

UNCLASSIFIED
CLASSIFICATION

PROJECT EVALUATION SUMMARY (PES) - PART I

Report Symbol U-447

1. PROJECT TITLE Practical Training in Health Education			2. PROJECT NUMBER 631-0009	3. MISSION/AID/W OFFICE USAID/Cameroon
			4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY) 631-83-2	
			<input checked="" type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION	
5. KEY PROJECT IMPLEMENTATION DATES			6. ESTIMATED PROJECT FUNDING	
A. First PFO-AG or Equivalent FY 1977	B. Final Obligation Expected FY 1979	C. Final Input Delivery FY 1982	A. Total \$ 1,998,000	
			B. U.S. \$ _____	
			7. PERIOD COVERED BY EVALUATION From (month/yr.) June, 1977 To (month/yr.) June, 1982 Date of Evaluation Review _____	

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

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
<p>No actions required.</p>		

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS			10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT		
<input type="checkbox"/> Project Paper	<input type="checkbox"/> Implementation Plan e.g., CPI Network	<input type="checkbox"/> Other (Specify) _____	A. <input type="checkbox"/> Continue Project Without Change		
<input type="checkbox"/> Financial Plan	<input type="checkbox"/> PIO/T	_____	B. <input type="checkbox"/> Change Project Design and/or		
<input type="checkbox"/> Logical Framework	<input type="checkbox"/> PIO/C	<input type="checkbox"/> Other (Specify) _____	<input type="checkbox"/> Change Implementation Plan		
<input type="checkbox"/> Project Agreement	<input type="checkbox"/> PIO/P	_____	C. <input type="checkbox"/> Discontinue Project		
11. PROJECT OFFICER AND HOST COUNTRY OR OTHER BANKING PARTICIPANTS AN APPROPRIATE (Names and Titles)			12. Mission/AID/W Office Director Approval		
Ray Martin, USAID/Cameroon John W. Hatch, University of North Carolina Dr. P.C. Mafiamba, MOH, Cameroon			Signature: <i>Ronald D. Levin</i>		
			Typed Name: Ronald D. Levin, Director		
			Date: 7/6/83		

EXECUTIVE SUMMARY

Date: June 10, 1983

Project: 631-0009: Practical Training in Health Education

Country: Cameroon

Period of Project: July, 1977 - June, 1982

I. What constraint did this project attempt to relieve?

The project attempted to relieve constraints caused by lack of health knowledge and lack of a grass roots strategy to implement health activities, which lead to preventable health problems ultimately interfering with the production and development processes.

II. What technology did this project promote to relieve this constraint?

The project proposed a nationally coordinated practical health education training system and strong community organizations which would increase the number of health - related development activities identified and undertaken by rural populations.

.III. What technology did the project attempt to replace?

The technology to be replaced included a service delivery system obsessed with curative medicine, lack of understanding of the potential health benefits possible through self-help and cooperative actions, and reward systems that encouraged less productive activities to the neglect of more productive ones.

IV. Why did project planners believe that intended beneficiaries would adopt the proposed technology?

Preliminary project analyses showed that target villagers were willing to organize for community action and that they were receptive to medical techniques proposed by training courses.

V. What characteristics did the intended beneficiaries exhibit that had relevance to their adopting the proposed technology?

Beneficiaries had adequate education level to understand training courses, and they had a village structure within which the health activities could fit.

VI. What adoption rate has this project achieved in transferring the proposed technology?

Some of the training targets were not achieved because they were overambitious. However, village committees were developed as anticipated and national health education training system is functional.

VII. Has the project set forces into motion that will induce further exploration of the constraint and improvements to the technical package proposed to overcome it?

The Ministry of Health is currently planning to use the PTHE model for other regions of Cameroon and ultimately for the whole country. They view the model as viable.

- VIII. Do private input suppliers have an incentive to examine the constraint addressed by the project and to come up with solutions?

Certainly, private businesses have the opportunity to open pharmacies to the target areas, in order to provide drugs to support the medical technology proposed.

- IX. What delivery system did the project employ to transfer technology to intended beneficiaries?

The project formed a national coordinating committee, village committees, a health education program in the primary schools, the training of health personnel using the team concept, and 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.

- X. What training techniques did the project use to develop the delivery system?

The training techniques included visual aids, seminars, conferences, in-service training, team concept approach to the training of health personnel, and practical exercises for primary school children to develop in them a sense of responsibility for their own health.

XI. What effect did the transferred technology have upon those impacted by it?

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.

This indicates that rural populations in the two divisions were actively responding to community organization efforts.

For levels of activity, performance was quite good.

Consequently, target villagers are now more actively initiating health-related activities.

PRACTICAL TRAINING IN HEALTH EDUCATION

(631-0009)

Summary

The Practical Training in Health Education Project (PTHE), implemented from 1978-1982 in Cameroon, was a project aimed at stimulating community organization in the realm of health. The project, implemented by the University of North Carolina in collaboration with Cameroon's Ministry of Health, attempted to increase the number of health-related development activities initiated by rural populations by developing a nationally coordinated practical training system. This training system was composed of village, institutional, and national-level structures, which were integrated by common training themes. Village level structures included village committees, primary school health education programs, and health center teams. Institutional level structures included in-service and field training programs. The national structures included a national coordinating committee, a visual aids production center, seminars and conferences.

Although the project fell short of targeted outputs for reasons described in this report, the goal of the PTHE project - to increase the number of health-related development activities identified and carried out by rural populations - was well-served by the village health committee program, given the extreme constraint of field worker numbers. Numbers of health related development activities increased dramatically in all of the 245 villages contacted by field workers in the two divisions, as did awareness of public health problems and local-action solutions.

Also important to note is the fact that the Ministry of Health's Department of Preventative Medicine was interested enough in the P.T.H.E. model that they mobilized a large-scale inter-ministerial evaluation of the project. Although the evaluation has been delayed, it illustrates that the MOH views the community participation approach as replicable in other parts of Cameroon.

Actual outputs achieved included:

- 1) 21 itinerant agents trained and fielded with transportation;
(target was 40).
- 2) 136 village health committees created of which 60% are active.
(Target was 240, of which 80% were active.)
- 3) 160 villages working regularly with itinerant agents.

Typical village health committee activities included spring improvements, pit latrine construction, community clean-up days, organization of family pharmacies, nutrition, education, creation of village food markets, and so on. (See pgs. 13-14 of summary report.)

In-service training activities included 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. (See pgs. 14-16 of summary report.)

Pre-service training activities fell quite short of expectations. (See pgs. 16-17 of summary report.)

Primary school health education included the training of teachers and the development of a guide to health education in primary schools. (See pgs. 17-19 of summary report.)

An audio-visual aid center was never developed (See pg. 19 of summary report.)

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PTHE PROJECT 631-0009

SUMMARY REPORT

PRACTICAL TRAINING IN HEALTH EDUCATION PROJECT

Prepared for the USAID Mission to the
United Republic of Cameroon
Under Contract No. afr-c-1432

Submitted by:

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September 30, 1982

The preparation of the PTHE final report was coordinated by Eugenia Eng, the Project Assistant Coordinator, and Michael Davies, the Project Community Organization Technician. Jim Herrington, the Project Research Assistant, made significant contributions in data analysis and discussion of findings. John Hatch, the Project Coordinator; Guy Steuart, the Project Associate Coordinator; and Paul Seaton, the Project Administrative Officer, each prepared several sections for this document. Darryll Candy, the Chief of Party, and Nancy McCharen, the Project Training Technician, provided valuable insights through their written reports to UNC for inclusion in the final report.

P THE 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, SOCCOPE). 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 Bandongoue 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	-3.97	10
Post-	11	318.27	123.61		

Mefou Division

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

^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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PTHE PROJECT 631-0009
FINAL REPORT
PRACTICAL TRAINING IN HEALTH EDUCATION PROJECT

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Four years of living and working side by side with the people of Cameroon represent more than the fulfillment of a contractual agreement to provide technical assistance to the Ministry of Health's Practical Training in Health Education Project. For the experience not only produced positive results in outcomes and additional insights for problem-solving, but it also produced positive professional and personal relationships which deserve special recognition.

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Acknowledgments continued

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And foremost, we want to express our deepest gratitude to the people living in the Kadey and Mefou from whom the Project drew its energy and direction. They were our partners in development.

LIST OF ABBREVIATIONS AND ACRONYMS

Cameroonian Organizations

CESSI	Center for Advanced Nursing Training
CUSS	University Center for Health Sciences
ENISFAY	School of Midwifery and Nursing in Yaounde
GURC	Government of the United Republic of Cameroon
HES	Health Education Service
MINAGRI	Ministry of Agriculture
MINEDUC	Ministry of National Education
MINPLAN	Ministry of Economic Affairs and Planning
MINSAF	Ministry of Social Affairs
MOH	Ministry of Health
PTHE	Practical Training in Health Education

Other Organizations

AFR/DR	Development Resources for Africa Office (USAID)
CIDA	Canadian International Development Assistance
HNPO	Health, Nutrition, and Population Office (USAID)
OCEAC	Organization for the Fight Against Indemic Disease in Central Africa
ODV	Organization of Dutch Volunteers
UNC	University of North Carolina
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USAID/W	USAID Headquarters in Washington, D. C.
USAID/Y	USAID Mission in Yaounde
WHO	World Health Organization

Miscellaneous

CE	Cours Elementaire
CM	Cours Moyen

Abbreviations continued

COP	Chief of Party
CP	Cours Préparatoire
IA	Itinerant Agent
PCV	Peace Corps Volunteer
VHC	Village Health Committee

Chapter 1

INTRODUCTION

". . . the final positive goal of maintenance of health can only be achieved by the people themselves through being possessed of adequate education in and practice of health knowledge." This statement made in 1934 by John B. Grant, the pioneer of community-based primary health care, reflects the profound influence he had had on the health care delivery system of the People's Republic of China at that time, and continues to have on world wide efforts to integrate community development and health. The principles developed by Grant guided the approach used by the Practical Training in Health Education (PTHE) Project to reduce the debilitating effects of preventable disease by increasing the ability of community people themselves to meet their health-related needs without the constant intervention of health personnel.

The more usual approach of stimulating and educating populations at risk to adopt more health promotive behaviors was not producing results which corresponded to the level of human and financial resources invested. The missing ingredient was a health care delivery system's inability to mobilize internal resources of a community and external resources available to a community because health workers were not able to graft technical knowledge and skills onto the daily life experiences and priorities of the people they served.

For the Government of the United Republic of Cameroon (GURC), the PTHE Project represented a concerted effort to expend health education activities to its rural population by re-orienting the work of Ministry of Health (MOH) personnel at all levels. To accomplish this health workers from the individual village to the National Service needed to be trained to be able to implement specific strategies and methods of health education which were community oriented in focus and development oriented in practice.

This is the story of the four year Project. The full detailed description of the activities, methods, and approaches used in PTHE is presented in this document. The project's findings, analysis, and interpretation are discussed in assessing the degree to which PTHE fulfilled its original intent in terms of process and ultimate outcomes. Both general and specific recommendations based on the PTHE experience are made to enable similar efforts in the future to learn from the Project's mistakes and to gain strength from the Project's successes.

1.1 Objectives of Final Report

The usual purpose of a final report is to provide administrative closure for a project by documenting what had been planned initially, what was actually implemented, how well the activities were executed, and to what degree the objectives were met, and by proposing specific recommendations based on the findings. This final report for PTHE, however, has been written with an additional purpose in mind. While the final report's organization and content should meet the normal requirements of an administrative document, the particularly strong emphasis given to the various processes of implementation and evaluation should serve the useful purpose of a planning document.

Program planners and technicians with a special interest in specific strategies and methods used in the development of community-oriented primary health care services should find Chapters 2 and 3 to be the most valuable in terms of practical information. Chapter 2 describes in detail the particular strategies and methods selected for PTHE at the community level, the direct service level, the supervision and support level, and the community development level. The overall conceptual framework used in the project provides the rationale for selecting these strategies and methods. PTHE Project assumptions are explicitly stated as well, and are assessed in retrospect as to the degree to which they were correct.

1.1 continued

Chapter 3 presents and evaluates each Project activity designed to implement the strategies and methods described in Chapter 2. The activities discussed are organized by program components according to the population served:

- Village communities
- Health and other agency personnel
- Faculty and students of training institutions
- Primary school teachers and students
- Audio-visual aid center staff

Quantitative and qualitative evaluation findings are presented and discussed for each program component in terms of how well the activity itself was implemented and the degree to which it contributed to the effectiveness of the planned strategy.

Chapter 4 focuses on the complex system of PTHE administration spanning from UNC-Chapel Hill to its field office in Yaounde, to the MOH, to the USAID mission in Yaounde, to the USAID in Washington, and to other principal donor agencies. The detailed discussion and analysis of the multifaceted roles and responsibilities are presented by administrative units, while the major management areas of communication, personnel, and finance, are presented as separate sub-sections. Program administrators and managers should find Chapter 4 to be a valuable source of practical information for planning and managing any major program involving more than one agency. The detailed analysis of the management system should serve as a case study in organizational development.

Finally, Chapter 5 offers specific recommendations to the MOH in terms of the continuation and diffusion of certain PTHE Project strategies and methods. This final report signifies the end of the pilot phase and the beginning of full national program planning by the MOH in Cameroon.

1.1 continued

Recommendations are also made to USAID concerning the development of similar technical assistance projects in Cameroon and in other African nations.

1.2 Terms Of Reference

It is anticipated that this final report will be of particular interest to the MOH and USAID as PTHE Project collaborators and as organizations which have invested an enormous amount of financial and human resources into its support. Therefore, in the writing of this report, two terms of reference were kept in mind for sifting and selecting through the tremendous amount of information, data, findings, documents, and personal insights accumulated over the past four years. The terms of reference are the following:

a) Usefulness of the PTHE experience to the MOH for diffusion to other parts of Cameroon

The decision to choose two very distant and different areas (the Mefou and Kadey districts) for PTHE Project implementation was based on the rationale that factors such as ethnicity, population density, socio-economic status, geography, degree of isolation from resources, and occupation, could influence the project outcomes. Through the relatively wide range of these factors found in the Mefou and Kadey Districts, findings could be compared and contrasted more precisely to answer questions concerning generalizability and replicability of PTHE strategies and methods.

Thus, the discussions and recommendations contained within this document have been developed to provide the MOH with pertinent data and methods for making well-informed decisions about which PTHE strategies and methods can be effectively diffused, under what conditions, and how.

1.2 continued

Comparisons are explicitly made between the Mefou and Kadey outcomes to present any significant differences. Ethnographic and demographic factors are examined, when the data are available, to explore plausible explanations for the differences observed.

Unanticipated outcomes, both positive and negative, are also included in the analysis of PTHE strategies and methods. With any pilot project as intensive in activity and extensive in time as PTHE, unintended side effects will undoubtedly occur. More often than not, an analysis of unanticipated benefits or barriers can provide valuable insight into the practical aspects of implementing new strategies and methods.

b) Usefulness of the PTHE experience to USAID for replicability in other African nations

For the purpose of this final report, "replicability in other African nations" is not meant to imply the precise duplication of PTHE in its entirety in another country. PTHE represented an attempt, intensively and systematically, to apply an approach to community participation in primary health care and preventive action and to train personnel in the strategies and methods of such an approach in Cameroon. But there does emerge from this experience a number of more widely applicable considerations appropriate to the establishment and development of similar programs in other African settings.

