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SUMMARY REPORT

PRACTICAL TRAINING IN HEALTH EDUCATION PROJECT

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PTHE PROJECT SUMMARY REPORT

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SUMMARY OF RECOMMENDATIONS

Village Community Organization and Development

1. Committee Days should be continued in the Mefou and Kadey as well as introduced into all other divisions where village committees are intended to produce health-related outcomes.
2. Evaluation Days should be continued in the Kadey and Mefou as well as introduced to all other divisions where the role of health workers is to become more community oriented in practice and the role of their supervisors is to support the team approach to service delivery.
3. The recruitment of itinerant agents from the ranks of nurses-aides should be further examined by selecting individuals from several health personnel cadres to fulfill this critical role to systematically monitor differences in performance before making a policy.
4. Nurses-aides should, however, receive basic training in community health and community organization skills as part of the nurses-aide school's curriculum, given that this cadre of health personnel works most consistently at the village level.
5. Village committees should not be forced to comply with a set of predetermined criteria for how it is to be structured and what its activities are to address. Flexibility in terms of existing decision-making and leadership patterns, competing priorities from harvest, and multi-ethnicity must be considered in community organization work.
6. Other "pilot" health centers in additional divisions should be established to continue the steady and systematic extension of community oriented primary health care rather than a fragmentary and superficial attempt to cover an entire region or country at once.

Training

7. The trainers guide, developed through PTHE, should be further tested and expanded in the field by the MOH Training and Continuing Education Service to develop training plans with specific objectives for each level of health personnel.
8. Training of supervisory personnel such as the heads of health centers should include community diagnosis and needs assessment techniques as skills they themselves must understand in order to sufficiently support the responsibilities of outreach workers.

9. Diffusion of PTHE training activities should begin with health personnel at the ministerial service level and then the divisional level in the field to ensure greater participation in and support for redefining the role and responsibilities of health center staff.

Training Institutions

10. MOH should continue to invest in the Mefou Division Health centers to maintain appropriate field training sites for students.
11. MOH should designate a qualified trainer to work with nursing schools' directors and faculties to design feasible field training programs for each school.
12. The Training and Continuing Education Service of the MOH should follow-up the specific requests from the Assistant Nursing Schools in Abong-Mbang and Mbalmayo, OCEAC, CUSS, CESSI, AND MINSAF, and MINAGRI for technical assistance in organizing basic training for their students.

School Health Education

13. Further experimentation should be carried with the Teacher's Guide in both the pilot divisions and outside. Any distribution of the Guide must be accompanied by orientation sessions.
14. Diffusion of the PTHE school health component should become a major responsibility of the established MOH-MINEDUC sub-commission to carefully select additional pilot schools in other areas of the country where relations between the community personnel are willing to collaborate to support school health education activities.

Future Development of Effort by the GURC to Integrate Primary Health Care and Community Development

15. A structure exists whose potential has not been tapped--the rural co-operatives (SOCOODER, CENADEC, SOCCOPEP). By their charters they financed local community projects through a fund fed by cocoa or coffee sales. Contacts at all levels, but especially divisional level and down, should be made to encourage use of co-op funds for community health projects, such as stocking village pharmacies.
16. Concerted efforts to introduce a new approach must focus training on the roles of the upper cadres of personnel first to strengthen their orientation and ability to support the work of personnel under their supervision and the activities under their jurisdiction.
17. The MOH must establish career lines and incentives for physicians and nurses to receive public health training such that a step-by-step replacement of clinical specialists can occur at the ministerial Division Head level to ensure high level support for community oriented primary health care.

18. CUSS and CESSI should give serious consideration to the establishment of a public health degree program to train health education specialists and physicians in public health.
19. Intermediate goals and outputs intrinsic to the community organization process must be delineated in future program designs to ensure that health workers are not under pressure to produce outcomes which lack basic community support, understanding, and commitment.

Recommendations to USAID

20. Primary health care project designs should ensure a thorough introductory phase of training, seminars, and experiences for high level MOH personnel with special focus on those individuals who will carry primary responsibility as well as those who will play complementary support roles in program development and management. Community organization and health education principles related to primary health care must be the central themes.
21. Subsequent to this, a phased introduction to the project approach should begin at the lower ministerial levels, such as Chiefs of Service and below, to establish a strong cadre of decision makers who will constitute a critical mass of technical managers and trainers on whom future program development will depend.
22. Project Agreements with host countries should stipulate requirements for close coordination of efforts among all ministries relevant to community development and health, and thereby overcoming organizational precedence of territoriality and duplication of efforts.
23. While the notion of host country counterparts to project technicians is a sound means for ensuring integration, the design of particular services rather than individuals should more effectively allow for personnel changes and the diffusion of new knowledge and competencies.
24. The selection of pilot centers within pilot areas should be the focus of project activities rather than the entire zone to allow for more intensive work for more precise monitoring.
25. Preparatory training and orientation of middle level health personnel, such as provincial and divisional level health officials, in non-pilot areas to assume diffusion roles after USAID funding ceases should be stipulated in the project design to occur 12 months prior to the end of technical assistance.

