to identify the specific data collection sites within each region. The objective was to identify sites which exemplify the main socio-cultural contrasts within each region. One dimension of the choice was the rural-urban dynamic. Given that the rural population is proportionally more important than the urban population, that the incidence of diarrhea is higher in rural areas, and that the socio-economic level of the population is relatively lower in rural areas, it was decided that two thirds of the study sites would be rural and one third urban. Given the need to limit the length and cost of the study and, likewise, to deal with the linguistic configuration, it was only possible to include two rural and one urban site in each of the regional samples. In linguistic terms, each of the rural sites represents a different language and in the case of the urban site in each region, the language of the groups to be included in the sample would be the same as that of one of the rural sites. This configuration implied that the study would be carried out in two languages in each region, and in a total of 12 languages for the entire country.

2.3.1.3. Choice of groups per site:

In the study as a whole, priority was given to the interviews with mothers, given their central role in diarrheal disease management and secondarily, with grandmothers and fathers. The number of groups to be interviewed by region was as follows:

Number of groups and number of persons interviewed per region

type of group	no. of persons per grp.	no. of grps. rural sites	no. of grps. urban sites	total no. of grps. interviewed	total no. of persons interviewed
mothers	6-10	4	2	6	36-60
grandmothers	6-10	2	-	2	12-20
fathers	4-8	2	-	2	8-16
Total no. of grps.		8	2	10	56-96

2.3.2 Health personnel study

For the health personnel interviews it was planned that 10 persons would be interviewed in each of the 6 regions, 4 at each rural site and 2 at the urban site. Individuals to be included in the sample would be those working in the various MSP depts., MCH, dispensaries, health centers, who

are responsible for consultations of diarrheal children. Convenience sampling would be used by the supervisors to identify individuals to be interviewed upon arrival at each site.

2.4 Development of data collection instruments:

2.4.1 Community data collection

The development of the community data collection instruments was begun with the technical working group. Unfortunately, due to the fact that the persons involved were not available to work full-time on the study, the task was completed by the consultant in collaboration with the anthropologist.

The conceptual basis for community data collection was a model which the consultant developed based on various health-seeking models from medical sociology, with elements of medical anthropologist Kleinman's work on health care systems. (See "Processus Therapeutique en Matiere des Maladies Diartheiques", Figure 1) The model examines the process which a mother goes through when her child has a bout of diarrhea, first in terms of how she perceives the problem and secondly, in terms of what treatment procedures she follows. As regards the perception of the illness, the model includes factors related to: the perception of the magnitude of diarrheal diseases; the terminology used for different diarrheal diseases; the perception of symptoms; the perception of causes; the perception of the possibilities of prevention; and the perception of the danger of diarrheal diseases. Regarding treatment of diarrheal diseases, the model includes consideration of: the source of treatment whether it be at the family level, in the traditional health sector, or in the bio-medical/modern health sector; and of the type of treatment in terms of liquids, to include ORS and SSS, breast-feeding, nutrition, and medicines and other remedies.

This model was presented to the MOH members of the working group and together they formulated specific objectives for the study relative to the different factors of perception and treatment. (Appendix B: Les objectifs specifiques de l'etude qualitative en matiere des maladies diartheiques) Input from several officials in the Dept. of Preventive Medicine was sought as regarded specific information on diarrheal disease beliefs and practices which they hoped to obtain from the study.

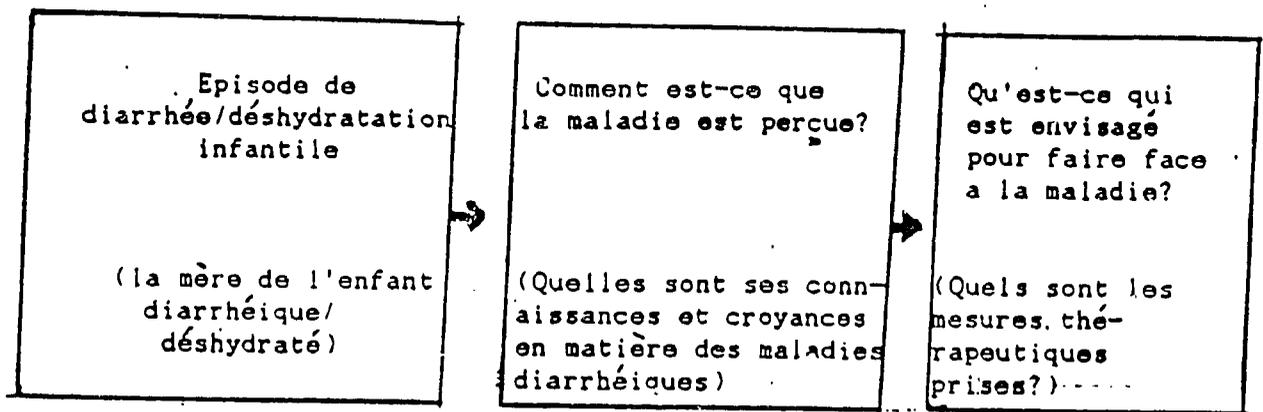
The consultant noted that at present nutritional aspects of diarrheal disease management seem to be given limited importance at the national level of the MOH. Given the importance of information on child feeding practices for the the formulation of nutrition-related CDD health education messages particular attention was given to data collection on nutritional practices with young children in the formulation of the specific study objectives. The specific objectives would serve as the basis for all data collection and analysis. During the interviewer training, the interviewers were each required to learn by heart both the health-seeking model and the specific objectives.

Figure 1:

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Modèle conceptuel pour l'étude en matière des maladies diarrhéiques

Processus thérapeutique en matière
des maladies diarrhéiques



-importance/ampleur

-terminologie

-symptômes

-causes

-prévention

-danger/conséquences

-sources des mesures thérapeutiques

* secteur familial

* secteur traditionnel

* secteur bio-médical

-type de mesures thérapeutiques

* liquides (SRO et SSS)

* allaitement

* alimentation

* médicaments

Based upon the specific objectives, three discussion guides were developed for use with the groups of mothers, grandmothers and fathers. (Appendix C: Focus group discussion guides) The discussion guides consist of 12-15 open-ended questions and were to serve as the starting point for the group discussions.

2.4.2 Health personnel data collection

Given the fact that the preparation of the study was more than a full-time task, and that the members of the technical working group were not able to work on the study activities on a full-time basis, certain tasks, such as the development of the interview instrument to be used with health personnel were the responsibility of the consultant and anthropologist. The basis for the development of the interview guides was a model of the interaction between health personnel and community members during diarrheal episodes. (See Appendix E) Specific objectives for this part of the study were developed relative to the factors in the model pertaining to health personnel's knowledge of and attitudes towards the community's management of diarrheal disease, and secondly, pertaining to the advice which they give on diarrheal disease management.