As a result of this four year experiment, certain strategies and methods were shown to be more effective than others, with some needing additional testing in Cameroon and in other countries. The role of USAID in facilitating, providing support for, and monitoring similar programs through pilot projects in Africa is a crucial one.

1.2 continued

Fully recognizing that PTHE is not the definitive model in the community development approach to primary health care delivery, the final report makes specific references throughout as to how the role of USAID can be more effective in the development of such a model. Both the technical and management aspects of collaboration are included in the analysis and recommendations.

Chapter 2

OVERVIEW OF PTHE PROJECT PROPOSAL

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 Services (CUSS), and Coordinating Agency for the Fight Against Endemic Diseases in Central Africa (OCEAC). In December 1976, the final and approved 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.

2.1 Project Purpose

It was the role of PTHE to draw from the pool of world experience in health promotion, mass mobilization and community development, those generic principles best suited to maximize opportunities for health improvement in Cameroon. The project seemed especially attractive as few additional resources would be required and the cost would be low.

However, technical resources which were available to Cameroonians were not focused in ways likely to have an impact on health problems facing the people. The service delivery system was hampered by pre-occupations with curative medicine, lack of understanding of the potential health benefits possible through self-help and cooperative actions, and reward systems that encouraged less productive activities to the neglect of more productive ones.

2.1 continued

Health workers did not understand the potential value of their technical input into activities focused toward health promotion, underestimated the potential of villagers to resolve organizational conflicts, and simply did not know how to stimulate, encourage and guide self-help efforts at the village level. These were the barriers to be overcome by PTHE. Some were ones that could be managed through education and practical experience while others institutional and quite probably beyond the reach of PTHE's potential influence for encouraging cooperative action.

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 that the aim of health education is to assist communities to meet these 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 Mefou Divisions. 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 has 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.

2.1 continued

The Project raised 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 required 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 supervisory and training responsibilities also needed additional training to provide 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:

1. 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.

2.1 continued

- 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.

2. THE INSTITUTIONAL LEVEL:

- In-service training of faculty from health training institutions
- Field training from CUSS-CESSI and other health training institutions students.

3. 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 a 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 by consistently using central themes throughout all training activities and focusing on specific skills needed for the effective functioning of each level of personnel. All related agency workers from other ministries were included in PTHE training sessions to promote greater collaboration. The PTHE Project assumed that true 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.

2.1 continued

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.

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:

2.1 continued

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

2.2 Project Assumptions

The theoretical foundations and practice principles of community organization and health education in relation to primary health care services have a long history of development. Their more visible emergence and recognition today is a result of the failure of more traditional strategies to meet expectations for results from evaluation research, practice experience, and basic research. The applicability of the following principles and theories to PTHE is clear, but it should be noted that they are equally applicable to similar programs in developing as well as developed countries of the world.

Success in the treatment and prevention of the main communicable diseases and other health problems of rural Cameroon is to a considerable, indeed critical, degree dependent on the extent to which the people themselves, by their own initiative and health promotion behaviors in their daily private lives. This would include the extent to which they themselves deal practical solutions to environmental hazards such as latrine building and the protection of water supplies; whether they adopt more hygienic methods of infant care and feeding, following more balanced diets, use medical care services more discriminantly, and use professional advice and services with respect to pregnancy and delivery.

Thus, while services themselves have a technology to deliver, (e.g., immunization or medical care), and while clinical personnel may attempt to educate and persuade those who do use such services, those clients represent only a part of the population at risk or in need. Moreover, such advice tends to be effective primarily where it relates to a more or less immediate sense of urgency by the client and is likely to have little effect on daily preventive life-styles and behavior. For example, daily habits of personal hygiene, of infant feeding, or of local environmental management are notoriously insusceptible to persuasion attempts which are confined to clinical settings.

2.2 Project Assumptions

Outreach activities, having considerably greater potential for efficacy, also have serious constraints. First, the disproportion between numbers of health personnel and the size of catchment populations is such that universal individual and family contact between worker and people is simply not possible. Secondly, geographical distances, road conditions, and lack of transport limit the accessibility of local populations, particularly in rural areas, to health center staff.

Moreover, in attempting to overcome such personnel and logistical problems, services often concentrate on using a variety of mass media with their typical information - disseminating and compliance exhorting messages. The results of this are too often disappointing. Usually, too, matters are not much improved by combining with the mass media a variety of didactic teaching methods with small groups of people. Both mass media and didactic teaching, as well as the more efficacious group discussion methods, all of which attempt to reach as many of the intended beneficiaries as possible, have a definite place in health programs. However, they simply do not come up to expectations if they are not components of a broader, more strongly participatory strategy, led by indigenous community leadership and care-givers where the momentum is a function of the needs and motivations felt by the people themselves.

It is clearly apparent in rural areas that human communities constitute social systems in which the membership is socialized during growth and development to particular beliefs, perceptions, interpretations, daily life-styles, and ways of coping with normative living problems and dealing with health and survival issues. The community also provides for its membership, beyond more immediate kin and non-kin networks, a broader support system that exerts in numerous ways a continuing influence that favors compliance with existing life-styles rather than innovation, and that ensures security and stability rather than change.

2.2 Project Assumptions

The major influences upon stability and change in rural communities are exerted primarily by those particular members whose roles are seen and largely accepted as decision-makers, opinion-leaders, advice-givers, and models whose influence extends beyond the boundaries of their own more immediate daily personal networks. Even within kin-group organization itself, decision-making roles of the members (father, mother, grandparents, uncles and aunts, etc.) are differentiated and to considerable extent determine what is acceptable behavior in the group.

Therefore, health service outreach interventions do not come up to expectations where:

- a) the individual, or even the kin-group, is the exclusive unit of practice since the motivation and capacity to deviate from community norms is very limited, and especially if persuasion comes from an outsider.
 - b) the focus is primarily or exclusively on teaching the people at large what are commonly culturally alien ideas and practices generated by "external" health workers.
 - c) the inside view and experience of needs and priorities of the people themselves are merely "taken account of", but in fact do not become the mainstay of community health action.
 - d) the existing leadership, decision-making, advice-giving individuals and groups indigenous to the community as well as the styles they customarily use in these roles are not central to program action.
- Increasingly then, the community as a social system (not simply a population or aggregate) needs to be seen as a particularly important unit of practice in which the appropriate strategy is to mobilize community decision-makers to a point where, under their leadership, the community becomes an active partner in a program. With outreach worker support and technical assistance, the ultimate aim is for the community to assume responsibility for all those aspects in which the behavior and efforts of the people themselves are essential for program success.

2.3 Logical Framework

The logical framework is primarily a project planning device, but can also be used to re-examine the original project design as a necessary prelude to evaluation. It sets the stage for determining and validating the degree to which project outputs have been produced; whether these outputs have contributed to the achievement of project purposes; and whether this achievement has made a significant contribution to the higher order goal. The logical framework can also establish the practical limits of responsibility of project management. Articulating the project planning assumptions in explicit and operational terms should permit a clear separation between manageable interests and those factors which appear to be beyond the control of the project management team. For evaluating the degree of managerial control, it is necessary to examine the original planning assumptions about the role of external factors and to validate the hypothesized relationships between project inputs and outputs.

However, there are three major limitations to the logical framework methodology for project planning and evaluation. First, it does not ensure that a project directly addresses the most critical constraints to goal achievement, or that the project approach is the most effective means for overcoming those critical constraints unless the planners had explicitly chosen to explore alternative ways and approaches. Secondly, the logical framework methodology offers no guidance for examining the process of change with regard to equity and the recipients of benefits, such as access to resources, community participation in decision-making, and fruits from development activities unless these aspects have been explicitly stated in the project goals or purposes. Thirdly, the methodology provides no guidance on proven strategies and techniques, cost and feasibility of replication, concentration on key problem areas, and other important technical factors.

The development and use of the logical framework methodology in the PTHE Project proved to be a helpful tool for monitoring the progress of pro-

2.3 Continued

ject management in terms of expected inputs from the various donor agencies, and GURC institutions, and of the validity of operative assumptions. However, as a technical planning and evaluation tool, the logical framework made minimal contributions to the design and assessment of PTHE strategies and methods.

The most salient explanation for the ineffectiveness of the logical framework is derived from the untimely but much needed decision to drastically revise what the MOH, UNC, and USAID perceived to be a loosely formulated and unrealistic logical framework. This decision was made after eighteen months of PTHE Project implementation. Both the original and revised versions are discussed and analyzed in detail in the following sub-sections.

While the revised logical framework was a marked improvement for project management, the methodology continued to be inappropriate to the technical planning and evaluation needs of PTHE. The Project's approach and focus were integrally tied to the process of community participation in making decisions related to health and development. Indicators of changes in equity and level of self-determination are critical measures for monitoring and ultimately evaluating how well the various PTHE strategies and methods elicited community participation. The logical framework essentially did not include process measures in its definition of inputs, outputs, and validating assumptions. A more in-depth discussion of the specific strengths and weaknesses of the original and revised logical frameworks for PTHE follows.

a) The Original PTHE Logical Framework

The original version of the PTHE logical framework was formulated in Yaounde by the USAID Mission and the MOH (see appendix). With the exception of precise detail concerning the conditions of various donor agencies, the logical framework was finalized with the Project Paper at a meeting held in Yaounde on October 27, 1975. Thus, a full three years would pass before a technical assistance contract would be signed with UNC in June 1978 and the PTHE field operations would begin in September 1978.

2.3 Continued

Given this difference in time, one could anticipate changes in personnel and organizational commitment. By 1978, eleven of the twenty-two participants who had attended the important October 1975 meeting were either no longer in Cameroon or holding different positions. Three key MOH representatives - The Director of Preventive Medicine, the Chief of Health Education Service, and the Assistant Chief of Health Education Service, had been reassigned to posts outside of the PTHE program in the intervening period. Consequently, PTHE began operating under a logical framework for which virtually none of the important personnel involved from the MOH, USAID, or UNC could explain, understand, or justify. Many questions were raised, such as how certain numbers in the outputs had been calculated, what was precisely meant by donor agency inputs, and what was the relationship between certain measures of achievement and their stated means for verification. They were never addressed until the mid-project evaluation was conducted in March of 1980.

An immediate and most critical discrepancy between the original logical framework and the situation existing in 1978 was the drastically reduced commitment from donor agencies. WHO had entirely withdrawn its resources. Consequently, faculty support from CUSS and CIDA (Canadian International Development Assistance) was no longer available. UNICEF began retreating from its original input of 200 motorcycles, construction materials and audio-visual materials. OCEAC reduced its contribution as well. For a detailed discussion, see Sections 3.3 and 4.5. These serious changes in the level of inputs would undoubtedly alter the level of outputs projected in the original logical framework. Modifications were not initiated formally until March 1980 and prior to that time, PTHE field operations used the UNC Technical Proposal as a planning document and never referred to the logical framework.

b) Revised PTHE Logical Framework

As a result of the March 1980 mid-project evaluation, the original logical framework was fully analyzed and assessed for relevancy and usefulness to

2.3 Continued

the further development of PTHE. The recommended revisions made by the mid-project evaluation team and the actual reformulation of the logical framework by an outside consultant were strongly supported by the MOH, UNC, and the USAID Mission's Project Development and Evaluation Office. However, the Project Agreement was never amended nor ratified officially for reasons which remain unclear to UNC. Nonetheless, informal agreement among the MOH, USAID, and UNC that there was no need to continue to evaluate PTHE on the basis of the original logical framework, permitted the Project to operate under the revised version (see Appendix B) for the last two years.

The revised version is unquestionably a more precise and realistic project planning and evaluation tool. It does not, however, overcome the inherent limitations of its methodology as discussed earlier. The following discussion focuses on the modifications made and the rationale behind them. Chapter three of this final report refers only to the revised logical framework in the discussion of PTHE Project outcomes.

Project Goal

Essentially, the originally stated goal was reworded to be more concise about what was meant by increasing "the ability of the rural populations... to participate in development activities." The same was done for the associated objectively verifiable indicators, which also had been defined in very broad terms, to more clearly state what is to be measured in behavioral terms. Thus, attainment of the revised project goal, "to increase the number of health-related development activities identified and undertaken by rural populations" would be measured by the degree to which the "village leadership organizes to implement programs for health improvement according to local priorities" and the degree to which "villagers increase the use of specific public services within the Ministries of Agriculture, Education, and Social Affairs." A review of annual reports would serve as the means for verification. However, in the revised logical framework the type of reports are specified and limited to those which are accessible and contain the information needed.

2.3 Continued

Project Purpose

The originally stated purpose of PTHE "to develop and implement a nationally coordinated practical health education training system which responds to the needs of rural populations in the Mefou and Kadey districts of Cameroon" was not modified. However, the objectively verifiable indicators were revised to more realistically reflect the conditions to be expected, if the purpose has been achieved. The original indicators had included WHO, CUSS, and OCEAC training programs to be coordinated by the MOH. Needless to say, the withdrawal of input from these three organizations before PTHE operations had begun, warranted the elimination of this particular indicator.

The remaining indicators of the Project purpose achievement in the original logical framework had the same problem as those at the goal level of being general and not stated in specific behavioral terms. Thus, the revised end project status to be expected as an indicator of achievement of purpose would be:

1. An Interagency Coordinating Committee meeting regularly to review all aspects of the practical health education training system;
2. PTHE methods (needs assessment, planning, training, design, active participation, team work, trainee follow-up) are being utilized by Key services in the MOH;
3. a national plan is implemented for an expanded practical health education program in the primary schools;and
4. materials developed by the audio-visual centre are being distributed nationwide.

The means of verification listed for the purpose level in the original framework had included what appeared to be indicators of-rather than methods for-verifying, i.e., "system of reporting and planning between participating bodies" and "health and other sectors workers planning village projects to-

2.3 Continued

gether." Additionally, it was not clear as to which indicator was to be verified by which means. The revision explicitly matched each means of verification to its corresponding indicator, and specifically cited the documents and the methods to be used.

Outputs

The only major modification made in the narrative statement of outputs expected from PTHE was the addition of an "audio-visual workshop, constructed, equipped, and operational in Yaounde." Minor changes consisted of attaching such terms as "effective" and "expended" to make a qualitative distinction about expected outputs.

It was, however, in revising the magnitude of outputs as objectively verifiable indicators which had required the most time and energy. The difficulty was not question of the need for modification, because the MOH, UNC, and USAID all agreed that the original numbers were overly ambitious. Rather, the problem was arriving at quantifiable outputs which would be realistic, given the resources and conditions available, so that quality of outputs would not be compromised; yet would be convincing numbers for demonstrating the potential magnitude of benefits to be received from the PTHE strategies and methods. Ultimately, agreement was reached, and the revised figures are explained below:

(1) 40 itinerant agents trained and in the field with means of transportation by June 1982

The original output was 120 field level workers which was not only overly ambitious, but quite nearly impossible. Given the number of government hospitals, developed health centers, and elementary health centers in the Kadey and Mefou Divisions combined (34) and the very limited pool of health personnel in the field from which to choose, the MOH would only be able to assign at the maximum to PTHE one it-

2.3 Continued

inerant agent per elementary health center, one per developed health center, and two per hospital - for a total of forty field level health workers.