Chapter 1

INTRODUCTION

1.1 Background

On October 27, 1975, a meeting was called and presided by the Cameroon Ministry of Health (MOH) to finalize the Practical Training in Health Education (PTHE) Project Paper. Twenty-two representatives of the proposed donor agencies for the Project attended (MOH, USAID, UNICEF, Peace Corps, WHO, Canadian International Development Assistance--CIDA, University Center for Health Sciences--CUSS, and Coordinating Agency for the Fight Against Endemic Diseases in Central Africa--OCEAC). In December 1976, the final version of the Project Paper was distributed by the USAID/Yaounde Chief of the Health Nutrition, and Population Office (HNPO). The PTHE Project Agreement between USAID and the Government of the United Republic of Cameroon (GURC) was signed on July 11, 1977. The University of North Carolina (UNC), School of Public Health's Department of Health Education was contracted in June 1978 to provide four years of technical assistance to the Project, and field operations began in September 1978.

The PTHE Project represented the MOH's concerted effort to expand health education activities to the entire population, and especially those living in rural areas. To accomplish this, the MOH needed personnel trained at every level, from the individual village to the national service, who would be able to implement specific strategies and methods of health education which were community oriented in focus and development oriented in practice.

The PTHE Project operated as a part of the day-to-day activities of the MOH under the Division of Preventive Medicine. The PTHE Project team was composed of three UNC professional health education specialists and three MOH ministerial level health professionals who were based in Yaounde to initiate and monitor all Project related activities in the field. The PTHE team members were:

MOH Director of Preventive Medicine	PTHE Project Director
UNC Clinical Assistant Professor	PTHE Chief of Party
UNC Clinical Assistant Professor	PTHE Training Technician
MOH Staff Member of Training and Continuing Education Service	PTHE Counterpart for Training
UNC Clinical Assistant Professor	PTHE Community Organization Technician
MOH Assistant Chief of Health Education Service	PTHE Counterpart for Community Organization

Technical and administrative support to the PTHE field team were provided by the UNC home base team in Chapel Hill who were full-time university faculty and staff members. Their positions and percentage of time commitment with PTHE were the following:

Project Coordinator	20%
Associate Project Coordinator	14%
Assistant Project Coordinator	100%
Administrative Officer	100%

The four year collaboration among the MOH, USAID, and UNC has been described, analyzed, and documented in an extensive final report written by UNC. This is a summary of that report prepared for the USAID Mission to the United Republic of Cameroon. The intent of the summary report is to share the findings and recommendations resulting from the PTHE Project with a wider audience. Reference is made to the final report more complete and detailed information.

1.2 Objectives of the PTHE Project

The ultimate goal of PTHE was to increase the number of health-related development activities identified and undertaken by rural populations. Two basic health education principles are implied in this goal statement. The first is that community people are capable and willing to find solutions to problems they themselves believe to have high priority. The second principle is the aim of health education is to assist communities to meet the needs in the healthiest way possible.

To operationalize these principles and to achieve the project goal, PTHE would develop and implement a nationally coordinated practical health education training system which responds to the needs of the rural population in the Kadey and Me. u Divisions. For the essential barrier to the realization of improved health status had seldom been the lack of technical knowledge among health workers or the cost associated with the application of this knowledge. Rather, it had rested with the problems health workers had had in identifying effective means for (1) transmitting this knowledge in a meaningful way to populations at risk, and (2) stimulating and supporting organized, informed citizen action in solving community health problems.

The Project would raise health issues within a community organization and development framework in which program outputs were grafted onto the motives and needs experienced by the people themselves. Citizen action, rather than initiatives imposed by external sources, was the prime source of change. This approach would require an understanding on the part of the health worker of the values and beliefs of the people they serve, particularly as these relate to specific health issues and their attitudes toward change. Therefore, intensive and systematic in-service training of health workers in the field was needed to redefine their roles toward a more community-oriented practice of primary health care. Health personnel with supervision and training responsibilities also needed additional training to provide the critical support to health workers whose focus of activities have been redirected. Central level health officials with decision-making and policy-making responsibilities needed to participate in training

as well to coordinate and guide the direction of pre-service and in-service training occurring in training institutions and in the field. To accomplish these Project ends, a three-tiered system of training had been designed and implemented:

A. THE VILLAGE LEVEL

Village Committees--The formation of village committees as a result of community organization efforts. Through these committees, villagers prioritize felt needs, assess available resources, and find their own solutions.

Primary Schools--The introduction of a health education program into the primary school which places emphasis on application rather than theory and develops in school children a sense of responsibility for their own health through in-service training of school teachers and curriculum development.

Health Center--The training of health personnel using the team concept to integrate health education and health promotion into health service delivery. The training of a member of the health center staff as Itinerant Agent to fulfill the roles of liaison between the health center and the villages, and of community organizer.

Other Services--In-service training of other agency personnel working towards community development at the village level, e.g., teachers, agricultural extension workers, sanitarians, social welfare agents, etc.

B. THE INSTITUTIONAL LEVEL

In-service training of faculty from health training institutions (particularly those in Bertoua and Yaounde).

Field training for CUSS-CESSI and other health training institutions students.