The individual interview which was developed includes a series of 10 questions, the majority of which have pre-coded answers, but several which are open-ended in nature and for which a content analysis of the responses will be done. (See Appendix F)

2.5 Recruitment of interviewers:

Once the study sites for each region were identified along with language spoken at each of those sites, the interviewers could be identified. The objective was to identify three women and one man for each region, and two persons who spoke each of the 12 languages to be used in the study. Criteria for the choice of the interviewers were established including the educational level of state diploma nurse (infirmier diplome d'etat) or its equivalent. This criteria turned out to be difficult to respect especially given the fact that there are relatively few women who hold that degree and that a greater number of women interviewers were needed. Therefore, a degree of flexibility was used in the final choices.

The plan was to recruit most of the interviewers from the MSP, but there was a desire, as well, to identify some individuals from the other collaborating ministries and agencies involved in the national CDD program.

The process of identifying the necessary interviewers was exceedingly difficult especially given the fact that at the Ministry level in Yaounde there are no definitive lists of who is posted where in the country. After 6 or 7 days of trying to contact the regions in the interior of the country through either formal or informal channels, the list of potential interviewers was complete. 25 interviewers were identified, 17 from the MSP, 3 from the MINASCOF, 3 from the Dept. of Community Development in the Ministry of Agriculture and 2 from CARE.

3. Planning and conducting interviewer training (Aug. 1-12)

3.1 Planning interviewer training

All 25 of the interviewers, 4 for each of the 6 regions in the study sample, were to participate in a 5 day training workshop in Yaounde. The content of the training was planned to a great extent by the consultant, due to the inability of the two individuals who had been chosen to collaborate on this activity, Anne Domatab and Mr. Ngouana, to participate fully in this time consuming task. They did take responsibility for some of the more logistical aspects of organizing the training program.

The goal of the training was to prepare the interviewers to conduct the focus group study on diarrheal diseases in the different regions of the country. (The training workshop did not deal with the health personnel interviews given that the 25 interviewers were responsible only for the community level data collection. Interviews with health personnel were to be carried out by the supervisors.)

The objectives of the training are in Appendix C. The main topics included in the training program were the following: the national CDD program; the assessment of community knowledge and practices as a step in the development of health education strategies; socio-cultural factors and health-related behavior; differences in the perception of health problems on the part of health professionals and communities; steps in the organization of a focus group study; the specific objectives for the CDD study; group dynamics and facilitation techniques; verbal and non-verbal communication; note-taking, coding and analysis of focus group data.

The first day of training was intended to orient the participants to the rationale for conducting a qualitative community study as a first step in the development of a community health education program. This topic was addressed through analysis of a number of case studies of community health programs. The other 4 days of training were to be very practical in nature and to consist of group listening and questioning exercises, role plays on interviewing skills, simulations of focus group discussions and practice facilitating a focus group with groups of women in the neighborhoods of Yaounde. These practice sessions were to be conducted in the same 12 languages that would be used in the national study so that the experience resembled as much as possible the data collection process which would be followed in the regions. Following the practice sessions, each pair of interviewers would code and analyze the data collected, just as they would do later in the regions.

3.2 Conducting interviewer training

The training was held from Aug. 8-12 in the OCEAC conference room in Yaounde. 22 of the 25 interviewers participated for the entire 5 days while the other 3 joined the training late. The four study supervisors,

three from the MSP plus the anthropologist, participated mainly as participants in the training workshop though they were frequently called upon to facilitate group exercises. The consultant had major responsibility for facilitation of the sessions.

The participants were very enthusiastic about the study and participated actively in all of the workshop activities. The only problem which arose was disgruntlement on the part of some participants with regards to the per diem rates. In the evaluation of the training, 92% of the respondents said that the training objectives had been "completely obtained." As regards the length of the training, 83% of the respondents said that the length of the training was appropriate, while 17% said that it was too short. It is the consultant's belief that to prepare interviewers to conduct a study of this nature, who do not have prior experience with qualitative research, a 5 day training session is both necessary and appropriate.

4. Supervision of data collection in first region (Aug. 15-26)

Data collection in the first region, The Forest Region, was carried out from Aug. 15-26. The consultant accompanied the first team of Bulu interviewers to the first rural site, Ebolowa, several hours south of Yaounde. Along with the two interviewers, two supervisors were present, Anne Domatab and Flavien. In addition, Dan Ebah from EPS assured the logistical follow-up. The following week the consultant traveled to the east of the country to Batouri, the second rural site in the region accompanied by supervisors Flavien and Ngouana, and logistics person Ebah.

During the four days of data collection at each of the sites, the consultant attended all of the group and individual interview sessions and provided feedback to the interviewers both in terms of group facilitation and likewise, in terms of the content of the information collected, during the data coding and analysis sessions which followed each of the data collection experiences. The consultant attempted to demonstrate the behaviors and procedures to be followed in observing the interviews, in providing feedback to interviewers, in supervising the coding of data, and in facilitating the data analysis sessions, she carefully discussed each aspect of the process with the supervisors so as to assure that they would be able to assume full responsibility for these tasks in the subsequent regions.

Following each group discussion, the tape recording of the session was listened to by the team of interviewers, their notes completed and then coded. Once the data was coded, a discussion of the data relative to the specific objectives of the study was held to summarize the findings and to identify aspects of the information which were either missing or incomplete. Such insufficiencies in the data were systematically recorded and formulated in question form for use the following day with either the groups or individuals interviewed. The afternoon and evening of the fourth day of data collection at the site, a written synthesis of the findings was outlined following review and discussion of the data

collected in the different interviews at the site.

5. Analysis of first region data and preparation of report of findings.

5.1 Community data analysis

As discussed above, the initial data analysis was done at each study site on the last day of data collection. Following the data collection at the 3 sites, two rural and one urban a 3 day session was held to discuss and synthesize the findings from the 3 sites. This session was held in Yaounde with 2 of the 4 interviewers who had worked in the region, 3 MSP supervisors, the supervisor-anthropologist, and the PRITECH consultant. Based upon the specific study objectives, conclusions were drawn and a draft of the regional findings written.