Additionally, the UNICEF contribution of 200 motorcycles earmarked for 120 itinerant agents had been drastically reduced to 20. Thus, given the obvious need for transportation in performing outreach activities, the number of field workers had to more realistically respond to the number of motorcycles available.

(ii) 240 committees established of which 80% are rated as "active" by June 1982

The original figure of 788 village health committees was based on 100% coverage of towns, villages, and hamlets in the Mefou and Kadey of 500 and 288 respectively. However, the question of how many committees could one itinerant agent be expected to develop and maintain at an active level over time needed to be considered. Based on collective experience and insight, the decision was to set a maximum of six committees per itinerant agent, and of these one could expect 80% to be active (for which a rating scale had been established). Given 40 itinerant agents to be trained by PTHE, the total number of committees would be 240.

These two indicators of an effective program of village health committees implemented in the Kadey and Mefou would be verified through a review of the MOH Health Education Service Reports, the Project's own three month evaluation reports, monthly reports from itinerant agents themselves, and through regular site visits.

(iii) 160 Health workers and 30 Peace Corps volunteers effectively trained and implementing programs of health education in 16 Health Centers by June 1982

2.3 Continued

The magnitude of this output was not changed, but it was reworded to indicate that the focus of work for health personnel and Peace Corps volunteers would be the development of health education programs for the health facilities themselves which would support the outreach program for itinerant agents.

Peace Corps volunteers were intentionally included in this particular output because their role in PTHE had been redefined as a result of the mid-project evaluation. Initially, volunteers were to work as counterparts to itinerant agents. However, the responsibility of community organization proved to be problematic cross-culturally and is discussed in detail in Section 4.5. The MOH, UNC, and Peace Corps strongly supported the mid-project evaluation recommendation that the volunteer be seen as a member of the health center to assist personnel in organizing health education activities and hygiene projects in the health center or schools, and to serve as a back-up or technical advisor to the itinerant agent when necessary.

(iv) Training materials and designs developed and utilized by PTHE in 4 MOH in-service training programs by June 1982

(v) 25 workers from other services trained, of which at least 8 utilize training to undertake specific health activities by June 1982
Indicators iv and v had not been included in the original logical framework's objectively verifiable indicators of an effective in-service training program for health and other workers in the Mefou and Kadey. The addition of these two indicators would more adequately reflect the scope of work involved and more accurately measure the degree to which this output would be realized than the sole indicator of 160 health workers and 30 Peace Corps volunteers.

2.3 Continued

(vi) 2 Graduating classes of CUSS and CESSI will have completed field training in PTHE sites by June 1982

(vii) One graduating class of assistant nurses will have completed field training in PTHE sites by June 1982

(viii) 20 Professors from health training institutions will have received PTHE in-service training by June 1982

Indicators vi, vii, and viii correspond to the output, "program of practical training for CUSS/CESSI and other health training institutions operational", of the revised logical framework. This particular output combined three outputs from the original version which had anticipated separate training programs for OCEAC mid-level workers, CUSS students, and ENISFAY students and faculty.

The corresponding indicators originally set at 100 OCEAC mid-level nurses, 400 CUSS students, and 10 ENISFAY faculty were based on assumptions made in 1975 which were no longer valid in 1978. OCEAC had converted from training programs of six months to a two year epidemiology program with only 20 students entering per year, 8 of whom would be Cameroonian. CUSS had been expected to collaborate with PTHE to train 45 fourth year students, 20 third year students, and 15 health education students per year. However, a health education diploma program was never established by CUSS and only their fourth year students in the community medicine track were following a program that included field practicums in rural areas. ENISFAY had been expected to alter its program to that of field training for one group of 15 students per month of the academic year, but never did. It had also been anticipated that the ENISFAY faculty would attend five-day seminars offered by PTHE on an annual basis, but internal difficulties between the MOH and ENISFAY prevented faculty from participating.

2.3 Continued

Given these conditions, it was necessary to decrease the level of output and state it in terms of classes rather than in numbers of students. The realities of national attrition, reduced resources from WHO, and other unanticipated but probable changes within the training institutions themselves warranted less rigidly stated outputs.

(ix) Teachers from 8 pilot schools will have received in-service training by June 1982.

(x) Teachers instruction manual developed by June 1982

The original indicator of 511 primary school teachers trained had been based on the total number of teachers in the Mefou (340 teachers and the Kadey (171 teachers). It had been expected that PTHE would conduct in-service training for them on a regular basis throughout the life of the Project. However, by the time the Project actually had begun, the Ministry of National Education (MINEDUC) was in the process of reforming the educational system. Thus, in-service training of teachers at the scale originally proposed by PTHE would have caused confusion for the MINEDUC which had not yet determined direction or priorities for the reform. A more confined and intensive pilot effort yielding well documented information would be much more useful to the MINEDUC for establishing policy.

The additional output of a teachers manual was a need expressed by primary school teachers in the field and key MINEDUC officials in Yaounde.

(xi) Workshop constructed by December 1980

(xii) Audio-visual personnel hired by December 1980, including 1 Peace Corps volunteer, 1 Cameroonian audio-visual specialist, and 1 Cameroonian Artist

2.3 Continued

(xiii) Management System within the Health Education Service in place, including procedures for processing requests and reordering supplies.

(xiv) 20 Health education posters/brochures printed and distributed by June 1982

Indicators xi - xiv correspond to the output of an audio-visual workshop to be constructed, equipped, and operational in Yaounde. Since this output had been omitted from the original logical framework, these indicators has been added to the revised version.

Inputs:

As discussed earlier, there had been serious reductions in the level of input from donor agencies. The logical framework was revised to accurately reflect what could be expected in terms of personnel, equipment, facilities, and other commodities from the MOH, USAID, Peace Corps, UNICEF, and OCEAC. CUSS and WHO were eliminated entirely. The inputs from each agency were stated in greater detail to reduce ambiguity and the possibility of conflicting expectations.

2.4 Original Strategies and Methods

a. 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. Consideration was given to the difficulty health workers and other professionals often experience in attempting to relate non-technically trained persons and the frequent failure of professionals to remember the years of socialization responsible for their reliance on scientific theories to explain disease. 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 IA with knowledge of patterns of community cooperation and collective action within the community. Techniques required for obtaining social data useful in planning cooperative activities at the village level were different from those used when the unit of practice was the individual or the family. It was important to carry out this phase well as the types of objectives defined in the Project Paper included a broad range of activities with most of these dependent on the ability of health workers to increase the level of technical knowledge possessed by villagers and to encourage collective action.

2.4 Continued

It was known too, that technically trained people often give instructions and expect new information in and of itself to result in desired change. However, when desired project outcomes required continuing actions and behavior change to achieve impact, 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 assessment as well as community diagnoses 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. A key element in modern development theory is the notion that commitment to the task must be sufficiently strong to see the effort through to successful completion.

It was also well known that villages in the Mefou and Kadey differed greatly in size, ethnic composition, prior experience on collective projects, technical awareness, access to service, local pride, and in other ways. Given these differences, it was assumed that starting points and tasks selected by various villagers would be varied. Conceptually, the mandate for action was sufficiently broad to accommodate anticipated differences in needs assessment outcomes that this process would generate.

2.4 Continued

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.

It was envisioned that needs assessments would serve the dual purpose of expanding options for the community while being cognizant of the value of encouraging a process that enables village people to select tasks of their own choosing through an orderly approach for assessing needs from the perspective of their cultural value system and history.

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.

2.4 Continued

b. Health Center Staff Development

The term "Staff Development" rather than "Staff Training" is preferred because it implicitly recognizes that the efficiency and effectiveness of personnel is dependent not only on training in the more formal sense but in a variety of complementary experiences that contribute to the expertise and increasing sophistication of staff. Thus, the nature of staff supervision and support, the experience of participation in proper planning and implementation, the accessibility of technical assistance as needed, participation in conferences, etc., make valuable contributions to staff quality and, very importantly, to staff morale.

The role of health center staff in community development is a complex one, requiring a capacity to face and to manage apparent set-backs, to be patient in laying the necessary groundwork with local communities before expecting to see specific health or health-related outcomes, to be able to elicit and to respond to needs felt by communities themselves that may often conflict with health service objectives and indeed to facilitate the development of village leadership rather than assume the leadership oneself.

With a health service dominated at the ministerial level by physicians (clinical specialists - - - rather than public health specialists), health centers in Cameroon were likely to have orientation toward delivery of services that in important respects conflict 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.

2.4 Continued

It s success would depend on consistent, continuous team work on the ground, with support and incentives provided from the top.

(i) 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 of sanitation (through latrine construction) and of potable water (through the protection of water sources).

To leave it at that would clearly be a misleading oversimplification. Not only might it be extraordinarily difficult to graft an external model (the health committee), onto existing indeginous village organizations and self-help modes, but the sanitation and water issues might, more often than not, simply not be priorities, even health priorities, in the eyes of the villagers themselves.

If the purpose is to facilitate community self-help action (in contrast to dependent expectations of health services providing the solutions and resources), then this might be achieved through a variety of alternatives demanding careful preliminary diagnostic work. Thus, there may be existing organizations concerned with community development established by another ministry (such as agriculture) or private agency (such as Save The Children) onto whose present activities, more specifically health-related problems, could be grafted. Even if health committees as such in numerous villages seemed more appropriate, there would remain the important task of securing the interest and involvement of local leadership that would first need to be identified, and secondly, would need the credibility and influence

2.4 Continued

among the villagers themselves to not be seen as a puppet group set up by health service personnel.

If the purpose is to reduce intestinal diseases through better sanitation and water as priority needs to be addressed from the health service viewpoint, it might frequently be necessary to secure the trust and goodwill of the villagers as well as to provide them with preliminary experience in successful problem-solving in addressing health-related issues nearer to the priorities felt by the villagers themselves. These might, for example, include such felt needs as first aid expertise in dealing with injuries as infant survival and health, or agricultural-related needs in which itinerant agents would collaborate with agricultural workers.

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.

2.4 Continued

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 health center role in PTHE might be seen as having the following main contributions:

- enhancement of the community organization component
- substantive enhancement of clinical and MCH goals through health education in the health center itself
- provision of affective and instrumental support, and maintenance of the morale and commitment of itinerant agents.

In regard to the first contribution, substantive enhancement of the community organization component should involve 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

2.4 Continued

residence.

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

Concerning substantive enhancement of clinical and MCH goals, health center staff should involve the more deliberate and systematic inclusion of behavioral, social, and cultural factors elicited in patient histories. This information would provide the basis on which health education and care may be proved.

The third contribution of health center staff in providing affective and instrumental support to itinerant agents would include 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.

(iii) Training Model

As mentioned earlier, this is less a training model than it is a staff development model. Development and training strategies, determined to a considerable extent by the nature of community organization work as described above, should be characterized by:

2.4 Continued

- (1) Participatory problem-solving rather than didactic methods.
- (2) On-site and off-site workshops and a balance of intellectual learning in discussion settings with experimental work in the field.
- (3) Substantial inclusion of team and inter-personnel complementary groups and roles.
- (4) Learning experience and workshop groups to include where possible, more than 1 representative of each health center.
- (5) Supervisor learning to enhance supervision skills.
- (6) Learning experience involving front-line workers from all collaborating ministries and agencies.
- (7) Technical assistance through on-site follow-up of participants in workshops.
- (8) Monitoring of overall health center activities and personnel roles to ensure the pervasiveness of personnel development aspects throughout.

2.4 Continued

c. Supervision and Support System

As indicated earlier, the introduction and maintenance of a community organization component into primary health care services demands, for its success, a well developed supervision and support system and this is relevant at the local level of front-line workers among themselves as well as vertically through the system. Divisional, provincial, and ministerial level personnel need to take general responsibility for monitoring progress, providing incentives, ensuring technical assistance availability, and appropriate material resources on tap as needs arise.

Clearly too, the program cannot work unless these high management level personnel take the initiative in forcing the pace and do not simply assume that all is progressing well, unless specific problems are presented to them for solution or assistance. To do this adequately, they must clearly be committed to the program, backed by a sound knowledge of the principles involved, and of the practical issues and obstacles in implementation and have realistic expectations of the advancement of intermediate and ultimate goals.

It is 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 involves, among other things, a close attention to the roles of counterparts to the project technicians and to assuring that key personnel at all levels are acquiring continuously improved knowledge and experience in the nature, principle, application, and effects of community organization.

To whatever extent the UNC field staff has to initiate reporting to higher management levels, raising issues and problems, and bearing the burden of maintaining momentum, prospects for short-term, intermediate, and certainly long-term success are reduced.

2.4 Continued

(i) 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. If the link is weak, then the chain of initiative is broken.

Therefore, the closest and most careful supervision, support and monitoring need 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. Supervision of health centers (as opposed to hospitals) is the responsibility of the Chief of Preventive Medicine.

(ii) 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. Provincial level personnel were not officially named to PTHE positions, given that PTHE operated in only one division of their provinces, and principally through one service of Preventive Medicine which was the Health Education Service (HES).

Nevertheless, 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. Annual reports from these provincial health officials are used by MOH to determine postings of national nursing school graduates, transfers of personnel, and establishment or upgrading of public health facilities. Provincial delegates have primary responsibility

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2.4 Continued

its chief and staff have the closest possible association and learning experience with PTHE 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 (e.g. Agriculture's Community Development Division) be available to him and his own MOH staff.
- insist on being present, indeed making presentations whenever possible, at training workshops, conferences, and other appropriate meetings at the very least, to indicate clearly the seriousness of the MOH in sponsoring the program.
- 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.
- ensure that the pilot divisions of the Project in the Mefou and Kadey, through their respective headquarter personnel, are adequately performing their supervision and support roles.
- ensure that every possible resource - Cameroonian, USAID, or other international agency - be tapped to secure in-and-out-of-country training and experience (both short-term and long-term, including degree programs) for MOH personnel at all levels.

(iv) Training Model

Clearly the ideal situation is when the higher management levels of

2.4 Continued

personnel who are frequently the least knowledgeable about the nature of PTHE operations, admit their need to learn and become full participants in as much personnel development and training activities as possible. Under usual circumstances, the "training" model here becomes more obviously a "personnel" development model and needs to include therefore:

- 1) The use of every opportunity by the PTHE team to brief and explain the PTHE operations at regular planning review meetings with divisional, provincial, and ministerial level personnel.
- 2) The inclusion, in as active and visible a role as possible, of these personnel in workshops and conferences and in planning and evaluating such activities.
- 3) The provision of literature, consisting of published reports of similar developments in other countries, particularly of Africa, that would, over the period of PTHE, indicate unequivocally to such personnel the generally recognized and appropriateness and feasibility of the strategy.
- 4) Encouragement of the writing and publication of articles concerning the Cameroon program; in each case, no matter what the role of the UNC staff in preparation of such publications, the Cameroonian participants are the senior authors.
- 5) Invitation of such personnel, at every opportunity, to visit and "inspect" more successful examples of community organization at local health center level.
- 6) Pressure constantly for the fullest possible use of available training money (e.g. USAID) to provide short-and-long-term training, for appropriate MOH personnel.

2.4 Continued

In this respect, since almost all medical personnel at the key ministerial level are clinical specialists, (obstetricians, gynecologists, or urologists), opportunity must be taken, including contacts with the Inspector General and the Ministry to press the need for public health specialists to be trained and for attractive career prospects to be open to them.