C. THE NATIONAL LEVEL

Establishment of a visual aids production center.

Establishment of a national coordinating committee composed of representatives from other ministries and collaborating agencies to act as an advisory body to the Ministry of Health concerning the development of the PTHE Project.

Provision of seminars or conferences at least once a year.

Provision of scholarships for further training abroad in health education.

These three levels were integrated with one another consistently using central themes throughout all training activities and focusing on specific

skills needed for the effective functioning of each level of personnel (see Chapter 2). All related agency workers from other ministries were included in PTHE training sessions to promote greater collaboration. The PTHE Project assumed that the community development can only be realized through the integration of all services and resources available to villagers. The MOH believed that health personnel could effectively act as initiators and coordinators of this integration through the application of practical health education strategies and methods.

Expected PTHE Project outputs to be used as objectively verifiable indicators of project achievement in the pilot areas of the Kadey and Mefou Districts are the following:

- 40 itinerant agents trained and in the field with means of transportation by June 1982.
- 240 village committees established, of which 80% are rated as "active" by June 1982.
- 160 health workers and 30 Peace Corps volunteers trained and effectively implementing programs of health education in 16 health centers by June 1982.
- Training materials and design developed and utilized by PTHE in four MOH in-service training programs by June 1982.
- 25 workers from other services trained, of which at least 8 utilize training to undertake specific health activities by June 1982.
- 2 graduating classes of CUSS and CESSI will have completed field training in the PTHE sites by June 1982.
- 1 graduating class of assistant nurses will have completed training in PTHE sites by June 1982.
- 20 professors from health training institutions will have received in-service training by June 1982.
- Teachers from 8 pilot schools will have received in-service training by June 1982.
- Teachers' instruction manual developed by June 1982.
- Audio-Visual Workshop constructed by December 1980.
- Audio-visual personnel hired by December 1980, including one Peace Corps Volunteer, one Cameroonian audio-visual specialist, and one Cameroonian artist.
- Management system within the Health Education Service in place, including procedures for processing requests and reordering supplies.

20 health education posters/brochures printed and distributed by
June 1982.

These outputs are stated within the revised logical framework for the PTHE Project, which is attached as an appendix and described in detail in the final report.

The use of the Kadey and Mefou Districts as pilot areas for the Project was a conscious strategy for diffusion. That is, the selection of two contrasting districts in terms of sociodemographic and ethnographic characteristics as well as degree of access to resources would allow for the testing of PTHE strategies and methods under a range of conditions. The results would then provide valuable information to the MOH for making decisions about where and how to extend PTHE activities after the life of the Project.

Chapter 2

GENERAL FINDINGS

2.1 Community Participation and Action

The strategies used were based on the perceptions that transmitting essential technical knowledge in a meaningful way to populations at risk and stimulating and supporting organized informed citizen action would be the major challenges presented by the Project. It was felt that practical health education strategies and methods should include opportunities for professionals to "rediscover" the theories of disease causation held by village people and to learn of their perception of health, its relative priority in their lives, and the roles they saw themselves playing in health promotion projects.

Community diagnosis was our essential phase in the development of operational plans for each village. As defined in PTHE, community diagnosis was as much a learning experience for the professional as it was for the villager. In addition to the collection of information on population, age, number of households, and identification of important persons, the community diagnosis was designed to provide the itinerant agent with knowledge of patterns of community cooperation and collective action within the community. It was considered essential to analyze the social structures of the village, its leadership patterns and networks of communication as well as the dynamics of intra-community cooperation and conflict. An understanding of a village's past successes and failures in collective action was encouraged in that collecting a natural history of such events would often identify influential persons and provide insight into patterns of cooperation and conflict.

Thus, the community diagnosis was a particularly important method for health workers to implement. As an unobtrusive technique for understanding how a community functions, it was perceived to be closer to the usual style of transmitting information and would additionally have the advantage of placing the village person in the expert role at a point of early contact in his/her relationship with the health worker.

Conducting needs assessments as well as community diagnosis were considered to be on-going activities as it was anticipated that internal dynamics as well as notions of health needs would continually change in response to increased levels of technical awareness, experience in problem-solving, and availability of resources. Given these differences, it was assumed that starting points and tasks selected by various villagers would be varied.

According to the original strategy, needs would be determined through interactions among villagers and in concert with the itinerant agent, technical resource persons, and others who might help a village explore its potential for health promotion. The only constraints envisioned were that the task actually selected be achievable within a reasonable time frame, and that it be related to health.

The development of skills essential to enhancing self-reliance were viewed as being of greater importance than the actual tasks selected as a village's first work project because eventual success of the model would be dependent on the community's ability to organize, work cooperatively, define tasks, carry out objectives, use technical resources in planning, and mobilize broader participation. Carrying out these tasks with as high a degree of local autonomy as practical rather than having tasks assigned by staff workers was perceived as the best approach for achieving project objectives. The village health committee or other designated village groups able to carry out the tasks of technical knowledge enhancement and who could conduct cooperative health related development activities would become the catalyst for blending the resources of the village people, health workers, school teachers, agricultural agents, government administrators, and others able to contribute to health promotion.