The primary objective of the three day session was to analyze the data from the region and to produce a draft report. But secondly, and of great importance for the continuation of the study in the other regions was to equip the supervisors with a methodology for analysis and synthesis of community data, so that they would be prepared to take charge of the same process in the other regions. Given the fact that careful syntheses of the site data had already been prepared, it was possible in the 3 days allotted for this task to formulate the conclusions and complete the draft report. Beyond the three day period, the report must be edited and put in final form.

5.1.1 Community data findings

The report of the regional findings is not included here as the final editing and typing is not completed prior to the consultant's departure from Cameroun. Nevertheless, a few of the salient findings from the interviews with mothers and grandmothers are included here.

Knowledge of diarrhea and dehydration: All of the mothers identify diarrhea to be a common childhood disease but only a minority, in both the rural and urban areas, are familiar with dehydration and able to describe the symptoms thereof.

Terminology used for diarrheal diseases: Mothers use 9 or 10 different terms to signify different types of diarrhea, with those differences attributed to different symptoms and causes.

Explanation of cause: For virtually all types of diarrhea identified by women, they have explanations of their cause. Most of the causes identified are related to factors "not scientifically proven to cause diarrhea." In a minority of cases, they site "scientific factors" as the causal agents.

Danger of diarrheal diseases: Some diarrheas are believed to be benign while others are known to potentially cause death.

Treatment of diarrheal diseases: Virtually all episodes of diarrhea are

which they potentially can acquire which can strengthen their communication with the communities with which they work.

4. Training of interviewers

To assure good qualitative data collection, the training of interviewers must be more rigorous than that necessary for quantitative/survey data collection. Interviewers must have indepth understanding of the conceptual basis, goals and objectives of the research; they must be sensitized to the socio-cultural factors related to health beliefs and behavior; they must develop skills in verbal and non-verbal communications and in group dynamics. To assure proper training of interviewers, the 5 day long training workshop is believed to have been both appropriate and necessary.

5. The training of all 25 interviewers at once

The decision was made that all 25 of the study interviewers would be trained at once by the PRITECH consultant, even though many of them would not be immediately involved in the data collection. Given the critical importance of the training of interviewers in a qualitative study and that this was the first study of its kind to be organized by the ministry, it was believed to be preferable that all interviewers be participate in the training module prepared by the consultant. It will, however, be particularly important that for the latter regions in the study that the supervisors provide a refresher orientation to the interviewers before beginning data collection.

6. Participation of the Cameroonian anthropologist on the technical team for the study

The participation of Flavien Ndonko on the technical team was invaluable in terms of: the learning which MSP personnel acquired from him in developing their sensitivities to the cultural dimensions of health behavior; the development of a local human resource which potentially can be called upon by the MSP in future community health activities; the excellent quality of work done by Favien.

7. The ministry's assessment of this experience with qualitative research

This was the first time that the ministry had undertaken a qualitative research activity. There was a consensus on the part of those involved with the supervision and initial data collection process that qualitative data is extremely valuable in providing insights into how communities perceive given health problems and thus into how health personnel can better communicate with communities. Likewise, the supervisors expressed the belief that the focus group methodology is a tool which they will be able to use in the development of other community health activities.

8. The use of tape recorders in focus group research

In this study, data was recorded in two ways: notes were taken of the group discussion and likewise, the discussions were tape recorded. This approach proved to be quite acceptable and preferable to either of their techniques in isolation.

of human resources.

MSP: A substantive debriefing was held with Dr. Owona. A summary of the work done was presented to him as well as recommendations for the continuation of the study in the other regions. He expressed his satisfaction with the initial accomplishments with regards to the organization of the study, and the initial data collection. He assured his support for the completion of the study in the other regions.

A second debriefing session was proposed by the Dir. of Preventive Medicine, to include all of his dept. chiefs. The consultant and Anne Domatab prepared a detailed synthesis of the status of the work done on the study to that point in time, but unfortunately, due to unforeseen circumstances the meeting lasted only 20 minutes so that there was little time to either substantively present or discuss. Following the consultant's departure the departmental meeting was to be rescheduled so that these key people could be informed of the work done.

II. Conclusions and recommendations

1. Support provided to the consultant in Cameroon

Accomplishment of the goals of the consultancy was facilitated by the excellent collaboration and support which the consultant received from the USAID mission, the local PRITECH office and from the MSP.

2. Involvement of ministry personnel with the PRITECH consultant

The MSP, and Dr. Owona in particular, were very well intentioned in identifying individuals who could work with the consultant on the different activities related to planning and conducting the study. In some cases, however, such individuals did find themselves being over-extended given their other on-going responsibilities in their respective depts. Their participation on a full-time basis was not possible. In the future, for long consultancies such as this one, it might be advisable to split the consultancy in two, with a break of a month or so inbetween, so that the ministry does not feel that its personnel is being monopolized by only one program. The rationale for recruiting the Cameronian anthropologist to work as a consultant on the study was in part in response to the need to have someone who could work full-time with the consultant.

3. Criteria for choice of focus group interviewers

The use of ministry personnel with a reasonably good educational level, Infermier d'Etat, rather than individuals with advanced social science degrees, as has frequently been the choice in other countries, proved to be a satisfactory formula. It is believed that more important than the academic background of the potential interviewer is his/her knowledge of the local language and culture, the thoroughness of the training and the quality of the supervision during data collection.

In spite of the constraints associated with the use of health sector personnel as focus group interviewers, the advantage of involving them as interviewers as opposed to using "expert" researchers is the learning

treated first at home. Secondly, and mainly when the home intervention is judged to be insufficient, the traditional health sector is consulted. Only with a minority of the diarrheas identified by the mothers are children taken secondly to the modern health structures. The modern health structures are likewise used when the interventions at home and in the traditional health sector have failed and when the child's condition is very serious.

Liquids: The interviewers found it extremely difficult to get precise information on the quantities of liquid given during diarrheal episodes. Overall, however, mothers appear to give small quantities of liquid and in some cases almost no liquids at all.

Breast-feeding: Virtually all mothers continue to breast-feed during diarrhea.

Feeding practices: Overall mothers report that there is little change in the type or quantity of food given to children during diarrhea. Certain "hard" foods, such as beans, are sometimes added to the diet.

ORS and SSS: In rural areas, ORS packets are virtually unknown. SSS is known by a minority of women who have had some contact with the modern health sector structures. However, amongst those who report having used SSS, they describe numerous different recipes for its preparation which in most cases are incorrect relative to the ministry's recommendations for preparation.

Pharmaceuticals: A minority of women report having used drugs from the pharmacy with their diarrheal children.