2.4 Continued

d. Integrated Health and Community Development

The purpose of this strategy was to integrate and reinforce the efforts of the various front-line workers responsible for the development at the village level. All too often individuals and agencies involved in nation building tend to see their roles in isolation from the reality of dynamic interdependence and interaction essential to development. A focus on health was viewed as an element essential to the ongoing mission of those Ministries concerned with development. Indeed, many interventions favored by PTHE planners would require close collaboration with other Ministries. Some of the activities encouraged by PTHE would be primarily dependent on the skill and resources of other Ministries. For example, the MINAGRI effort in promotion of home gardening would be critical to nutrition improvement; the collaboration of the MINEDUC would be essential to the development and implementation of elementary school health programs.

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. (There was cooperation from these Ministries; however, the full potential of such cooperative ventures were not realized due in part to the MOH tendency toward choosing its own personnel when choices had to be made in regard to numbers of participants.) 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

2.4 Continued
development activity.

The notion of taking on additional tasks for which there is no economic incentive or other strongly tangible reward, and one in which a ministry other than one's own, might receive credit, would seem low priority for agencies already short on human and fiscal resources. Because of these considerations, in addition to the technical expertise participants would bring to the Committee, the Coordinating Committee was viewed as one that should participate in development of PTHE policy as well as at the technical level. The agencies projected for membership were:

<u>Ministry of Health</u>	<u>other GURC</u>
-Directorate of Preventive Medicine	MINAGRI
Health Education Service	Rural Engineering Service
Sanitation and Public Hygiene Service	Community Development Service
Nutrition Service	MINEDUC
Epidemiology Service	CUSS
Mental Health Service	Directorate of Primary Education
	School Health Service
	Extra-Curricular Activity Service
-Directorate of Health Services	Ministry of Social Affairs
Sub-Directorate of Hospital and	Social Development Service
Rural Medicine	Rural Animation Program
Nursing Care Service	Ministry of Youth and Sports
Maternal and Child Health Service	Ministry of Armed Forces
Training and Continuing Education	Ministry of Information and Culture
Service	Ministry of Planning and Economic Affairs
-Directorate of Studies, Planning and	Ministry of Animal Husbandry
Statistics	Ministry of Territorial Administration
-Directorate of General Administration	
-Technical Counselors to Minister	

2.4 Continued

International / U.S. Government

USAID

U.S. Peace Corps

OCEAC

WHO

ZAPI - EST

UNICEF

Dutch Volunteer Service

Representatives of all these service and agencies were present at one or more of the Coordinating Committee meetings, and some sent more than one delegate. Approximately forty members were foreign, the Director, at the first meeting of the Coordinating Committee, however, emphasized that the Committee could be expanded without obligation, and that it should be as large as possible. To a large extent, this numerous membership was its undoing as a technical advisory council (see Section 4.1b).

Chapter 3

Outcomes

3.1 Village Community Organization and Development Component

a. Inputs

(i) Village Committees

Organization of village health committees or village health level councils was the principal community organization strategy of PTHE. During the life of the Project, itinerant agents and Peace Corps Volunteers assigned to eighteen health facilities (9 Mefou, 9 Kadey) worked with a total of over 245 villages at various times; approximately 150 of these villages maintained functional health committees. The 245 villages represents 130 in the Mefou (20,500 inhabitants) and 115 in the Kadey (32,800 inhabitants). This includes a small number of semi-urban communities. In territorial terms, PTHE field action extended to all eight subdivisions of the Mefou (32 out of 41 groupments) and to all four subdivisions of the Kadey (10 out of 10 cantons), despite a critical shortage of itinerant agents. The number of itinerant agents in the field at any given time never surpassed twenty-one.

Itinerant agents (IA) benefited from PTHE in-service training sessions on a regular basis, and were supplied with Suzuki motorcycles (20 from UNICEF, 5 purchased by MOH in 1981). Initially, PCV's worked side by side with IA's in the village committee programme. With the arrival of the third and final group of PCV's in mid-1980, a redefinition of the PCV role broadened volunteer participation in health center activities and other community outreach, while the IA's assumed fuller responsibility for village health committee organization and development.

It should be said straight away that a large gap between community organization doctrine and practice manifested in PTHE field operations was never completely closed. In many ways it could never have been otherwise. PTHE was never given the opportunity to provide basic training to IA's. Brief in-service training sessions, and fairly regular consultations were the only means by which the chosen PTHE Community Organization strategy and techniques could be explained, examined and accepted

3.1 Continued

by IA's. Despite this handicap, the needs assessment and community diagnosis techniques were practiced, although to varying degrees, in the PTHE zones.

As might be expected with the introduction of a new approach and new methods of community work, resistance was encountered at several points. A deliberate, thorough-going attempt at cultivating awareness of public health problems, and organizing positive local action ran contrary to administrative pressure at different levels to establish as many village health committees as possible. This pressure was understandable, although counter-productive. The 788 village health committee target, originally designated in the logical framework, and pressure to achieve targeted outputs were often seen as the primary reason for supervision. In both the Kadey and Mefou, however, attempts at cutting short and/or forcing the pace of the collaborative education/organization process ultimately failed.

The Kadey holds some startling contrasts in this regard. In late 1979 - early 1980, a new sector was opened up outside Batouri by the PCV and newly-named IA (his predecessor, a Batouri native working in the area around Batouri south and west, was transferred to a secretarial post in Bertoua). Neither PCV or IA had a very thorough grasp of community organization methods and techniques, which led to a "rough and ready" attack in the sector in classic agriculture extension "take it or leave it" fashion. Each village on the road outside Batouri leading to Bertoua was approached on the idea of creating a health committee. Eight villages, many of which were smaller than 80 inhabitants, on a stretch of twelve kilometers of road, were given the "option" to create a health committee. If they so decided, the PCV-IA team would continue to come back and aid the village in future projects. Eight committees sprang up in the months of field work, bringing to thirteen the number of committees in the IA's work program. The initial burst of village enthusiasm, too well known to community/missionary workers in the sector, dissipated despite a Committee Day (described in detail later) in the sector in

3.1 Continued

June 1980. The PCV lost interest in community organization activities soon thereafter, preferring to work on other aspects of PTHE. The itinerant agent, left to his own, reduced his contact to monthly ones at best in the eight villages. During the 1982 MOH Overall Evaluation of PTHE, two of these villages were included in the sample for interview; an opportunity to study villages' attitudes. In both villages, response during interviews gave evidence of complete confusion regarding health committees. The village health committee to their mind, was composed of... the itinerant agent and the PCV. Complaints that the "committee" had not returned to meet with them regularly accompanied these views.

By contrast, other community organization activities in the Kadey around Ndélélé and Bandongoué followed the proposed methodology more closely. After two years of secondary contact with a number of villages (while struggling to maintain five health committees, four of which lacked enthusiasm), the Ndélélé team of 2 IA's and a PCV began to respond to invitations from other villages. A regular program of health education meetings was set up, and a fruitful collaboration with MINAGRI's Community Development and the Organization of Dutch Volunteers (ODV) was later established as these other services targeted the same villages for housing improvement and community farm projects. Success in the neighboring villages has revitalized one of the four old committees.

Bandongoué's participation in PTHE was short. The health center was integrated into the Project in September 1980. After a fairly thorough study of the sector, community outreach work began in earnest including collaboration with an ODV mobile maternal and child health clinic. Ten communities, including a coffee plantation work-camp, made up the program for the sector. Of these, four villages have opted for committee structures, the others work regularly with

3.1 Continued

the health center staff, and their women have organized their own groups. The form of committee might not exist, but the community organization process has slowly begun, and action is being taken by villages.

Bandongoué sector borders on the Batouri sector, opened up in late 1979. By mid-1982 differences in relative progress in community organization could not be clearer. Both Ndélélé and Bandongoué were more open to technical consultation than Batouri, and participated in the CD/PTHE (see Section 3.2) provincial seminar in Moundi early October 1981.

Certainly personalities and intangibles influence success in Community Organization work, and problems are not lacking in either Ndélélé or Bandongoué. However, the promise of effective action where sound methods are used is obvious in those two sectors, just as the dismal results of precipitation and lack of method are obvious in Batouri sector, among other places.

In the Mefou, of ten IA's named to the nine sectors, eight had been involved in the USAID funded PITT/OCEAC Project of 1972-1976 and/or the interim USAID/OCEAC Project. Where all but three of the eleven Kadey IA's have had nurses aide training, only two in the Mefou can say the same. Generally older, and generally set in the pattern designated during the later days of PITT/OCEAC, Mefou IA's were much less open to innovations in methods. As a matter of fact, their work circuits were little modified from the previous Project. (The peak of 1979 health committees in the division, before motorcycle accidents virtually closed two of the sectors, was reached in the PTHE first quarter of 1981. It was claimed in the PTHE Project Paper that 43 health committees remained from the previous Project in the Mefou.) In all cases, Mefou IA's were also re-

3.1 Continued

sponsible for leprosy control in their sectors, requiring a work style which contrasted sharply with that of a health education community organizer.

In many ways field staff or home base staff (UNC-CH) did not have full access to IA's in the field. This limited possibilities for introducing new methods and tactics. In-service training sessions and the annual seminars raised questions and offered possible answers to problems whose solutions lay in re-thinking community organization techniques presently in use - and this through role plays, case studies, and problem solving activities. The final group of PCV's in whose training UNC-CH had much more input, had a positive influence on field activities. The introduction of the quarterly evaluation forms in 1980 also helped to bring IA's and their supervisors to think in other terms - not just pit latrine counts, but in progressive levels of activity.

MOH difficulty in locating resources to assure the presence of IA's as a permanent cadre in health center staffs frustrated PTHE efforts to develop village outreach workers who were secure about their role. Despite this, some real progress was made, not just in physical outcomes, but also in the communities' levels of participation and interest in broader community issues.

Frequently support problems often got in the way of progress toward solving field methods and problems. IA's struggled with irregular fuel and maintenance service for their motorcycles which were the responsibility of the MOH. Such questions took up valuable time during quarterly evaluation days. The Health Education Service, responsible for community organization activities, was split along lines drawn by its Chief and Assistant Chief, with one being an advocate of aggressive

3.1 Continued

approaches to community organization and the other (who actually served as Project Counterpart) being unconvinced of community organization as a health education strategy; he was instead fixed on information dissemination models. Few others in MOH, with two notable exceptions, appeared to have more than vague ideas as to what community organization is, and how it relates to primary health care programs. These exceptions -- the Director of Health Services (who as sub-Director of Preventive Medicine had helped design PTHE) and an Ibadan-graduate health educator assigned to HES in 1981 -- were kept from fully participating in Project activities.

Nevertheless, PTHE experience had somewhat changed this situation, and is now seen as a precursor of the MOH National Program of Primary Health Care, which will be operational in the 1982/1983 fiscal year. It is interesting to note that the driving force behind primary health care in Cameroon is this same Director of Health Services (presently Technical Advisor to the Minister of Health). Appreciation of PTHE training and community organization methods often appeared greater outside the MOH, in MINAGRI, the Ministry of Social Affairs, and among territorial administrative authorities of the pilot areas.

Through participation in PTHE activities, the Divisional Officers of the Kadey and Mefou both became strong supporters of the Project. This was less true of sub-divisional officers who also participated less, although the majority could speak knowledgeably of PTHE activities in their sub-divisions, and some could (publicly) present health education, village-participation-in-promotion-of-health-speeches. On the MOH evaluation questionnaire, in answer to "Has the Project contributed to the development of your administrative unit?", the Kadey Divisional Officer and his 2nd assistant circled, "enormously". In the

3.1 Continued

Mefou, "very much" was circled. In all cases, they saw a promising future for PTHE type activities.

(ii) Committee Days

Committee Days - "Journées de Comités" - became a regular community organization activity of PTHE during the second year of the Project, (1979-1980). Conceived by the Soa (Mefou) IA, the idea fell clearly in line with plans for village level training activities. As organized during this period, Committee Days served several purposes which can be judged from a typical program that included speeches from political and administrative authorities; an environmental outing (a village walk-around to study improvements in environmental hygiene); and a practical demonstration of a village-level project (improvement of a spring with cement and plastic pipe, and roofing tin, or fabrication of latrine slabs). Committee Days were organized locally with deliberately limited central-level participation. In each IA's sector, a very active or promising village health committee would propose to host a day of health education activities, inviting representatives of neighboring villages and health committees. The local health center took responsibility for integrating appropriate political and administrative authorities, as well as representatives of other technical services, into the day's activities. PTHE supplied transportation for some participants and construction materials for the demonstration projects.

During the first round of Committee Days, from January to August 1980, twelve were organized with varying technical success. However, in terms of activating or re-vitalizing local Community Organization effort, the results were impressive. The presence of local authorities, divisional and sub-divisional officers, divisional medical officers and representatives of the MOH, greatly reinforced the foundation of PTHE activities. These same officials often participated in the demonstrations - mixing concrete, transporting gravel, framing slabs - which fur-

3.1 Continued

ther reinforced the impression of active government and party support of the PTHE effort. Over eighty (80) villages participated in these Committee Days.

For the Evindissi Committee Day in the Mefou, its organizers received a congratulatory letter from the Minister of Public Health. Spin-off projects, especially spring improvement, were common in neighboring villages in the months immediately following Committee Days, and demands on the Sanitation Service increased dramatically. CUSS/CESSI students in field training were able to participate in two Committee Days (Oman II, April 1980, Andock, January 1982).

The first round of Committee Days, with their political/technical mix, leaning somewhat more to the political, were to be followed by a round of less festive, more didactic Committee Days. Emphasis was to be less on political mobilization and more on health education and the transfer of appropriate technical skills. Such activities were ready at a formative stage; monthly VHC representative meetings were organized at Essi hospital in order to discuss problems, achievements, and public health questions; Ngoumou hospital organized village seminars on an annual basis - with limited PTHE input - bringing together several local services (Cocoa Development Service, Social Affairs Community Development) in a village for programs and practical demonstrations of nutrition, home economics, and environmental hygiene; one-day village seminars were now and again organized during the CESSI/CUSS field training. These models demonstrated the viability of such activities. Collaboration between Community Development Service and PTHE in Ndélélé sector, (1981-1982) also led to similar village level seminars with greater emphasis on food production and community gardens/farms. This is to show that local initiative was far from lacking.

3.1 Continued

However, the PTHE plans to launch a second round of Committee Days, as a follow-up to the first round and moving toward, fully locally-organized activities, were finally abandoned. The period for this new round had been projected for the first half of 1981 - a turbulent period administratively which saw the departure of the Project Director from the Ministry (March 1981); his replacement was not officially named Project Director until six weeks later. Thus, little action could be taken and the PTHE training funds, controlled by the MOH, were not available for planned activities. Without the MOH central level support and encouragement which were vital to these Committee Days, local initiative remained essentially isolated.

(iii) Evaluation Days

Quarterly evaluation days, organized at divisional level, were also a regular activity of the community organization and development component of PTHE. These quarterly meetings 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. Divisional Officers or their representatives often participated in these meetings, as did Sanitation and Public Hygiene Service field workers and staff. Health center teams worked in groups to develop quarterly plans for their respective sectors, with prospects for collaboration between health centers debated. Administrative problems were also discussed - and often resolved - at these meetings, which were chaired by respective divisional health officials. PTHE quarterly evaluation forms were collected at these meetings and previous results discussed. As this activity became routine, the responsibilities for organization and preparation shifted more and more to the divisional health officials with PTHE team personnel offering consultation when needed. Evaluation days also received official encouragement from the Minister of Public Health (in early 1981) as an initiative which would serve as a model throughout Cameroon for divisional level supervision. As

3.1 Continued

PTHE has drawn to its close, "Evaluation Days" can become to an increasingly greater extent, "concentration and planning days".