Villagers, itinerant agents, health center staff, and other front-line workers were very responsive to the application of community organization strategies in primary health care. The numerous requests from village leaders and health center heads to be included in PTHE Project activities during the fourth year provide strong evidence for the level of enthusiasm generated. Empirical results on the viability of community organization strategies and methods for eliciting health-related community participation and action are presented in Section 3.1.

2.2 Health Center Staff Development

With a health service dominated at the ministerial level by physicians (clinical specialists--rather than public health specialists), health centers in Cameroon had an orientation toward delivery of services that in important respects conflicted with the notion that communities and their "lay" leadership might have significant contributions to make to program and implementation. Outreach workers failed to understand that in the field the views of the communities, if only for very practical purposes, need to be treated with at least the same respect as those of health professionals.

The staff development and training task for PTHE was a formidable one. Its success would depend on consistent, continuous team work on the ground, with support and incentives provided from the top.

(ii) Itinerant Agent Role

This is the critical central role in the community development approach to primary health care delivery because front-line community organization work is the direct responsibility of the itinerant agent. Expressed simply,

it was specified that the itinerant agent would be responsible for the setting up of local "health" committees that would address the priority issues identified by the villagers themselves. Thus, the role requires competencies firstly in the social skills of community organization; secondly, in the elements of health such as communicable disease control, nutrition, infant care; and thirdly, in the ability to determine under what circumstances and from which available source to seek technical assistance. It also requires an ability to relate and work collaboratively with front-line personnel of other ministries. As the key link between the health care delivery system and the community, the itinerant agent must possess:

- (1) An ability to feedback to clinical personnel at the health center, information concerning villagers beliefs, attitudes, priorities, even local idiom that will be of most potential use in clinical work in relating both with the sick and with the pregnant women and mothers of infants using health care services.
- (2) An equal ability to elicit from clinical personnel relevant information for use in community organization such as the frequency with which certain illnesses and conditions are diagnosed and in which villages.
- (3) An ability to establish a collaborative relationship between the community leadership and clinicians, by encouraging the clinicians to make the health center experience particularly rewarding for this group. In this way, the community leadership will be stimulated to encourage villagers to use health services appropriately.

Finally, the itinerant agent role requires a capacity to make a work plan that does not follow the mechanical routine of giving a number of villages equal time as it were, but which rather invests effort where there is more likelihood of early movement and some success, going later to other villages that might provide more resistance to action and to change.

(ii) Health Center Role

The first role of health center staff would be to substantively enhance the community organization component by conducting at least crude epidemiological analyses of intake to delineate:

- (1) Major and most frequent conditions presented for treatment and in which villages serious conditions appear to be endemic, and which villages are not seeking care. This would provide itinerant agents with information relevant to priority health problems of various villages and, of course, those that are not using services.
- (2) Variations in maternal and child health status according to village residence.

- (3) Special attention to community leadership as gate-keepers and influencers of village beliefs and attitudes.

The second role of health center staff would be to substantively enhance clinical and MOH goals by involving the more deliberate and systematic inclusion of behavioral, social, and cultural factors elicited in patient histories. The information would provide the basis on which health education and care may be proved.

The third role of health center staff would be to provide affective and instrumental support to itinerant agents by including the full involvement and participation of itinerant agents in health center staff meetings and program planning, regular recognition of their achievements, supportive supervision as they run into difficulties, and ensuring the availability of more sophisticated technical assistance as needed from time to time.

Such activities as these, however, require further understanding and competencies of clinical personnel concerning the whole community development strategy, simple data analysis and epidemiological methods, and the significance of social and cultural factors in health education. This redefinition of the focus of health center activities was well-received by the personnel who were feeling the frustrations of patients returning time and time again with the same cases of preventable illness and at the same time, not having adequate equipment or medication to treat them. Health workers providing direct care were found to be very open to learn new skills which would enable them to use their time and existing resources more effectively and efficiently. For while their basic training had prepared them well for the clinical aspects of their work, health center personnel had very little understanding of the social and cultural influences on health-related behavior change. Moreover, continuing education activities were seldom offered to this level of personnel as a means for providing career incentives and additional skills to meet the realities of their situation in the field.

The in-service training needs of health center staff were assessed by PTHE prior to the development of each Project-sponsored training activity. During the four years the needs expressed were overwhelmingly along the lines of how to motivate people to prevent illness, to use services appropriately, and to comply with medical regimens. Thus, the PTHE orientation toward the team approach to health center staff development and the practice of community-oriented primary health care were perceived by health workers to be extremely relevant to their needs.

2.3 Supervision and Support System

It was particularly important through the whole life of the PTHE Project that upper level personnel be continuously concerned and active in respect to laying the foundations for the post-PTHE continuance and its diffusion to the rest of the country. This involved, among other things, close attention to the roles of counterparts to the project technicians and assuring

that key personnel at all levels are acquiring continuously improved knowledge and experience in the nature, principle, application, and effects of community organization.