Other remedies: Numerous home remedies with their roots in the traditional health sector are used including teas, baths and purges. Purges appear to be quite wide-spread and are used both as a preventive measure against diarrhea, as well as to treat the disease in order to "cleanse the system." During diarrheal bouts, children are often purged once in the morning and once in the evening.

5.2 Health personnel data analysis

In the case of the information collected in the health personnel interviews in the first region, all quantitative responses were tabulated and the qualitative responses were summarized by question. The analysis of the health personnel data will be done at the conclusion of the study on a national basis, with no attempt to take into account regional differences. There are therefore, no findings to report at this time.

6. Debriefing of USAID and MSP staff

USAID: A debriefing was held with Gary Leinan, Health and Population officer. He expressed his satisfaction with the outcome of the consultancy though expressed his concerns about the ability of the MSP to provide sustained support for an extensive national CDD program in terms

9. The language in which focus groups are conducted

All interviews in the community data collection will be conducted in the local languages rather than in French, English or Pidgin. This is believed to be of extreme importance insofar as health-related concepts are often intimately tied to linguistic realities.

10. The combined use of focus groups and individual interviews in the collection of community health data

The combined use of the two research techniques proved to be very satisfactory. The process involved analysis of a set of focus group data, identification of the incomplete or unclear information and the formulation of questions to be used in the individual interview in the same locality the following day.

11. Progressive data analysis during field data collection

During the data collection at each site, the data was systematically coded and analyzed on a daily basis. The data collection schedule was purposely light to allow for such a plan to be respected. It is believed to be extremely important that in the other regions and in future qualitative studies that this procedure be followed.

12. Supervision of interviewers during data collection

The job of the supervisor during data collection is critical to the success of the study and is extremely demanding physically and intellectually. Supervisors must be very motivated, interested in the topic under consideration, and have a solid grounding in qualitative methods. In light of these considerations, it was recommended that in the other regions supervision be assured by 1 person from the MSP along with the consultant anthropologist.

13. Participation of the interviewers in the data analysis

The interviewers were intimately involved in the data analysis process. In a qualitative study it is believed that the participation of those who have collected the data in the data analysis is extremely important and particularly in a case, such as this, where the supervisors do not speak all of the languages in which the study is being conducted.

Next steps in the development of the strategies to reinforce management of DD at the level of the community (IEC/health education) and health personnel

Following completion of data collection in the 6 regions:

Community data

1. Review results region by region and formulate global conclusions of community study.
2. Based upon those global recommendations, formulate recommendations for mass media health education content.
3. Region by region, analyze community treatment and preventive practices

and categorize them in terms of practices which are beneficial, harmful and of not apparent impact on the diarrheal child. Based upon this analysis and on the current medical advice regarding treatment and prevention, identify region-specific health education content for interpersonal communications activities.

4. Develop IEC strategy to include identification of target groups, and types of mass media and interpersonal communications activities and materials for each.

5. Develop, pretest and produce such materials.

Health personnel data

1. Analyze data from all regions, formulate conclusions and prepare report.

2. Based upon conclusions of health personnel data and community data formulate recommendations for strategy and content of CDD training activities and materials to target health personnel.

3. Develop training strategy for health personnel.

4. Develop, pretest and produce appropriate materials.

Appendix A:

Contacts made by consultant

MSP

Dr. Ghogomo	Dir. de la Medecine Preventive
Dr. E. Owona	Dir. Adjoint de la Medecine Preventive
Mr. Ndeso	Dept. d'Epidemiologie, Manager CDD Program
Dr. Fonfo	Dir. du dept. d'Epidemiologie
Dr. Edmond Ndjikou	Dir. du dept. d'Education pour la Sante (EPS)
Anne Domatab	Assistante au Dir. du dept. d'EPS
Dan Ebah	EPS
Tah Shadrak	EPS
Mr. Ngouana	Dept. de la formation professionnelle

USAID

Jay Johnson	Mission Dir. Yaounde
Bob Schmeding	Ag. and Rural Dev. Officer
Cary Leinan	Health and Population Officer
Robin Steinwand	PRITECH Representative
Dr. Jim Sonneman	Dir., Child Survival Project (Projet SESA)
Bob DeWolf	Projet SESA
Dorothy Sek	Projet SESA
Regina Dennis	Projet SESA

Save the Children

Dr. Nkodo	Health Director
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CARE

Judy Collins	Director, CARE Cameroun
Dr. Elinor Seumu	Health Program Coordinator

UNDP

Dr. Roger Molouba	Rep. WHO
Alain Mouchirou	Rep. FNUAP

Appendix B: Specific objectives of focus group study

19/88

Les objectifs spécifiques de l'étude qualitative
en matière des maladies diarrhéiques:

POUR LES MERES, PERES, GRAND MERES ET GUERISSEURS

LA PERCEPTION DES MALADIES DIARRHEIQUES

Ampleur du problème des maladies diarrhéiques:

-savoir si les maladies diarrhéiques sont perçues comme les
maladies infantiles importantes

La terminologie utilisée pour diarrhée et déshydratation:

-connaître les appellations/termes utilisé(e)s par les mères pour les
différentes maladies diarrhéiques et le sens de chacun(e)

(Si les femmes perçoivent des différents types de diarrhée et
déshydratation, il est important de faire ressortir les appellations
qu'elles utilisent pour chaque maladie et la signification de chacune.)

Les symptômes des maladies diarrhéiques:

-connaître les symptômes de chaque type de maladie diarrhéique perçue
par les mères

Les causes des maladies diarrhéiques:

-connaître les causes de chaque type de maladie diarrhéique perçue par
les mères

La prévention des maladies diarrhéiques:

-connaître les connaissances et croyances des mères en matière de
prévention de chaque type de maladie diarrhéique

Le danger/conséquences de la diarrhée:

-savoir si les mères reconnaissent la relation entre la diarrhée et la
déshydratation

-connaître la perception de la gravité de chaque type de

diarrhée/déshydratation perçu par les mères
(Il s'agit de demander aux mères, à partir des différents types de diarrhée et déshydratation qu'elles évoquent, de les classer par ordre de gravité.)