(iv) Cleanest Village Contest

This PTHE activity needs to be placed in the context of GURC initiatives in other sectors in which contests for coffee and cocoa farms, live-stock raising, family gardens, and school gardens have been institutionalized in Cameroon. Thus, the idea for a contest for PTHE zones - the cleanest villages - with distribution of prizes as divisional-level ceremonies was an attractive idea, especially to the PTHE counterpart for community organization, who was the driving force behind the early contest organizational effort. The theoretical underpinnings of such a contest were, to say the least, weak. The change in behaviors sought by the PTHE was not likely to be advanced in any long term fashion by a single contest (as opposed to yearly contests through MINAGRI which aim at crop improvement and higher production). Be that as it may, the Cleanest Village Contest was launched in February of 1980 despite the fact that its conception and ministerial support remained tentative. By June 1980 conditions for eligibility, the judging process, and a proposal for prizes were fully defined and circulated with the Director of Preventive Medicine's signature. A scoring system was developed to judge both villages and individual compounds (see Appendix D). IA's beat the drums as did divisional level personnel (especially at the Committee Days) and by September 1980, seven sectors of the Mefou and three of the Kadey were candidates, each one presenting five villages. (competition took place at four levels: between the two divisions for the best average village score; between sectors within the division for the best average village score; within sectors for the best village score; and within villages for the best family compound score.) In November and December 1980, a jury passed in the candidate villages - fifty villages, with 1,620 compounds. This jury was composed of the PTHE Community Organization Technician, a CUSS-trained sanitation technician, and the Assistant Chief of Prev-

3.1 Continued

entive Medicine for the respective divisions. For Batouri sector, the jury was accompanied by the assistant to the sub-divisional administrative officer. Immediate results were not lacking: of 68 springs inspected, 45 had been improved or protected during the contest period; a large number of latrines, refuse pits, and animal pens were also built or improved during this period.

By late December the results had been calculated and were submitted to The Director of Preventive Medicine. What remained was to purchase prizes (family pharmacies, construction tools and materials, and household items for sanitation purposes for the most part), and to organize ceremonies for proclamation of results and distribution of prizes. However, support from the Division of Preventive Medicine flagged at this point. The counterpart for community organization no longer actively pushed for culmination of the contest. Dates were tentatively set and re-set. The Minister of Health's participation was solicited. Then, in March of 1981, the Director of Preventive Medicine was replaced. His successor had little knowledge of, or sympathy for, the Contest and initially buried the dossier. Under mounting pressure from various levels, dates were finally set for awards ceremonies, and prizes were purchased for distribution at the ceremonies by UNC-CH, with the promise of reimbursement by MOH. The Kadey ceremony in August 1981 was presided by the Secretary General of Eastern Province and was highlighted on national radio, a broadcast direct from Batouri. The Mefou ceremony held in September of 1981 at Mfou had the Director of USAID Mission in Yaounde in attendance.

While all prizes for the Kadey were purchased and distributed, those for the Mefou, far from numerous, were not. The bulkier prizes (principally at the village level) remained to be bought and delivered. Certificates signed by the Secretary General of MOH were distributed to all winners with the promise of speedy subsequent delivery of prizes. This, however, was not the case. Due to a misunderstanding on the part of

3.1 Continued

the Director of Preventive Medicine, purchase of the remaining prizes was blocked. As the months passed, the disappointment of the winning committees slowly turned into suspicions that their prizes had been stolen by IA's. Angry villagers were asked to write directly to the Minister of Health to voice their complaint, and in March a delegation of Mefou IA's presented the contest problems, among others, to the Minister and Secretary General. Prizes were finally purchased in May 1982, 7 months after the ceremonies, and distributed in early June. This, needless delay seriously affected IA - Committee relationships in these sectors, and certainly poisoned the air in Project circles. The Director of Preventive Medicine was publicly criticized by the Minister in an MOH "reunion de concertation" in June 1982 for his interference in the smooth running of the Contest. After initial enthusiasm for the concept, including willingness on the part of both divisional administrative officers to study possibilities for future divisional-level contests, the Cleanest Village Contest lost most, if not all, of its advocates for future versions.

(v) Other

The MOH supplied five (5) Suzuki 100cc motorcycles to IAs in June of 1981 and financed fuel and maintenance for IA's and PCV's through a monthly indemnity from October 1980 on. UNICEF provided 20 Suzuki 120cc motorcycles in 1977, and spare parts for those same bikes in 1979. By the end of the Project, 5 were beyond repair, 1 was lost, and 3 awaited repairs.

3.1 continued

b. Outputs

(1) Presentation of Methodologies and Measures

A number of different instruments were employed to assess the performance of PTHE at village level in the village health committee program. First, a Quarterly Evaluation Report form (see Appendix) was developed by UNC/CH as a method of longitudinally measuring changes in the two principal area of PTHE activity, namely 1) Health center activities (discussed in Training Component, Outputs section 3.2b(i) and 2) community action. Eighteen health centers (9 in the Kadey, 9 in the Mefou) and approximately 160 villages were evaluated through a point system established by the PTHE technicians (UNC/MOH) based on the Quarterly Evaluation Report forms. Points were accumulated by villages and health centers through increasing level of activity or expanding services. NB, The Quarterly Evaluation Report form was not institutionalized until the third-quarter 1980--the beginning of the third year of the Project.

The community action section of the Quarterly Evaluation Report form was designed to reflect the extent to which village populations (those with committees and those without) responded to community outreach activities. Specifically, community action category areas included presence/absence of: regular contacts with village elders, analysis of village organization and power structure, assessment of felt needs, creation of village health committees, regularity of committee meetings, and health-related projects undertaken and/a completed. The target number of points per village committee was 45. In other words, if a committee demonstrated full achievement in all of the above categories over the three-month quarter, a point score of 45 would be attained.

The second instrument employed to assess PTHE impact at village level was a questionnaire administered to villages, in order to determine villagers' perceptions of their village health committee. A semi-structured

3.1 continued

interview instrument was developed by an evaluation team composed of MOH, CUSS and UNC members in late 1981, and pre-tested by UNC field in early 1982 (see Appendix F). The interview focussed specifically on 19 variables addressing respondent knowledge and perceptions of:

- (1) the village health committee and its activities (village clean-up days, improvements of water sources, health education, latrine construction, family pharmacies, or other to be specified).
- (2) family use of health centers, presence or absence of patient/group health education and the range of subjects discussed (personal hygiene, diseases, and their prevention, nutrition, environmental sanitation, maternal and child health, others to be specified).
- (3) the extent to which the itinerant agent and/or village health committee actually improved living conditions in the village.
- (4) the degree of participation of the respondent in health committee activities (attendance at meetings, participation in work days, contribution of financial/material resources, and hygiene inspections).

Forty villages, twenty in each PTHE pilot division, were included in the survey. All forty had officially organized health committees, and care was taken to balance the sample with both active and inactive committees. School masters were seen as the best choice of civil servants to administer the interviews; the Divisional School Inspectors were asked to name interviewer candidates, two for each of the ten sectors, based on the following criteria: (a) native speaker of dialect of villages to be surveyed, (b) familiarity with villages to be surveyed, (c) posting in close proximity of villages to be surveyed. (For the composition of the sample selected see Appendix G).

3.1 continued

PTHE technicians then carried out orientation sessions for each team (Kadey and Mefou) of ten school masters/interviewers to explain the questionnaire and develop basic interview skills. In each of the sample villages, five persons were to be interviewed, namely: the village chief, two village health committee members, and two non-members. At least one of these five was to be female. Thus each of the twenty school masters was to interview ten people, in two villages, for a total study population of 200 individuals. In order to facilitate the data analysis procedure, the interviewers were given two copies of the questionnaire per respondent-- one copy to be completed during the interview in the field and one upon which responses would be more neatly copied for eventual submission to the MOH evaluation team (MOH/CUSS/UNC).

A third evaluation methodology was employed by PTHE to assess the personal characteristics of itinerant agents in relation to his/her achievements in the implementation of the community organization component of the Project. As part of the methodology for both predicting the outcome of IA efforts (in terms of Quarterly Evaluation Report community action scores), and Itinerant Agent questionnaire (see Appendix H) was conceived. Developed by UNC/CH and revised by the UNC field office, the questionnaire was completed by eighteen IA's in the Kadey and Mefou divisions in February 1982 at quarterly evaluation days. The questionnaire was based on seven main areas of interest, namely 1) demographic characteristics (age, sex, marital status, number of children, previous work experience, etc.), 2) frequency of help-giving, both professionally and privately (family, legal, religious health advice, etc.), 3) inability to give help due to lack of training, lack of time, etc. 4) referral behavior for the same areas under help-giving, 5) helpseeking behavior for these same areas, 6) social status (as reflected in membership in organizations, offices held, etc., and 7) work load and success rate in Project activities (number of communities served, health committees created and functioning, etc.).

3.1 continued

A total of 61 individual variables were examined and analyzed in conjunction with each IA's Quarterly Evaluation Report. Community action scores for the period third quarter 1980 to first quarter 1982.

3.1 Continued

b. Outputs

(ii Findings

Relative to the logical framework target outputs for the village health committee program, the following results were achieved:

<u>Logical Framework Target</u>	<u>Actual Output</u>
40 itinerant agents trained and fielded with transportation	21 itinerant agents trained and fielded with transportation ¹
240 village health committees created of which 80% are active	136 village health committees ² created of which 60% are active (160 villages actively working with IA's)

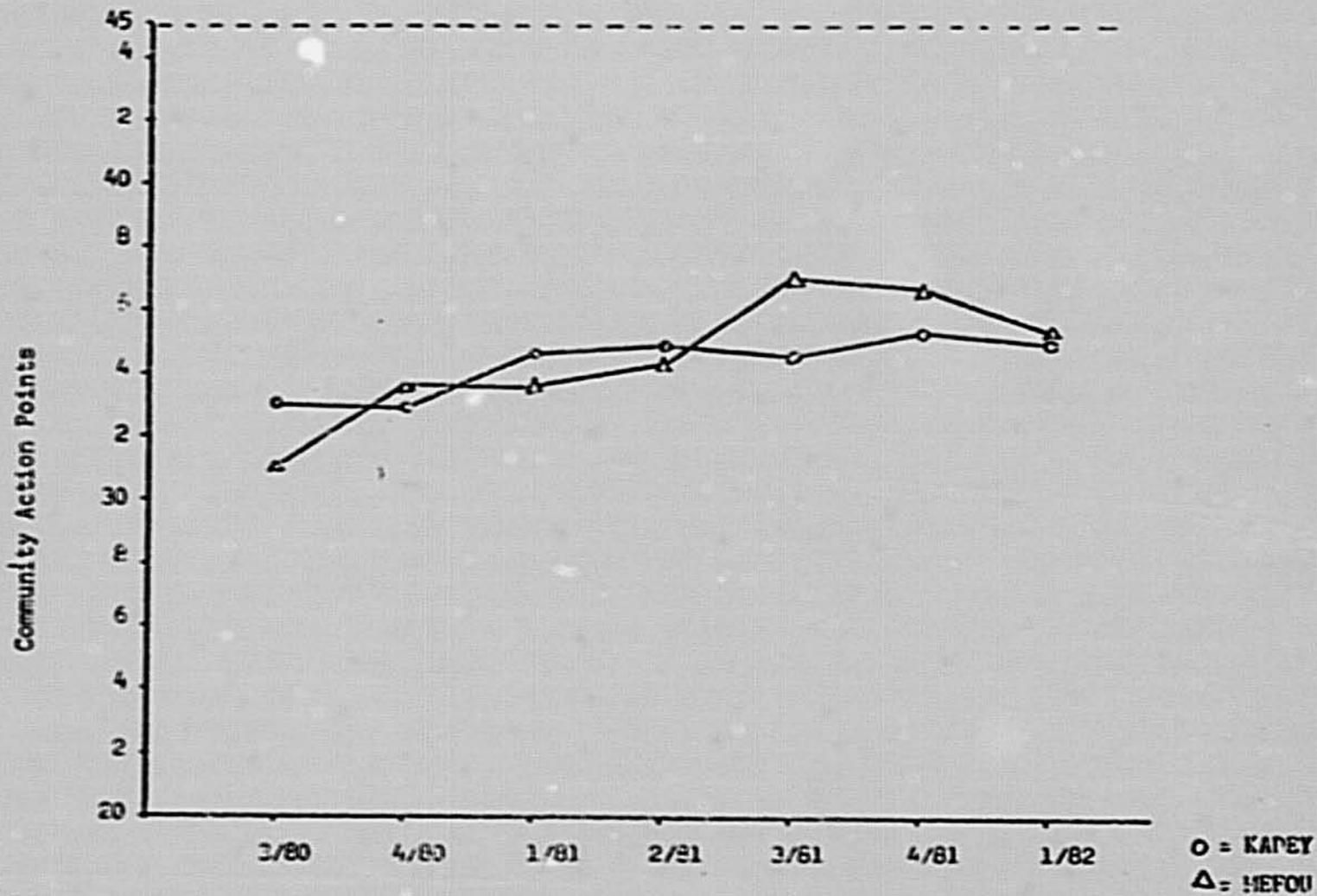
Mean quarterly scores for village health committees, from the Quarterly Evaluation community action report, are shown in Figure 1 for each division for the period 3rd quarter 1980 to 1st quarter 1982 (July 1980 to March 1982). The target score for a committee was set at 45 - a score which indicates that the committee was actively demonstrating integration of health promotive skills and knowledge in their activities. It is clear from Figure 1 that both the Kadey and Mefou improved in mean quarterly scores for the eighteen month period under consideration. Overall both divisions improved mean scores with the Mefou demonstrating a net change of nearly five points and the Kadey a net change of slightly more than two points, in comparison of mean scores from the 3rd quarter of 1980 and the first quarter of 1982 (the beginning and closing quarters of the eighteen month period). The point range for the Mefou reveals a lower limit mean of 31 points and an upper limit mean of 37.1 points, whereas the Kadey demonstrates less variation, with a lower limit mean of 33 points and an upper limit mean of 35.5 points.

¹This total does not include four IA's who left PTHE zones, for various reasons, during the life of the Project. There were never more than 21 IA's in the field at any given time.

²This total does not include nine (9) committees in the Mvog Amougou groupement of Mefou which were organized in 1975-1980 but were no longer monitored following the incapacity (motorcycle accident) of the IA in February 1981.

FIGURE 1

Mean Community Action Scores for Kadey and Mefou Divisions by
Yearly Quarters for 1980 - 1982



3.1 Continued

Overall community action scores, by division for the same period (July 1980 to March 1982), are depicted in figure 2. Overall scores reflect the level and extent of community action in the division, and include scores from village health committees as well as scores from villages without committees working regularly with PTHE agents. Scores for the Mefou peaked in the first quarter of 1981 (shortly after the Cleanest Village Contest) and then trailed off through each of the succeeding quarters - a net loss of approximately 300 points. Kadey scores were stable through the third year of PTHE before rising dramatically through the fourth year, surpassing the overall score of the Mefou by the third quarter of 1981 - a net gain of 900 points. The dotted lines indicate, for each division, the ideal levels of activity; i.e. each IA with six active health committees, increasing to nine active committees each after three years of PTHE operations.