Role of Health Personnel at Ministerial Level

Within the MOH, the PTHE Project was placed under the direction of the Division of Preventive Medicine. The director of this division was then the Project Director of PTHE, and it was expected that he would:

- Work in close relationship with the Director of Health Services to ensure fully integrated PTHE operations on the ground at the local health center level.
- Be constantly working to integrate PTHE principles and practice into the overall work of his own Directorate which is particularly appropriate to the use of community organization as a major component in developing more effective programs than are currently operating.
- Ensure that the Health Education Service is as closely involved as possible since it would seem that responsibility for PTHE post-contract continuance and diffusion should be assigned to this service.
- Ensure through the Coordinating Committee that appropriate ministries, particularly Agriculture and Education, be as actively involved in program operations as possible and that their special expertise be available to him and his own MOH staff.
- Take a leadership role in planning the diffusion of project principles to the rest of the country and in raising associated issues in all contacts with provincial and divisional level personnel to prepare them for their ultimate divisional roles.

Role of Health Personnel at Provincial Level

Provincial level is the largest territorial unit to which the MOH posts functionaries: the Provincial Delegate, who sits atop the hierarchy of the health infrastructure in the province, and the provincial Preventive Medicine Section Chief, who supervises the divisional section chiefs and provincial services of Preventive Medicine. Solid cooperation and support are needed at this level, most especially in the area of personnel and material; i.e., ensuring adequate staffing and supplies in the PTHE pilot divisions.

Role of Health Personnel at Divisional Level

The expectation would be that divisional level personnel--the divisional Chief of Health Services, and especially the Chief of Preventive Medicine

and his assistant--would provide an essential link between health center personnel operations and the provincial and ministerial level. Therefore, the closest and most careful supervision, support and monitoring needed to be conducted at this level. For this reason, the Chief of Preventive Medicine and his assistant were officially named PTHE coordinator and supervisor, respectively, in their divisions.

Almost all of the health personnel placed in key Project related supervisory positions are clinical specialists, particularly those at the ministerial level. Their orientation to public health principles and practice was found to be weak relative to the expectations of Project technicians. Consequently, ministerial commitment to PTHE strategies and methods was compromised by the lack of understanding of generic health education and community organization theory among the majority of MOH directors and chiefs of service.

The work and enthusiasm of health personnel in the pilot divisions, from the chiefs of preventive medicine to the itinerant agents, were often confused by the mixed messages they were receiving from the ministerial levels, who emphasized outputs, and from the Project technicians, who emphasized process outcomes. For those health workers who grew committed to the application of the community organization process in ensuring village participation and action, the perceived lack of support from high level decision-makers was even more frustrating. The inability to adequately respond to village leaders and health center staff initiating requests to participate in PTHE activities was truly a missed opportunity for Project expansion and diffusion.

In the final analysis, a strong support and supervision system was not developed during the life of the Project.

2.4 Integrated Health and Community Development

PTHE envisioned involving senior and mid-level personnel from other Ministries in scheduled training activities in-country as well as internationally. It was felt that Ministries whose ongoing operations might be easily expanded to include health promotion would provide special opportunities for achievement of Project goals with but limited additional input from PTHE. The Ministries of Education and Agriculture seemed especially appropriate for this type of cooperation. Curriculum development in educational institutions responsible for training teachers, nurses, agricultural agents, physicians and sanitarians was especially emphasized as a Project priority. Graduates of these institutions, it was reasoned, would soon be in service throughout the nation and many of them would be involved in development activity.

Therefore, the Project established an Interministerial Coordinating Committee to participate in the development of PTHE policy as well as to integrate and reinforce the efforts of various front line workers responsible for development at the village level. Approximately forty representatives of all these services and agencies attended the bi-annual meetings. To a large extent, this numerous membership was its undoing as a technical

advisory body. The Coordinating Committee was never able to function beyond the bounds of receiving progress reports from Project staff.

However, PTHE field activities for front-line workers did emphasize the integration of health and community development by involving other ministry workers in training as trainers and trainees, by including integration strategies in training designs, and by offering technical assistance to other agencies in the design and implementation of training for their students. Nonetheless, the full potential of cooperative ventures was not realized due in part to the MOH tendency toward choosing its own personnel when decisions were made in regard to numbers of participants.

Chapter 3

RESULTS AND RECOMMENDATIONS CONCERNING THE DIFFUSION OF PTHE PROJECT STRATEGIES AND METHODS

3.1 Village Community Organization and Development

As initially conceived, this component was extremely ambitious in its targeted outputs--in four years every human settlement in the two pilot divisions was to be organized into health committees through a mass program of community organization with nearly 250 field workers in the front line. The number of field workers became a major constraint in the achievement of targeted goals. Actual outputs were:

- 21 itinerant agents trained and fielded with transportation (Revised log frame: 40 IA's trained and fielded with transportation).
- 136 village health committees created of which 60% are active (by Quarterly Evaluation standards).
- 160 villages working regularly with itinerant agents (Revised log frame: 240 VHC's of which 80% are rated as active).

Despite this constraint, the divisions were fairly well covered territorially--32 out of 41 groupements in the Mefou and all ten of the cantons in the Kadey had at least one health committee among their villages, with 245 villages contacted during the life of the Project covering a population of over 50,000 (Mefou: 130 villages, 20,500 inhabitants; Kadey: 115 villages, 32,800 inhabitants). The extent of field work was greater than could normally be expected from such a small number of itinerant agents.