LES MESURES THERAPEUTIQUES

La source des mesures thérapeutiques:

-connaître les sources des mesures thérapeutiques utilisées par les mères en cas des maladies diarrhéiques (secteur familial, secteur traditionnel, secteur bio-médical)

Le secteur familial: il s'agit de tout conseil et traitement envisagés dans le cadre de la famille par des parents, des amis, des voisins

Le secteur traditionnel: il s'agit de tout conseil et traitement donnés par des guérisseurs traditionnels

Le secteur bio-médical: il s'agit de tout conseil et traitement donné par les agents de santé relevant des structures sanitaires modernes

(Pourquoi choisissent-elles un secteur plutôt que les autres?
Est-ce que certaines maladies diarrhéiques sont mieux traitées dans un secteur que dans d'autres?
Comment évaluent-elles l'efficacité des apports de chaque secteur?)

-connaître l'ordre dans lequel les différentes sources de traitement sont utilisées/consultées par les mères

(Qu'est-ce qui est fait d'abord, en deuxième et troisième lieu?)

Types de mesures thérapeutiques:

allaitement:

-connaître les pratiques concernant l'allaitement maternel pendant la diarrhée/déshydratation

(Pourquoi est-ce qu'elles continuent ou modifient ces pratiques?)

-connaître les pratiques concernant l'allaitement artificiel pendant la diarrhée/déshydratation

(Pourquoi est-ce qu'elles continuent ou modifient ces pratiques?)

alimentation:

-connaître le type et moment de l'introduction des premiers aliments/aliments de sevrage y compris les ingrédients et préparations

(Pourquoi ce type d'aliments est donne et pourquoi a ce moment?)

-connaître les aliments donne et supprime lors de la diarrhée/deshydratation

(Pourquoi est-ce que ces aliments sont donne et supprime? Quels effet ont-ils?)

liquides:

-connaître les quantités et types de liquides donne lors de la diarrhée/deshydratation

(Est-ce que certains liquides sont mieux? Pourquoi sont-ils mieux? Pourquoi sont-ils donne en petite/grande quantité?)

-connaître l'expérience des femmes avec la solution saleo-sucree (SSS) en terme du mode depreparation, mode d'administration, avantages et inconvenients

-connaître l'expérience des femmes avec les sachets de SROs en terme du mode de preparation, mode d'administration, avantages et inconvenients

medicaments:

-connaître les types de medicaments traditionels et modernes utilises en cas de diarrhée/deshydratation

(Pourquoi ces medicaments? Quels est leurs efficacite?)

Appendix C: Focus group discussion guides

1. Mothers
2. Grandmothers
3. Fathers

No. _____

GUIDE DE DISCUSSION: MERES (M)

Date _____

Identification du groupe

Region _____	Nombre de femmes _____	Appellations des maladies diarrheiques:
Site _____	Enqueteurs/enquetrices:	_____
Localite _____	_____	_____
	_____	_____

1. Quelles sont les principales maladies des enfants dans la region?

2. Est-ce qu'il y a quelqu'une parmi vous dont l'enfant a souffert d'une maladie diarrheique pendant les deux dernieres semaines?

3. Comment est-ce que vous avez su que c'etait la diarhee/deshydratation? (symptomes)

4. Qu'est-ce que vous avez fait? (les etapes)

a. Qui avez vous consulte?

b. Quel traitement avez-vous utilise? (nature et quantite)

c. Quel etait le resultat du traitement?

d. Avez-vous donne a boire/manger?

5. Quels sont les meilleurs traitements?

Comment est-ce que ces traitements agissent sur la maladie?

6. Qu'est ce qui, d'apres vous, cause ces maladies diarrheiques?

7. Est ce qu'il y a une saison ou les enfants ont plus de ces maladies

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diarrheiques? (Quand? Pourquoi?)
Est-ce que ces maladies peuvent être dangereuses pour les enfants?
(Est-ce que certaines sont plus graves que les autres?)

9. Quels sont les premiers aliments que vous donnez à vos bébés?
et quand? (en plus du lait maternel)

10. En cas de diarrhée/déshydratation est-ce qu'il faut donner à manger
et à boire à l'enfant qui allaite?

Si oui: quoi? quand?

11. Quand les enfants qui sont sevrés ont la diarrhée/déshydratation faut-il
leur donner ou boire et manger?

12. Quels sont les aliments qui sont particulièrement bons pour l'enfant
diarrhéique?

13. Quels sont les aliments qui sont mauvais pour l'enfant diarrhéique?

14. Est-ce qu'il est possible de protéger les enfants contre ces maladies
diarrhéiques?

La solution salée sucrée (SSS) et les sels de réhydratation orale (SRO):

* Si les mères ont déjà parlé de la SSS ou des SRO leur poser
ces questions:

15. Comment avez-vous utilisé la SSS/les SRO? (préparation: ingrédients,
mesures ustensils)

16. Quel a été le résultat/effet? (administration: comment,
quand, quantité)

* Si les mères n'ont pas déjà parlé de la SSS ou des SRO, leur demander:

17. Est-ce que vous connaissez: la SSS? les sachets de SRO?

Si oui, est-ce que vous les avez jamais utilisés?

Si oui, poser les questions no. 15 and 16.

No. _____

GUIDE DE DISCUSSION: GRAND-MERES (M)

Date _____

Identification du groupe

Region _____	Nombre de femmes _____	Appellations des maladies diarrhéiques:
Site _____	Enqueteurs/enquetrices:	_____
Localite _____	_____	_____
	_____	_____

1. Quelles sont les principales maladies des enfants dans la region?

2. Que faut-il faire pour avoir les enfants sains et forts?

3. Comment est-ce que vous conseillez de faire avec les enfants atteints des différentes maladies diarrhéiques? (maladie par maladie)

a. Que faudrait-il faire en terme d'allaitement? (pourquoi?)

b. Que faudrait-il faire en terme d'aliments? (pourquoi?)

-l'enfant qui tete?

-l'enfant qui est sevre?

c. Que faudrait-il faire en terme de liquides? (pourquoi?)

d. Quels autres traitements sont efficaces? (nature et quantite)

e. Comment agissent ces traitements?

4. Quels sont les meilleurs traitements pour les différentes maladies

diarrheiques?

5. Ou sont mieux craites les differentes maladies diarrheiques:

a la maison,

chez le guerisseur

a l'hopital

6. Qu'est ce qui, d'apres vous, cause ces differentes maladies diarrheiques?

7. Y a-t-il une saison ou les enfants ont plus de ces maladies diarrheiques? (Quand? Pourquoi?)

8. Les maladies diarrheiques, peuvent-elle etre dangereuse pour les enfants?

(Est-ce que certaines sont plus graves que les autres?)

8. Est-ce qu'il est possible de proteger les enfants contre ces maladies diarrheiques?

9. Est-ce que vous avez entendu parler: de la solution salee sucee?
: des sachets de SRO?

Si oui, quelle est l'utilite de la SSS/SRO?