Results from the Village Population Questionnaire are displayed in Table 1. Frequency data were collected on nineteen (19) variables, as described in section 3.1b (i). Other interview items included originally proved to be unuseful for analysis, due to confused and irregular responses on four of them. The interview items used can be classified in the following manner:

- items 1-5: village health committees activities
- items 6-12: use of health center facilities, health education programs at centers and the range of subjects discussed
- items 13 & 14: perceptions of health committees and itinerant agent contributions to improved living conditions
- items 15-19: participation in health committee activities

Considered on the whole, responses to the Village Population Questionnaire were quite favorable. Within the Kadey division of 100 interviewers, 79% responded favorably regarding the function of the VMC, health center and IA. Similarly in the Mefou division, 68% of 100 interviewees responded favorably.

Figure 2
Overall Community Action Scores By Division

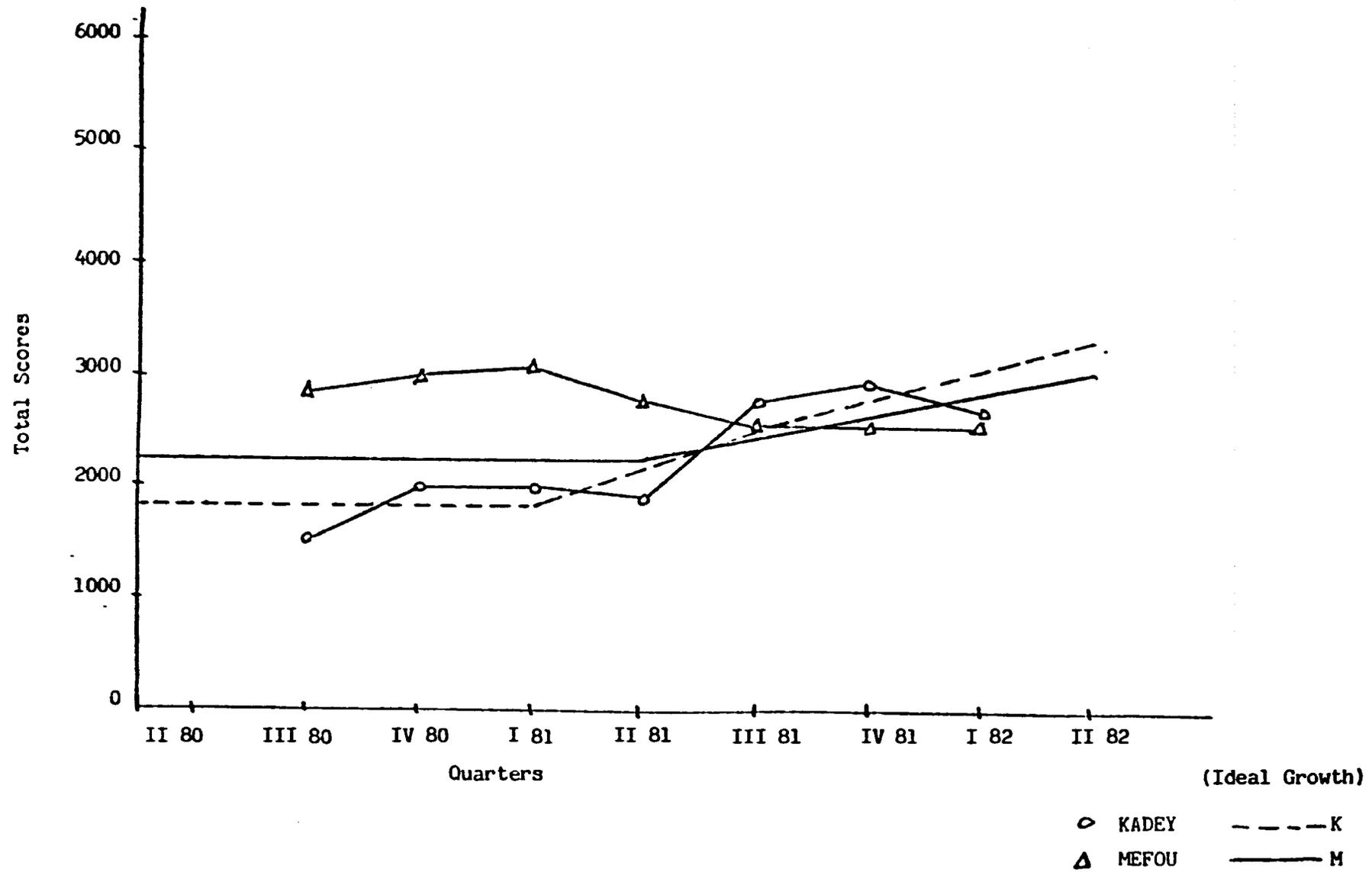


TABLE 1

Village Population Interview For The Mefou
And Kadey Divisions In Villages With Village Health
Committees

INTERVIEW ITEM

INTERVIEW ITEM	MEFOU DIVISION					KADEY DIVISION				
	Percent Responding				(N) TOTAL	Percent Responding				(N) TOTAL
	%YES	%NO	%NA	%NR		%YES	%NO	%NA	%NR	
1. Does the VHC have Village Clean-up Days?	55.0	45.0	-	-	100	76.0	24.0	-	-	100
2. Does the VHC improve and/or protect water points?	82.0	17.0	-	-	100	87.0	13.0	-	-	100
3. Does the VHC promote health education?	63.0	37.0	-	-	100	75.0	25.0	-	-	100
4. Does the VHC promote latrine construction?	80.0	20.0	-	-	100	93.0	7.0	-	-	100
5. Does the VHC encourage family pharmacies?	15.0	85.0	-	-	100	29.0	71.0	-	-	100
6. Does your family frequent a health center?	87.0	11.0	-	2.0	100	93.0	6.0	-	1.0	100
7. If yes, does the health center offer health education?	78.0	8.0	10.0	4.0	100	77.0	20.0	2.0	1.0	100
8. What subjects of health education: Personal Hygiene?	61.0	18.0	18.0	3.0	100	68.0	9.0	22.0	1.0	100
9. : Diseases and Prevention?	60.0	19.0	18.0	3.0	100	52.0	25.0	22.0	1.0	100
10. : Nutrition	39.0	39.0	18.0	4.0	100	64.0	13.0	22.0	1.0	100
11. : Environmental Sanitation	48.0	31.0	18.0	3.0	100	62.0	15.0	22.0	1.0	100
12. : MCH education?	39.0	41.0	16.0	4.0	100	40.0	37.0	21.0	2.0	100
13. Does the VHC improve village living conditions?	93.0	6.0	-	1.0	100	77.0	21.0	-	2.0	100
14. Does the IA help to improve village living conditions?	91.0	9.0	-	-	100	66.0	32.0	-	2.0	100
15. Do you participate in VHC activities?	84.0	15.0	1.0	-	100	91.0	6.0	-	3.0	100
16. If yes, in assisting at meetings?	72.0	12.0	16.0	-	100	88.0	3.0	6.0	3.0	100
17. If yes, in human investment (time)?	66.0	18.0	16.0	-	100	89.0	2.0	6.0	3.0	100
18. If yes, in material investment (resources)?	38.0	46.0	16.0	-	100	37.0	54.0	6.0	3.0	100
19. If yes, in hygiene inspections?	31.0	54.0	15.0	-	100	48.0	43.0	6.0	3.0	100

NA = Not Applicable

NR = Not Responsible

3.1 Continued

Figure 3 and Figure 4 present in graphic detail the breakdown of interviewee responses, according to village chief status and VHC membership by division. The respondents perception of VHC committee activities (items 1-5) and respondent's participation in VHC activities (items 15-19) are plotted as bar graphs representing the percent of positive responses given by village chiefs, village health committee members and non-members. It should be noted that village chief are not necessarily health committee members and therefore are presented as a separate category of respondent.

The instrument described in section 3.1 b(i) was used to assess seven main areas of interest concerning Itinerant Agent behavioral and social characteristics in relation to project implementation and achievement. Given the large number of variables considered, the questionnaire was probably ambitious in scope. Yet PTHE considered the assessment of IA characteristics socially and behaviorally as important factors in predicting future performance in achieving project goals and objectives.

However, in preliminary assessments, the IA questionnaire has proven unsuitable for sophisticated statistical manipulation such as in multiple regression analysis. Better definition and consideration of variables would enhance this instrument's predictive power and utility.

Yet several results have been obtained from the IA questionnaire in relation to areas such as: (1) the frequency of Itinerant Agent help-giving for situations of sickness/illness, marital problems, family problems, job information, religious consultation, legal political problems, and sanitation advice; (2) social status and work experience in the community and professional field, respectively, and (3) work load and success within PTHE Project community organization. These are displayed in Figures 3, 4 and 5 as bar graphs depicting mean levels of response by the eighteen (18) Itinerant Agents in the study.

Figure 3

Frequency of Positive Responses to Items 1-5 on Population Questionnaire by Village Chiefs Village health Committee (VHC) Members, and VHC Non-Members in the Mefou and Kadey Divisions.

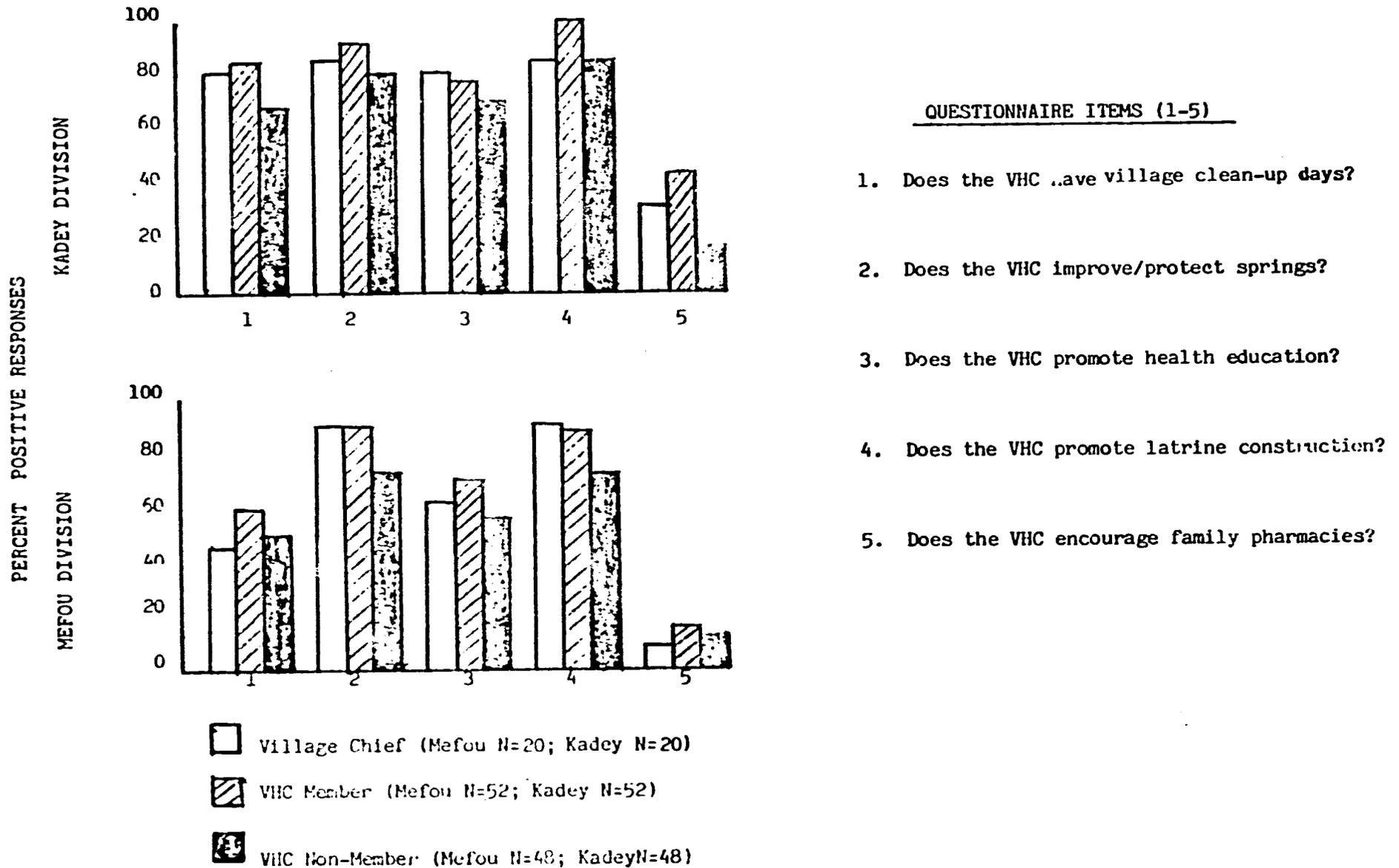


Figure 4

Frequency of Positive Responses to Items 15-19 on the Population Questionnaire by Village Chiefs, Village Health Committee (VHC) Members, and VHC Non-Members within the Mefou and Kadey Divisions.

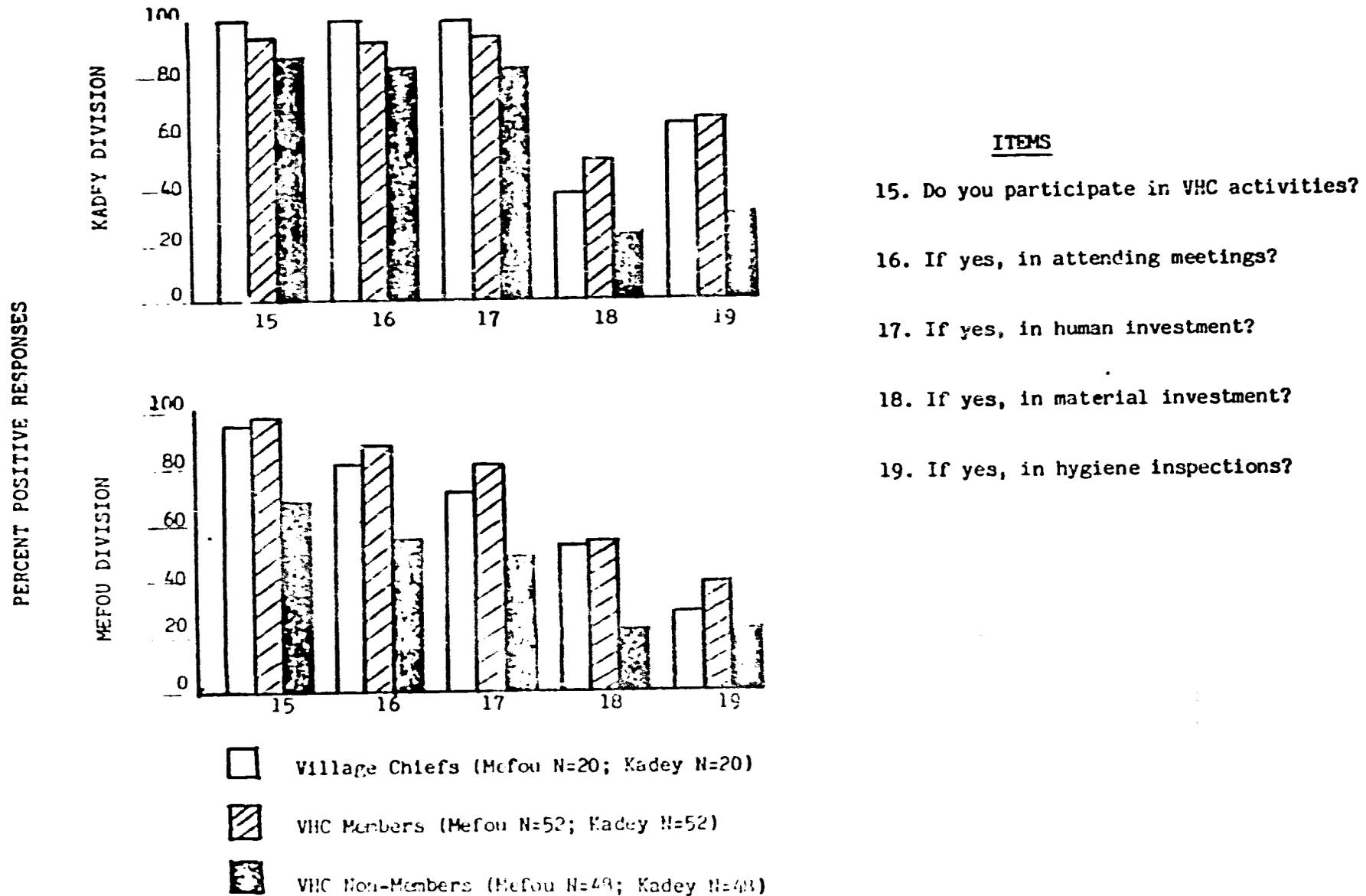


Figure 5

Frequency of Helpgiving by Eighteen (18) Itinerant Agents as Determined by Responses on the I.A. Questionnaire.