Activity levels for health committees and participating villages actually surpassed ideal levels based on itinerant agent numbers in the two divisions; this was true for five of the seven quarters from July 1980 to March 1982 in the Mefou and four of the seven during the same period in the Kadey. (Level of activity determined by Quarterly Evaluation report scores.) This indicates that rural populations in the two divisions were actively responding to community organization efforts. The goal of PTHE--"to increase the number of health-related development activities identified and carried out by rural populations"--was well served. For levels of activity, undifferentiated for quality and process, performance was quite good.

VHC activities ranged from spring improvements and pit latrine construction to community clean-up days to organization of family pharmacies to nutrition education to creation of village food markets. Mean scores,

again from the Quarterly Evaluation reports, for VHC's in the Mefou and Kadey saw net changes of +2 for the Kadey and +5 for the Mefou during the period July 1980 to March 1982. An increase of two points in the mean score could indicate one additional village-level project per committee per quarter. While field efforts never achieved the result of 80% of VHC's earning "active" status, it should be noted that in order to be considered active, a VHC, in addition to completing a process of community diagnosis and needs assessment, and creating a committee structure, would meet regularly and undertake and/or complete health-related projects in every quarterly period of its existence.

Problems were never lacking administratively and logistically. While field performance was actually quite good, field workers continued to work under difficult conditions with little effective MOH support at the Directorate level. Logistical support for supervisor and itinerant work was often lacking. But PTHE has succeeded in making MOH officials aware of community organization as a health education strategy, and PTHE is now seen as a precursor to the National Program of Primary Health Care.

PTHE community organization activities, such as Committee Days and Quarterly Evaluation Days, received strong encouragement from the Minister of Health and were greatly appreciated by divisional-level administrators. Committee Days were developed from an early proposal of a Mefou itinerant agent. During Committee Days, several village health committees would send representatives to a model neighboring village for a full day of health education activities, including an environmental outing and a practical demonstration of a village-level project. Quarterly Evaluation Days, organized at divisional level, brought together IA's, head nurses, and PCV's from PTHE centers for discussions of problems encountered, possible solutions, innovative activities, training events and program planning. The National Program of Primary Health Care will likely integrate these activities into its local programs, just as village health committees remain a fixture in the PHC strategy.

Where sound community organization methods were implemented, PTHE field activities produced solid village health committee structures composed of villages able to discuss their public health problems and able to take actions to alleviate, if not to solve, those problems.

But much more flexibility in community organization work is necessary for village level programs--and this can be effectively promoted through refresher courses for both field workers and supervisors. It is the function of a health committee which is sought, and not merely the form. Experimentation should continue with structures adapted to local conditions. Thus pressure for numbers of committees should be restrained. A more accurate gauge of progress would be the number of villages taking up health-related activities.

3.2 In-Service Training

The In-Service Training component of PTHE consisted of in-service training for health personnel, technical assistance to MOH service and assistance

to the Ministries of Agriculture and Social Affairs in organizing continuing education courses.

In the four years of UNC technical assistance to the MOH the PTHE Project has organized:

- three seminars for front-line agents, representatives of several ministries, and administrative authorities, in Yaounde;
- two continuing education courses for heads of subdivisional hospitals and health centers in the Mefou and Kadey Divisions;
- orientation sessions in the Mefou and the Kadey for 18 health center teams composed of head nurses (or doctors), itinerant agents and Peace Corps volunteers;
- technical assistance to the Health Education Service of the MOH in designing and offering education courses for health educators and a national conference;
- technical assistance to the Training and Continuing Education Service of the MOH in designing and offering four provincial continuing education courses (Center South, North, West, and Littoral);
- technical assistance to the Community Development Service (MINAGRI) in organizing a continuing education course for rural development agents in Moundou, East Province;
- technical assistance to the Training Service of the Ministry of Social Affairs in training rural animators in Betamba.

Relative to the logical framework target output, the following results surpassed the stated outputs:

- 240 health workers and 35 Peace Corps volunteers trained and implementing health education programs in 18 active health centers. In the field, 82% of the health personnel working in the pilot division participated in in-service training. (Revised log frame: 160 health workers and 30 PCV's trained, activities in 16 health centers.)
- training design and material developed and used in four MOH provincial seminars, two HES seminars. (Revised log frame: design and materials developed for four MOH seminars.)
- 92 workers from other services participated in PTHE training sessions, of whom at least 52 undertook health activities by June 1982. (Revised log frame: 25 workers from other services trained, of whom 8 undertook health activities.)

Evaluation of PTHE health center performance over time--a reflection of training effectiveness--produced these results: for the period July 1980 to March 1982, both divisions showed net positive changes in scores on Quarterly Evaluations reports-- +8.5 for the Kadey, +5.4 for the Mefou in mean

scores. (Mean scores for the divisions rose to 36 and 36.7 respectively. Target score was 45.) A comparison of health center performance between PTHE centers and those of neighboring divisions (based on a health center inventory completed by head nurses and doctors in early 1982) revealed statistically significantly higher mean scores for PTHE centers, both in community action scores and in overall performance. PTHE centers generally offered a wider range of service both inside and outside of the health center. (Mean scores: Kadey = 50, Lom et Djerem = 41; Mefou = 51, Nyong et So-Nyong et Mfoumou = 35; out of a maximum score of 75.)