10. L'avez vous jamais utilise la SSS/les SRO? (preparation:
ingrédients,
mesures ustensils)
administration: comment,
quand, quantite)

11. Quel a ete le resultat/effet?

No. _____

GUIDE DE DISCUSSION: PERES (P)

Date _____

Identification du groupe

Region _____	Nombre d'hommes _____	Appellations des maladies diarrheiques:
Site _____	Enqueteurs/enquetrices:	_____
Localite _____	_____	_____
	_____	_____

1. Quelles sont les principales maladies des enfants dans la region?

2. Que faut-il faire pour avoir les enfants sains et forts?

3. Pour les bebes, quels sont les meilleurs aliments a leur donner?

4. Pour les jeunes enfants, quels sont les meilleurs aliments a leur donner?

5. Est-ce que vos enfants ont souffert des maladies diarrheiques?

6. Qu'est-ce qui a ete fait pour les traiter? (les etapes)

a. Qui a ete consulte?

b. Quel traitement a ete utilise? (nature et quantite)

c. Quel etait le resultat du traitement?

d. Est-ce qu'on lui a donne a boire et manger?

e. Est-ce qu'on l'a tete pendant la maladie?

7. Quels sont les meilleurs traitements pour les différentes maladies diarrhéiques?

8. Qu'est-ce qui, d'après vous, cause ces maladies diarrhéiques?

9. Y'a-t-il une saison où les enfants ont plus de ces maladies diarrhéiques?
(Quand? Pourquoi?)

10. Est-ce que ces maladies peuvent être dangereuses pour les enfants?
(Est-ce que certaines sont plus graves que les autres?)

11. Est-il possible de protéger les enfants contre ces maladies diarrhéiques?

12. Avez-vous entendu parler de: la solution salée sucrée?
: des sels de réhydratation orale?

Si oui, quelle est leur utilité?

Si oui, est-ce que vous les avez jamais données à votre enfant à la maison?

Quel a été le résultat/effet?

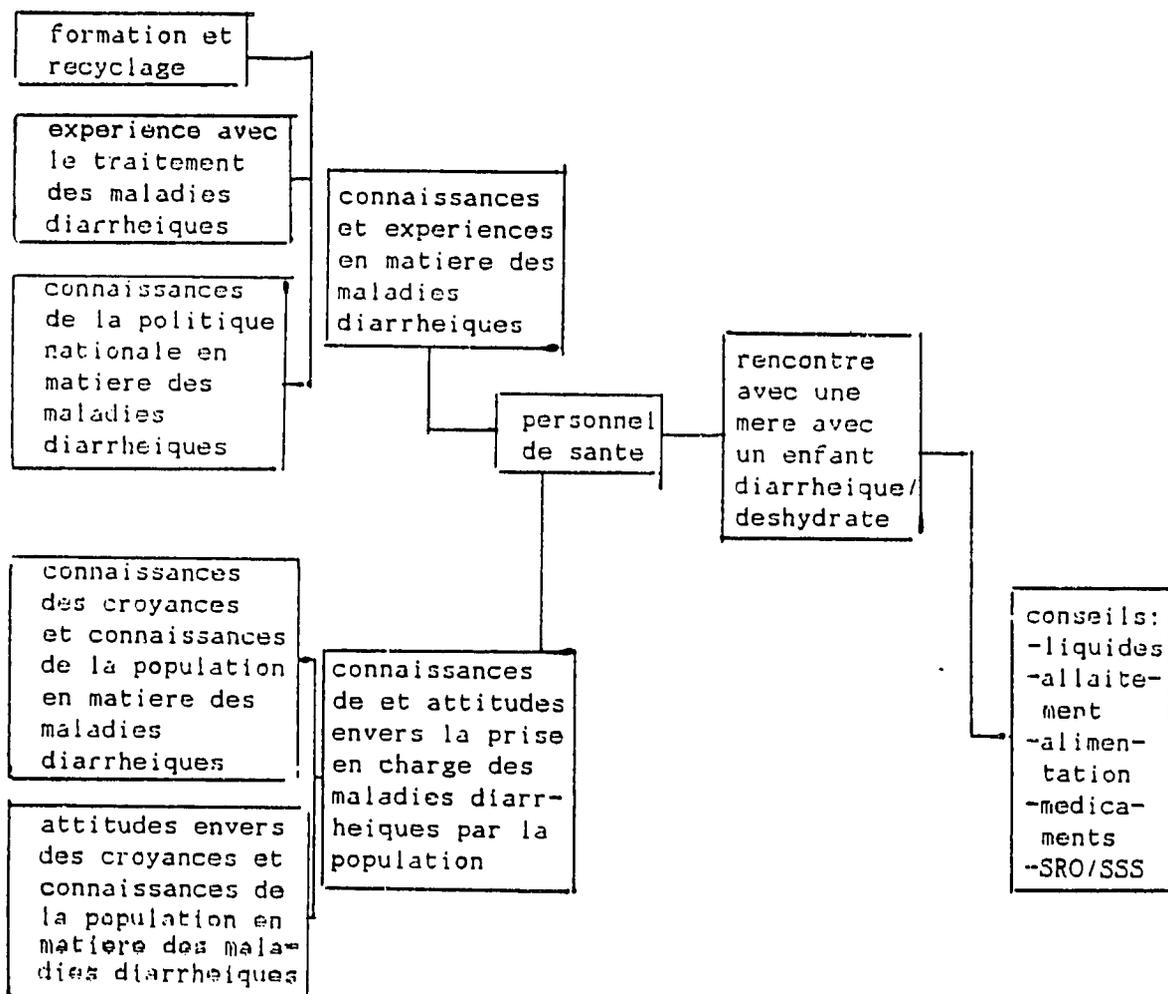
Appendix D: Model of management of diarrhea by health personnel

Aubel:

8/88

Modele conceptuel pour l'etude en matiere des maladies diarrheiques

La prise en charge des maladies diarrheiques
par le personnel de sante



Appendix E: Objectives for health personnel interviews

Etude LMD

8/88

Les objectifs spécifiques des interviews du personnel de sante

LEURS CONNAISSANCES ET ATTITUDES ENVERS LA PRISE EN CHARGE DE LA DIARRHEE ET DESHYDRATATION PAR LA POPULATION

- recenser leur connaissance des pratiques de la population en terme d'alimentation et de liquides donnees aux enfants diarrheiques
- connaître leur avis sur l'utilisation par la population des sources de traitement familial, traditionnel et bio-medical