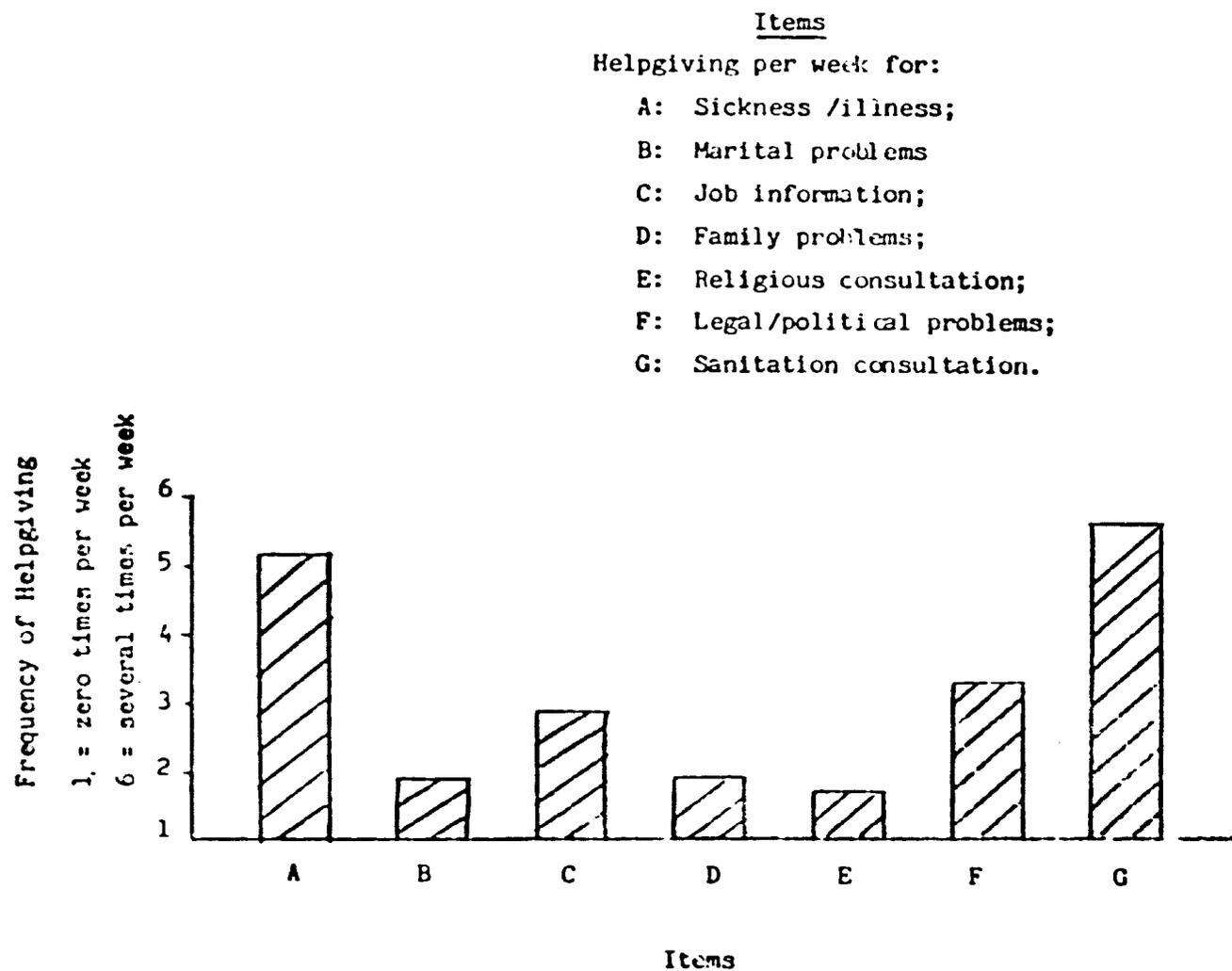


Figure 6

Mean Percent Responses of Eighteen (18) Itinerant Agents to Questions Concerning Social Status and Work Experience.

Items

- A: Percent belonging to one or more organization;
- B: Percent holding one or more offices within their organization;
- C: Percent serving three or more years as an Itinerant Agent.

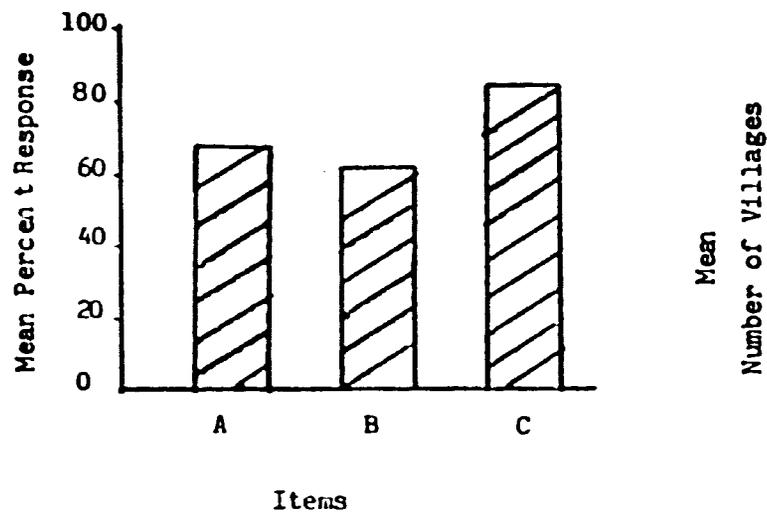
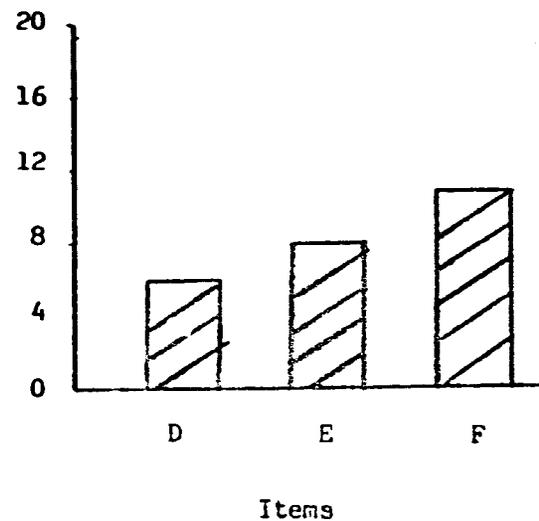


Figure 7

Eighteen (18) Itinerant Agents' Responses to Questions Concerning Work Load and Success in Mean Numbers of Villages.

Items

- D: Number Village Health Committee functioning after 2 years;
- E: Number Village Health Committees initiated;
- F: Number of Committees served by the Itinerant Agent.



3.1 continued

(iii) Discussion of Outcomes and Processes

Interpretation of the preceding findings cannot be so simplified as to confine discussion to outcomes i.e. achievement relative to logical framework targets. If this were so, Project evaluation would merely be a matter of counting the number of itinerant agents, and counting the number of active and inactive village health committees, and comparing the totals to set goals. This would completely ignore the Goal of the Project to concentrate on a small sub-set of indicators i.e. numerical targets.

The target of forty (40) itinerant agents trained and fielded was never reached; as shown in the preceding section, following an initial posting (December 1979) of eighteen IA's, the MOH never officially posted any other. Of the four IA's added to the list of operatives in the Kadey in early 1981, all four were already serving as head nurses in their respective health centers, which while being PTHE centers, did not have itinerant agents among their staffs. Thus for two years Nguielebok and Boubara had no itinerant agents in their sector. It was only by this late date - the middle of the third year - that all PTHE health centers and hospitals had assigned IA's on their staffs.

This could not help but affect output; the target of 240 health committee at Project end was based on an average workload of six committees/itinerant agent. The actual out - 136 committees for twenty IA's (or 145 committees for 21 IA's if the Mvog Amougou sector is included) compares favorably with this rate.

Figures 8 and 9 depict the number of itinerant agents in the field, over time, with the number of village health committees organized over the same time period. The flatness of the growth curve for number of health

Figure 8
Itinerant Agents Fielded

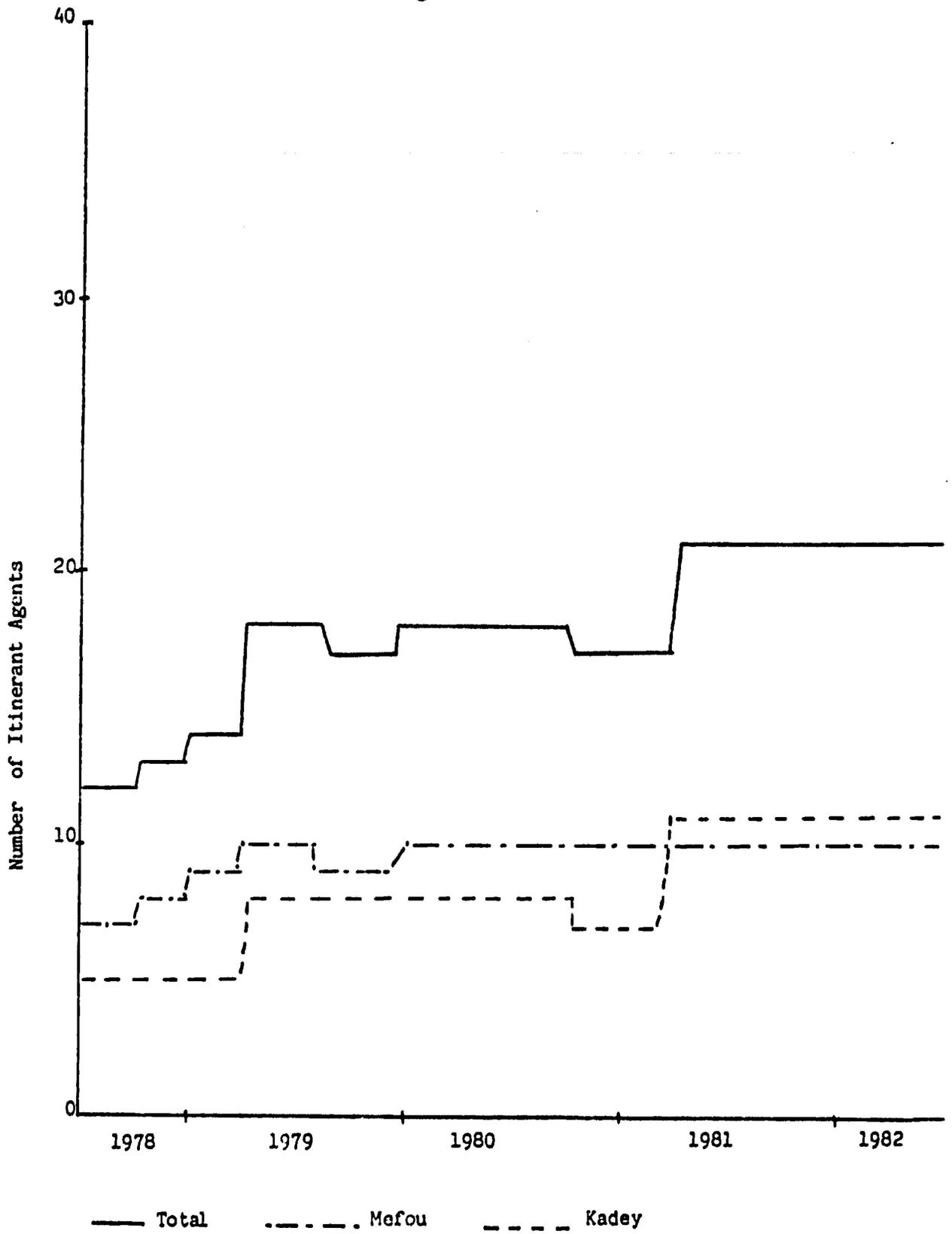
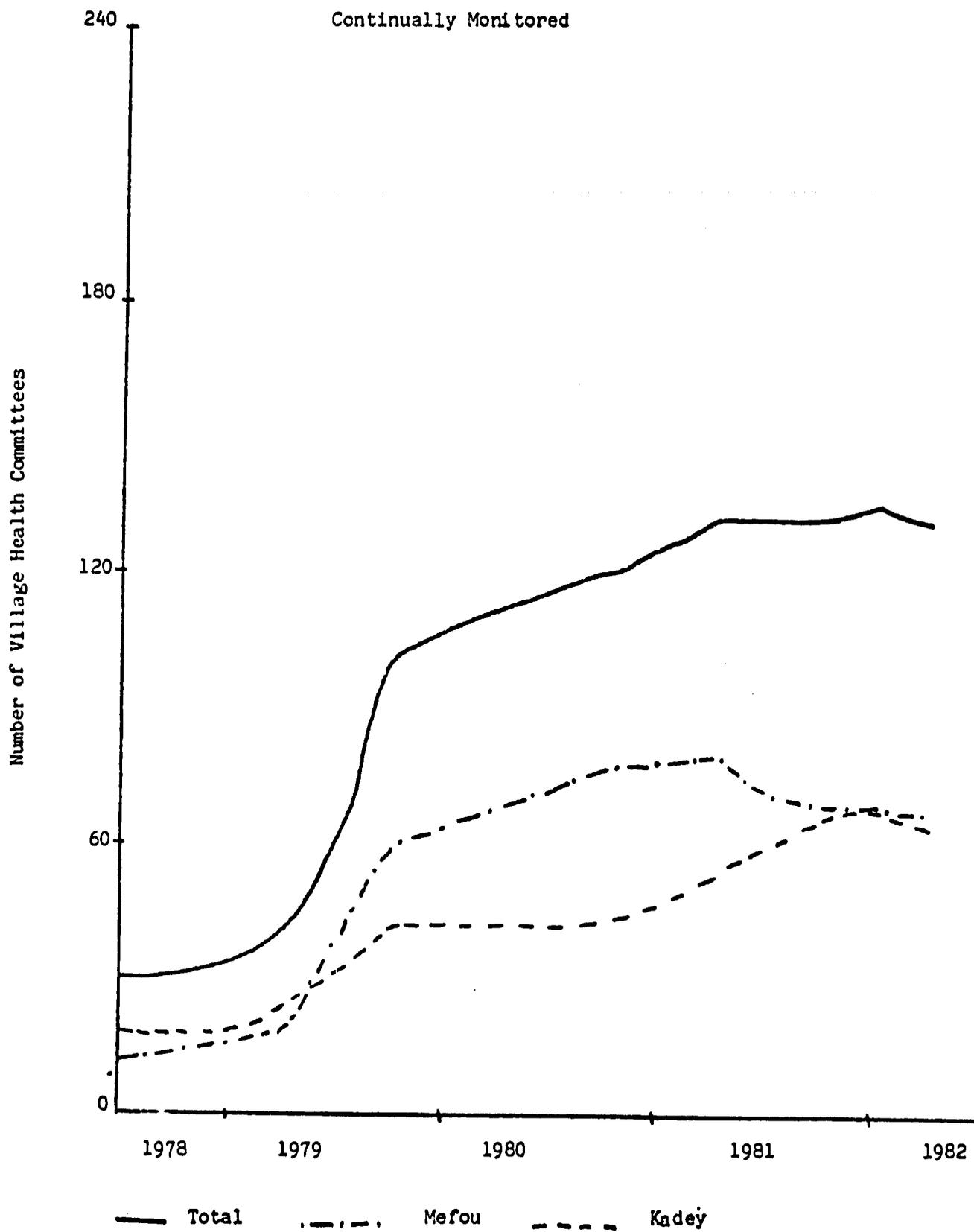