PTHE centers outperformed control centers without having benefited from increased material inputs: PTHE centers were no better stocked in drugs or equipment, nor more fully staffed, than the control facilities in their respective provinces.

Training activities were extremely popular with health personnel, both trainers and participants, and served beyond service upgrading as a motivation factor.

A product of this component, and potentially a major contribution to MOH training activities, is a Trainer's Guide developed during the four years of the Project. It is now available, in French and in English, from MOH for use by personnel involved in training and continuing education. The guide is set in order according to a step by step process of organizing a continuing education seminar i.e. the technical, logistical and administrative preparation of a seminar. Its principal section consists of 56 training activities covering eleven major community health topics; nearly all of these activities have been tested during the PTHE Project, and were designed or adapted for use in Cameroon.

3.3 Pre-Service Training

PTHE activities in this area never reached the ambitious levels set out in the Project Paper--target numbers which were seemingly set in ignorance of curriculum and calendar considerations. However, in its four years of operation, PTHE training saw the following levels of participation from faculty and students of training institutions:

	<u>Faculty</u>	<u>Students</u>
CUSS	0	160
CESSI	0	72
ENISFAY	6	0
BERTOUA NURSING SCHOOL	7	12
OCEAC	<u>0</u>	<u>20*</u>
TOTAL	7	264

*7 from Cameroon, 13 from Gabon, People's Republic of Congo, and C.A.R.

- three graduating classes of CUSS/CESSI participated in practical training in PTHE sites. (Revised log frame: two graduating classes of CUSS/CESSI)
- twelve assistant nurses (from Bertoua) participated in field training in PTHE sites. (Revised log frame: one graduating class of assistant nurses)
- seven faculty members of health training institutions participated in PTHE training activities. (Revised log frame: twenty faculty members)

These figures include fourth year medical students (CUSS), first year advanced nurses (CESSI), epidemiology students (OCEAC), and assistant nurses (Bertoua). For CUSS/CESSI training centered on a month-long field practicum, yearly; for OCEAC, three weeks of classroom and field work in health education; for Bertoua, participation by students in PTHE in-service training sessions in the Kadey (July 1979). ENISFAY faculty participated in PTHE seminars in Yaounde in 1978, 1979, and 1981.

The potential for PTHE influence on the re-orientation of health workers in the field to be more community-focussed will be multiplied through these students--who as future physicians and nurses will hold positions in the MOH infrastructure at the divisional, provincial, and national levels, as trainers, supervisors, and decision-makers. Through direct observation and practical experience in PTHE health centers, students gained knowledge and skills needed to initiate and support community action strategies. Classroom/seminar participation enabled faculty and students to review, and attempt, more active, practical training methods to be incorporated into their work. This commitment to a community health philosophy, and to a style of training which emphasizes practical exercises, active participation, and real life situations must be maintained. Thus, it is highly recommended that MOH continue to invest in the Mefou division centers to maintain appropriate training sites for students--CUSS/CESSI, ENISFAY, and Mbalmayo Nurses' Aide School. CUSS is presently building a field training site just outside Pandougou in the Kadey--a good reason to extend this recommendation of MOH investment to the Kadey (where Bertoua nursing school would also benefit).

To ensure that nursing school students also benefit from effective field training, MOH should designate someone to work full time with nursing school directors and faculty to design feasible programs for each school based on local conditions.

3.4 Primary School Health Education

A re-orientation of this component, from teacher training to curriculum development, was proposed by the PTHE Interministerial Co-ordinating Committee in December 1979. The following outputs were those achieved by Project end:

- Teachers from ten pilot schools received in-service training. (Revised log frame: teachers from eight pilot schools to receive in-service training)

-A teacher's guide to health education in primary schools was developed and tested. (Revised log frame: teacher's guide developed by June 1982)

In order to pursue the objectives of this component effectively, an Interministerial (MOH/MINEDUC) Sub-Commission for Primary School Health Education was created in January 1980 and functioned throughout the development of the PTHE program. This Sub-Commission established goals and objectives for health education at the primary school level (both general objectives and specific ones for grade levels) and generated a framework of themes out of which lesson plans could be developed. Rather than writing lesson plans at central level, work groups at divisional levels (Mefou and Kadey), composed of both health and education personnel, wrote up lessons plans on the line of the themes proposed by the Sub-Commission. These lesson plans, two sets of them (Mefou and Kadey) were then edited into a single teacher's guide by an editorial board made up of Sub-Commission members and a representative of the MINEDUC National Inspectorate.