LES CONSEILS QU'ILS DONNENT POUR LA PRISE EN CHARGE DE LA DIARRHEE ET DESHYDRATATION

- savoir ce qu'ils conseillent en cas de diarrhee pour ce qui est du type et des quantites de liquides a donner
- savoir ce qu'ils conseillent en cas de diarrhee en matiere d'alimentation de l'enfant qui tete et de l'enfant qui est sevre
- savoir ce qu'ils conseillent comme medicaments en cas de diarrhee
- savoir leur avis sur les avantages et inconvenients de la solution salee sucee (SSS) et des sels de rehydratation orale (SRO)
- connaître les conseils donnees quant a la preparation et l'administration de la solution salee sucee (SSS) et les sels de rehydratation orale (SRO)

Appendix F/ Health personnel questionnaire

Etude LMD

8/88

Guide d'Interview pour le personnel de sante

Region_____ Date_____

Site _____ Poste_____

Lieu_____ ville___ village___

1. Est-ce que la diarrhee est une maladie importante dans votre zone?
Oui___ Non___
Si oui, expliquez:

2. Est-ce qu'il y a certaines epoques de l'annee ou il y a plus de diarrhee et deshydratation? Oui___ Non___

Si oui, expliquez pourquoi:

[J'ai plusieurs questions a vous poser sur la prise en charge de la diarrhee par la population]

3. En cas de diarrhee, est-ce que la plupart des meres intervient a la maison avant d'aller au dispensaire/centre de sante? __oui __non

Si oui, qu'est-ce qu'ils font dans un premier temps?

4. En fonction de votre experience avec la population, est-ce qu'il y a beaucoup de meres qui negligent leurs enfants quand ils ont la diarrhee

___oui ___non

5. Comment expliquez-vous le cas des enfants deshydrates qui sont amenes au dispensaire/centre de sante a un stade tres avance de la maladie?

5b. Est-ce que vous savez comment la population appelle la diarrhee et la deshydratation dans leur patois? oui___ non___

Si oui, qu'est-ce qu'il(s) signifie(nt)?

D'apres votre experience, comment traite-elle ce/ces diarrhee/diarrhees et deshydratation?

6. A partir de votre experience, est-ce que la plupart des meres comprend le rapport entre la diarrhee et la deshydratation?
___oui ___non

7. A votre avis, pourquoi certaines meres consultent le guerisseur en cas de diarrhee?

[Voici plusieurs questions sur les conseils que vous donnez pour le traitement de la diarrhee et deshydratation]

8. Quels sont les conseils que vous donnez aux meres des enfants atteints de diarrhee? (Cochez chaque categorie incluse dans la reponse)

__ médicaments (ensuite voir question no. 8a.)

__ allaitement (ensuite voir question no. 8b.)

__ alimentation (ensuite voir question no. 8c.)

__ liquides (ensuite voir question no. 8d.)

(Completer seulement les questions suivantes qui correspondent aux reponses de la question no. 8)

8a. Medicaments

1) Quels medicaments sont prescrits: . dans quelles circonstances:

-----	-----
-----	-----
-----	-----
-----	-----
-----	-----
-----	-----
-----	-----

2) Normalement, est-ce que la prescription est pour:

- | | |
|---------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> un seul medicament | <input type="checkbox"/> 3 medicaments |
| <input type="checkbox"/> 2 medicaments | <input type="checkbox"/> 4 medicaments ou plus |

8b. allaitement

1) Quels conseils sont donnees?

- | | |
|-------------------------------------------------|-----------------------------------------------------|
| allaitement maternel: | allaitement artificiel: |
| <input type="checkbox"/> continuer a allaiter | <input type="checkbox"/> continuer comme d'habitude |
| <input type="checkbox"/> arreter a allaiter | <input type="checkbox"/> arreter |
| <input type="checkbox"/> diminuer l'allaitement | <input type="checkbox"/> diminuer |
| | <input type="checkbox"/> autre |

8c. alimentation

- 1) Quels conseils sont donnees: continuer a nourrir comme d'habitude
- arreter a nourrir
- modifier le regime alimentaire
mais continuer a nourrir

Expliquer les modifications proposees: -----

35'

8d. Liquides

1) Quels conseils sont donnés:

___ de donner des liquides

___ de ne pas donner des liquides

___ autre réponse

2) Quelles liquides sont conseillées:

___ eau

___ eau + sel + sucre (SSS)

___ SRO

___ autre_____

3) Quelles quantités de liquides sont conseillées:

___ moins d'un litre par jr.

___ 1 litre par jr.

___ plus d'un litre par jr.

___ autant que possible

4) Dans quels cas, conseillez-vous la SSS?

___ pour toute diarrhée

___ pour diarrhée + déshydratation

___ autre _____

5) Normalement, est-ce que vous prescrivez des médicaments avec la SSS:

___ oui ___ non

6) Quelles instructions donnez-vous pour la préparation de la SSS:

___ 8 morceaux de sucre + 1 cuillère de sel + 1 lt. d'eau

___ autre recette _____

7) Quelles conseils donnez vous pour l'administration de la SSS?

8) A votre avis quels sont les avantages et inconvénients de la SSS?

avantages: _____

inconvenients: _____

9) Dans quels cas, conseillez-vous les SRO?

___ pour toute diarrhee

___ pour diarrhee + deshydratation

___ autre _____

10) Normalement, conseillez-vous des medicaments avec les SRO:

___ oui ___ non

Quelles instructions donnez-vous pour la preparation des SRO:

___ un sachet dans 1 lt. d'eau

___ autre mode de preparation: _____

11) A votre avis, quels sont les avantages et inconvenients des SRO:

avantages _____

inconvenients _____

9. Comment expliquez vous le cas d'une mere qui a entendu parler de la solution salee-sucree ou des SRO et qui ne l'utilise pas a la maison?