During the academic year 1981/82, the guide was tested in ten pilot primary schools (five in each division). Teachers and directors of these schools had attended orientation sessions organized by PTHE to introduce the guides and to demonstrate the active instructional methods promoted by the guide. Two methods of evaluation were utilized during the test period--one of them being observation sheets for classroom lessons taken from the guide (completed by local evaluation teams made up of health personnel, instructors, and village health committee representatives), the other being a pre-test/post-test instrument for pupil health attitudes and knowledge. Separate tests for CE (third and fourth grades) and CM (fifth and sixth grades) were administered with the following test results:

Difference between means of Correct Responses on a Health Questionnaire administered to 3rd, 4th, 5th, and 6th grade students.

Kadey Division

Test	Number of Classes	Mean	SD	t-Value	df
Pre-	11	278.81	105.95		
Post-	11	318.27	123.61	-3.97	10

Mefou Division

Test	Number of Classes	Mean	SD	t-Value	df
Pre-	13	306.61	77.67		
Post-	13	330.38	81.70	-5.41 ^a	12

^aSignificant at the .005 level for one-tailed test.

Results, from a single year of instruction, are impressive. Beyond this index of success, other developments point out the very positive effects of this program. A National Conference on Health Education in Schools was organized jointly by MOH/MINEDUC in February 1982 for which the PTHE teacher's guide was central to discussion. Preliminary results from the test of the guide and its experimental timetable (separating hygiene from morale in the primary school program of instruction, expanding hygiene to practical health education, and consolidating instruction into single weekly sessions of 30 to 45 minutes by grade level) encouraged the MINEDUC Commission on National Reform of Primary Education to adopt a similar program as the national standard.

This component of PTHE demonstrated the rich possibilities of inter-ministerial efforts in the domain of public health; MOH/MINEDUC collaboration was effective from village primary school level to divisional level to ministerial level.

3.5 Audio-Visual Aid Center

In the original Project Paper, no mention is made of an audio-visual aid production center; USAID agreed to supply production materials for such a center, attached to HES, after subsequent talks, and the center was appended as an output to the revised logical framework of 1980. UNC/CH had no technical role to play in this area.

Despite the delivery of large stocks of material and the presence of two PC A-V specialists, the A-V production center never became functional during the life of the Project. A projected date of late October 1982 has been given for completion of renovation work on the HES office block which will eventually house the center.

Once the center is functional, it is recommended that (1) results from a survey of A-V needs and preference done at the May 1982 PTHE seminar be taken into consideration for establishing priorities of production, and (2) that the Primary School Health Education program be a primary focus for A-V production, with subjects taken from the experimental Teacher's Guide.

Chapter 4

- CONCLUSION

The Project has shown that a major barrier to the success of community oriented primary health care delivery rests in the seemingly simplistic technical approach which depends on less apparent, but very complex and sophisticated, strategies and methods. Health care providers the world over acknowledge the value of good nutrition, good hygiene, and clean water. Since the dawning of civilization, people have been concerned with the implementation of practices they believe to be essential for survival. Yet given this desire for good health and the presence of qualified technicians who understand the relationship between health, diet, hygiene, and water, why then is it necessary to develop special programs or projects to stimulate and encourage collective and individual behavior change?

It was clear to UNC and to those in the MOH who originally designed PTHE that in spite of differences in beliefs, habits, and behaviors found among various human societies, there are indeed generic principles that when rigorously and sensitively applied will in time produce health beneficial change. It was further known that insights gained from the PTHE experience in the Kadey and Mefou Divisions would prove useful to health planners and technicians in other parts of Cameroon and in other African nations where attempts are being made to reorient service delivery to be more responsive to people. The details of program design would, of course, be varied according to the unique characteristics and conditions of each local situation.

It was the task of PTHE to transmit these selected generic principles of development and behavior change to the people of two areas of a nation. This was accomplished, for the data clearly indicated an increase in the number of health-related development activities identified and undertaken by the villagers themselves. By the close of the Project, the level of village enthusiasm was high and the number of requests initiated by village leaders to participate in PTHE outreach activities provided enough evidence of people's responsiveness to the strategies and methods used.

However, it was in the area of developing an adequate support and supervision system for these workers that PTHE was unable to achieve. From all indications the major barrier was that high level decision makers in the MOH on whom the Project depended never clearly understood the theories and principles of community organization and health education. In the final analysis PTHE should have begun field operations by focusing on this level of personnel through more intensive and specially

designed training efforts to ensure the degree of orientation and commitment needed from them.

We also know that organizational boundaries within and between government agencies coupled with those of international donor agencies can often become barriers to achieving the very objectives they most wish to reach. Therefore, structural changes need to be seriously considered for distributing participation and ownership in primary health care more equitably among ministries, divisions, and services concerned with community development. Very significant lessons have been learned from the PTHE experience in terms of personnel management, financial management, and communication structure as important factors in the development process. In-depth analysis of how they influenced the process and direction of the Project is discussed in the full final report.

As Project technicians and coordinators, we strongly encourage the continuation of the PTHE approach within the MOH even if resources constraints dictate a reduction in efforts. It has always been our intent that MOH decision-makers should view the PTHE experience as an experimental one capable of generating understandings that will be useful for increasing the effectiveness of existing primary health care efforts within the Ministry. We did not discover a formula for universal success nor do we believe that there is likely to be one which would remain successful without continuous modification to meet the demands of changing economic and social realities.

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