10. A votre avis, pourquoi les meres ne suivent pas toujours les conseils du personnel de sante?

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Appendix G: Goals and objectives of interviewer training

8/88

Etude sur les maladies diarrheiques

La formation des enqueteurs

But de la formation:

-preparer les enqueteurs a mener l'etude sur les maladies diarrheiques dans les differentes regions du pays a base des discussions de groupe dirigees

Objectifs generaux de la formation:

1. connaitre la strategie du programme national de lutte contre les maladies diarrheiques
2. connaitre les buts et l'organisation de l'etude sur les maladies diarrheiques a base des discussions de groupe
3. connaitre les elements de preparation et d'animation d'une discussion de groupe dirigee et de depouillement des informations recueillies
4. pratiquer la conduite/l'animation d'une discussion de groupe dirigee en matiere des maladies diarrheiques
5. discuter le programme de l'enquete dans chaque region y compris l'organisation logistique

Objectifs specifiques de la formation:

- 1.1. connaitre les objectifs et composants du programme national de lutte contre les maladies diarrheiques
- 1.2. connaitre le rapport entre cette etude et les programmes nationaux d'information, d'education et de communication, et de formation du personnel de sante en matiere de lutte contre les maladies diarrheiques
- 1.3. connaitre les buts de l'etude sur les maladies diarrheiques

- 2.1. discuter la relation entre les facteurs socio-culturels et les pratiques de la population liees a la sante
- 2.2. identifier les differents facteurs qui influencent le comportement de la mere de l'enfant atteint de diarrhee

- 2.3 identifier les differences de perception des problemes de sante de la part de la population et du personnel de sante
- 2.4 decrire la discussion de groupe dirigee
- 2.5 identifier les differences entre les enquetes quantitatives et qualitatives
- 2.6 connaitre les differentes utilisations de la discussion de groupe dirigee
- 2.7 connaitre les avantages et inconvenients de la discussion de groupe dans la collecte d'information aupres de la population
- 2.8 connaitre les 11 etapes dans l'organisation d'une etude aupres de la population a base des discussions de groupe dirigee
- 2.9 connaitre les criteres de choix des regions, des sites et des groupes de personnes a enqueter dans cette etude
- 2.10 definir les roles des enqueteurs et des superviseurs lors du deroulement de l'enquete sur le terrain

- 3.1 connaitre les elements de base de la physiopathologie et du traitement de la diarrhee et deshydratation
- 3.2 citer les elements du schema "Processus therapeutique en matiere des maladies diarrheiques"
- 3.3 expliquer les objectifs specifiques de l'etude pour les meres, peres, grand-meres et guerisseurs
- 3.4 decrire l'utilisation des guides de discussion
- 3.5 prendre les notes lors des discussions de groupe dirigee
- 3.6 definir le role de l'animateur/animatrice lors de la discussion de groupe dirigee
- 3.7 identifier les elements de communication verbale et non-verbale qui bloquent ou qui facilitent la communication
- 3.8 identifier les problemes de dynamique de groupe qui peuvent se presenter lors des discussions de groupe et discuter comment les resoudre
- 3.9 decrire les 5 types de questions differentes qui peuvent etre utilisees dans les discussions de groupe et comment formuler chacun
- 3.10 utiliser la technique de l'ecoute attentive

3.11 depouiller les notes d'une discussion de groupe dirigee

4.1 animer une discussion de groupe dans un quartier de Yaounde

4.2 faire le depouillement initial des informations recueillies lors de la pratique

5.1 arreter un calendrier de collecte de donnees dans chaque region

5.2 definir les elements de preparation du deroulement de l'enquete pour chaque region

FORMATION DES ENQUETEURS

Emploi du Temps

le 8/8/88	Mardi le 9/8/88	Mercredi le 10/8/88	Jeudi le 11/8/88	Vendredi le 12/8/88
10:30	8:00 - 9:30	8:00 - 10:30	8:00 - 10:30	8:00 - 10:30
Introduction à la formation des participants	(la suite des étapes.....) 9:30 - 10:30 - La diarrhée et les éléments clés du traitement	- Les différents types de questions - L'Ecoute Active	SORTIES DANS LES QUARTIERS DE YAOUNDE POUR MENER DES DISCUSSIONS DE GROUPE	
10:45	10:30 - 10:45	10:30 - 10:45	10:30 - 10:45	10:30 - 10:45
11:30	10:45 - 13:00	10:45 - 13:00	10:45 - 13:00	10:45 - 13:00
Programme National de lutte Contre les Maladies Diarhéiques	- Les objectifs spécifiques de l'étude pour les discussions de groupe - Le guide de discussion	- Les exercices de pratique avec la discussion de groupe	SEANCES DE PLANIFICATION DE L'ORGANISATION DE L'ETUDE DANS CHAQUE REGION	
13:30				
acteurs socio-culturels et le traitement de la diarrhée				
14:00	PAUSE	13:00 - 14:00	13:00 - 14:00	13:00 - 14:00
16:00	14:00 - 16:00	14:00 - 16:00	14:00 - 16:00	14:00 - 16:00
Impact des facteurs culturels	- Simulation d'une discussion de groupe - Le Rôle de l'animateur dans la discussion de groupe - La communication verbale et non verbale	- La suite aux exercices - La traduction du guide de discussion		- Synthèse de la formation - Evaluation de la formation

Appendix I: List of interviewers

<u>NOMS</u>	<u>LIEU D'AFFECTION</u>
Mme Assana Abba	Méd. Préventive Ngaoundéré de la VINA
Mme Tidjani Ai	PMI Garoua
Mme ESSIBEN Agnès	PMI Centrale Douala (Douala/Bulow)
Mme Yecke Noëlle	Médecine Préventive Douala
Mme Assiem Marthe	Médecine Préventive Yaoundé
Mrs. Lena Eko	Provincial Delegation of Health Buea
Mme fonyonga Grace	PMI Buea
Mme Takam Jeannette	Service de Pédiatrie Bota AnnexLimbe
Mr. Mvongo Flauribert	Service d'Epidemiologie et du Paludisme YDé
Mme Anne Domatob	SES/MSP Yaoundé
Mr. Ahmat Ali	SPMP - H.P Maroua
Mr. Mohamane Laouane	Médecine Préventive Ngaoundéré VINA
Mr. Engolo Jean	Médecine Préventive Ebolowa NTEM
Mlle Evina Marguerite	Université de Yaoundé
Mr. Ndonko Flavien	Université de Yaoundé
Mlle Sike Bille	Minascof
Mme Martine Jeremie	Animatrice CARE/DC - Mokolo
Mlle Kouvou Cathérine	Animatrice CARE/DC - Mokolo
Mr. Ngouana Elie	Service de la Formation MINSANTE, Ydé
Mr. Ebah Daniel.	DMPHP/SES
Mr. Tah Shadrack	DMPHP/SES
Mme Bafama Antoinette	I.D.E SPMPHPC
Mlle Ngo Nkouth Bernadette	MINASCOF (SEP)
Mr. Noungang Dieudonné	MINASCOF (S.F)
Mme Rita MOORE	MINAGRI Buea
Mme Bediang née Mbamba Sara	CCD/Bafia

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