Figure 9

PTHE Village Health Committees Organized and Continually Monitored



3.1 continued

committees organized is largely attributed to the freeze on the number of IA's - they are necessarily parallel curves. Attempts to add new centers and increase the number of itinerant agents, beginning in mid-1980, never met with success. MOH did not ever clearly articulate reasons for this; lack of motorcycles was not a problem for late 1980 (4th quarter) onward. What was clear in the field, above all, was that MOH was not responding to increased demands for community outreach services.

The goal for PTHE - to increase the number of health-related development activities identified and carried out by rural populations - was well-served by the village health committee program, given the extreme constraint of field worker numbers. This conclusion is supported by the findings from Quarterly Evaluation Reports and the MOH Evaluation (village population) questionnaire. Numbers of health related development activities increased dramatically in all of the 245 villages contacted by field workers in the two divisions, as did awareness of public health problems and local-action solutions.

Figure 2 depicting the overall community action scores for the two Project divisions during the final two years of PTHE points this out clearly. Levels of activity in the Mefou were superior to the ideal level from third quarter 1980 through the first quarter of 1981. However, where growth should have continued subsequently, there was instead stagnation and slight decline. (This period of stagnation corresponds to the loss of the Mvog Amougou sector of M'fou through an IA motorcycle accident/incapacity, and to the post - Cleanest Village Contest deterioration of IA - committee relations in five of the nine Mefou sectors.) By the second quarter of 1981 Mefou IA's were averaging 9 villages (8 committees) in their workload. Levels in the Kadey remained close to the ideal, starting lower, but surpassing it during the 4th quarter of 1980 and the 1st quarter of 1981, and then increasing along the ideal growth line through the 4th quarter of 1981. This level of activity started off slightly below the

3.1 continued

ideal during the first quarter of 1982 relative to projected growth. (The first quarter of the calendar year in the Kadey brings the coffee and tobacco harvest preparation - a very difficult time to schedule community activities.) By the fourth quarter of 1981 Kadey IA's were averaging workloads of more than 8 village each (6:7 committees). It was expected that IA's work with a maximum of six villages at a time during the first three years of outreach work.

Thus for levels of activity, undifferentiated for quality and process, performance was quite good - and reflects responsiveness on the part of the rural populations in the two divisions. The volume of work performed by the IAs is also impressive.

UNC technical assistance was much more oriented toward the long range goal of PTHE, and it therefore sought to strongly emphasize, in training and in consultations, the necessary community organization processes, and the quality of the outreach work required to effectively pursue this goal.. The findings of the evaluation instruments shed light on these processes and clarified the progress made at village, areas often left in the shadow of the pursuit of quantifiable targets.

Figure mean community action scores for health committees, depicts relative progress in the two divisions. Net changes were slightly more than +2 for the Kadey and nearly +5 for the Mefou during the period July 1980 to March 1982. Mean committee scores reflect activity levels in the Mefou fairly accurately - given that work with committees almost exclusively defined IA work in the Mefou. For the Kadey it is a less accurate gauge - as IAs tended to work with a considerable number of village which did not choose to organize formal committees.

The peak in the Mefou mean scores (3rd quarter 1981) corresponds to the period immediately following the PTHE Front-Line Agent Seminar of May

3.1 continued

1981 (an increase of three points/committee from 2nd quarter 1981). The subsequent tailing off follows seasonal patterns in older committees (cocoa harvest in 4th quarter) and is due to a number of problems: IA relation with MOH and committees due to Cleanest Village Contest disputes and logistical difficulties. discussed above . The increase in mean scores paralleled to an overall decline in level of activity (figure 2) is due to the decreasing number of committees monitored for scoring: first quarter of 1981 overall activity levels are for 79 committees: the third quarter 1981 peak mean score is for 68 committee. In this manner a lower overall score is accompanied by an improved mean score for committees.

The slow progress in Kadey mean committee scores, contrasts with a dramatic increase in overall community action scores. A number of events account for this: in the second quarter of 1981 Mindourou¹ and Benguetiko were re-activated as PTHE centers and Bandongoue moved into full field operation, adding many villages into the count; these newly formed committees, in addition to deterioration in the Nguelebok and Boubara sectors, held down the division - wide averages despite greatly improved scores from Ndelele and Kette.

Progress is clear, in both divisions, among committees. While the magnitude may seem insignificant, several factors should be noted:

(1) the period under consideration, July 1980 to March 1982, includes 7 of the final 8 quarters of the Project's sixteen quarters. A levelling off of activity is predictable among committee after 18 months to 2 years, due to a necessary period of re-assessment of needs and reorientation of action.

¹Mindourou health center was destroyed by fire in July, 1980 and most of its personnel subsequently transferred; the center has not yet been rebuilt.

(2) the scoring system does not represent cumulative achievement; points are earned on the basis of each quarter's activities. As a committee works successfully to solve local problems through self-help projects, its potential to earn points in succeeding quarters actually diminishes. e.g. if all of the village springs are improved and protected, this area of committee action becomes closed. (Maintenance activities were not generally accorded points.)

(3) the magnitudes - +2 in the Mefou, +5 in the Kadey - must be seen relative to the scoring system. Two points translate in the scoring system as a village - level project undertaken or completed during the quarter under consideration. As an increase in mean committee scores this could represent an additional village-level project in each village of the division for each quarter of the year.

Findings based on the Village Population questionnaire Figures 3 and 4 are revealing for analysis of a number of factors concerning community organization processes within PTHE. In both divisions, 18 out of 20 chiefs of the sample villages are health committee members. This reflects a desired trend to incorporate traditional leadership into health committee activities. Participation of village chiefs in health committee activities (beyond attendance at meetings) varied from division to division and according to the type of participation. Kadey chiefs had higher levels of participation in village hygiene inspection and through human investment (physical labor), while Mefou chiefs had a higher level of participation through material investment (contribution of funds, building materials, tools, etc.). This may reflect a relatively higher level of personal wealth among Mefou chiefs.

Responses to questionnaire items 1-5 (Figure 3) give an idea as to the range of activities of health committees in the two divisions. Spring protection and latrine construction were far and away the most commonly

3.1 continued

perceived activities of Mefou committees - weekly clean-up days, health education sessions, and creation of village or family pharmacie trail behind. In the Kadey, where IAs were more open to a wider health education role (i.e. not strictly a sanitation worker role) committee activities were also generally more varied. Positive responses from committee members are 80% and above for four of the five questionnaire items, with the village/family pharmacy drawing nearly 40%, well ahead of the Mefou's (approximately 10%). This same trend to a more varried range of committee activities was also clean in the number of "other" activities of committees described by respondents.

Levels of participation (item 15 Figure 4) also shows differences between the two divisions, with levels of participation generally higher in the Kadey across the lines of chief, committee member or non-member. The sole exception to this is the area of material investment which, once again, might actually reflect the higher levels of personal wealth found in the Mefou. Non-member participation in health committee activities in the Kadey (items 16 -19) are high, and compare favorably with member participation in meeting attendance and human investment. (Hygiene inspection tends to be the province of committee officers and chiefs.) It is interesting to note the distinct difference in these levels from those of the Mefou, which lag behind member participation by a considerable amount. This could reflect a number of influences - average village size being larger in the Mefou -- but still lead to a hypothesis that Kadey village health committees were more successful in mobilizing village - wide participation in their activities. This is often easier in smaller villages and in newer sectors. But this may also further underline certain Mefou IA tendencies toward routinization of a circuit of sanitation inspections and health education talks aimed at an unchanging core of people (members) in the same village. Another study of these health committees in the Kadey, perhaps two years from now, could help corroborate some of these preliminary findings. What

3.1 continued

is obvious from all of this is that villagers in the Kadey were responding to community organization efforts -- and that Mefou Villagers also continued to respond, especially in sectors where methods were innovative (Esse) or where new zones were opened (Awae, Evindissi).

Findings from the Itinerant Agent questionnaire could have completed the image of community organization work and community organization workers in PTHE. Lack of predictive value of the findings certainly limits what can be said, on the basis of the questionnaire, about recruitment criteria for itinerant agents. The findings from individual items (figure 5.6 and 7) helping-giving, social status, work load -- help clarify the profile of the PTHE itinerant agent. Much more study is needed in this area to complement personal observations and individual experiences, and such research should be carried out throughout Cameroon, among community development and social affairs field workers as well as among health workers. This questionnaire, a useful instrument, will however need to be refined and the data-gathering process more closely monitored.

3.2 Training Component

a. Inputs

The training component of the PTHE Project consisted of in-service training for health personnel, technical assistance to MOH services, assistance to the Ministries of Agriculture and Social Affairs in organizing continuing education courses, and practical field training experience for CUSS/CESSI students.

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

- three seminars for frontline 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 of health educators and in organizing 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 MINAGRI Community Development Service 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;
- practical field training for three graduating classes of CUSS and CESSI students.

3.2 continued

A trainer's guide for organizing and implementing continuing education courses was developed as a result of the Project's training activities. It is presently available from the MOH in both French and English to be used by government personnel involved with training and continuing education. The first section of the guide describes the planning process in terms of steps to be followed in the technical, logistical, and administrative preparation of a continuing education course or seminar. A separate section is given to evaluation and follow-up of training. How to organize and write the final report is also included. The final and largest section of the guide consists of 56 training exercises covering eleven major community health topics such as community organization methods, principles and practices of public health education, and maternal and child health. These exercises were specifically designed or adapted for use in Cameroon. The large majority have been tested throughout the PTHE Project.

(1) Formal Seminars

Three PTHE seminars were conducted on an annual basis and held in Yaounde. Approximately 80 participants attended each time and approximately 10 trainers were included in each seminar's design and execution. The purpose was to develop and maintain the active support of all cooperating agencies in the two pilot areas of the Project. Participation from the ministerial, provincial, divisional, and local levels included public administrators, teachers, health educators, health workers, and agricultural extension agents. They were brought together for five days to gain a fuller understanding of the PTHE approach, with each seminar emphasizing a project component that was receiving special attention at that time.

The first seminar was held November 1978, after field operations began, to officially launch the Project. The basic principles of health education and community participation formed its theme to orient the participants to the rationale behind PTHE. The second seminar was held a year later and

3.2 continued

focused on the team concept of staff development within the health center and with other services. Four months after this seminar, intensive workshops on staff development for each health center in the Kadey and Mefou were conducted. The third and final seminar held in May 1981, concentrated on community organization strategies and methods to be used by frontline workers, i.e. personnel who provide direct service at the village level such as teachers, itinerant agents, and agricultural extension workers. While the Project had been training this level of personnel since the beginning, the major thrust of field activities for the last two years was on the village health committee component.

The training methodology used in these seminars also complemented PTHE activities in the field. Seminar leaders and facilitators were predominantly drawn from middle and upper-middle level health personnel from the Kadey and Mefou, who support and supervise health center activities. The May seminar marked the first time that representatives from other ministries were involved in the actual design and implementation. By involving them as seminar training staff in the design and execution of new training techniques, they would more than likely use or support the use of these techniques when they returned to their posts in the Project area. UNC field staff and their counterparts trained the trainers to develop and facilitate small group discussions, role plays, case studies, and structured small group exercises.

The use of a "question box" had also been instituted at these seminars. Throughout the five days anyone could anonymously submit a question or express a concern in writing with the knowledge that ministerial decision makers would then open the "question box" and respond verbally during a session on the last day of the seminar. This method was effective and well-received for overcoming communication barriers in a very centralized and hierarchical bureaucracy. Superficial as it was, the "question box" provided the first and only opportunity for open dialogue between policymakers

3.2 continued

and field workers. It was important to the PTHE approach that the definition of community participation in decision-making was as relevant in the context of a health infrastructure as it was in a village.

Proceedings from each seminar were compiled, printed, and distributed widely.

(ii) Workshops

Two hundred forty MOH personnel and 35 Peace Corps Volunteers were trained through 20 continuing education workshops conducted in the Kadey and Mefou Divisions.

The training objectives were:

- to prepare hospital and health center staffs to work as a team in carrying out a community health program and to integrate new activities into their daily work.
- to enable chief nurses of health centers and heads of hospitals to lead community health programs in their health facility.

To meet the first objective, a two-day workshop was held in each of the 18 health centers and hospitals involved with PTHE. The entire staff, including the Peace Corps Volunteer and the sweeper, participated together in training sessions aimed at: the use of statistics for planning health education programs; the establishment of staff development activities; improving patient education; developing maternal and child health activities; and techniques for community mobilization.

Nine workshops in the Kadey were held in March 1980 and nine in the Mefou in October 1980. Trainers were composed of UNC field staff, their counterparts, divisional Medical Officers and Chiefs of Preventive Medicine, and provincial MOH representatives. Due to the very limited amount of time

3.2 continued

available to the provincial and divisional health officials to be away from their duties, the trainers divided into two teams to conduct the workshops in two health centers simultaneously, and then formed one large training team for the hospitals.

These workshops were extremely successful in that they stimulated several health centers and hospitals to initiate their own workshops. The act of bringing together an entire staff for training in which the trainer came to them was very novel and well received by trainees and trainers alike. The experience strengthened the confidence of provincial and divisional health officials in the training techniques which were new to them as well as in the importance of continuing education for lower level personnel. The approach of conducting training in the health centers rather than the normal summoning of trainees to come to headquarters offered the health officials a more efficient use of their time and resources. That is, their already overstretched budget for transportation logistically limited their ability to supervise and support health center personnel. The situation was viewed as one of choosing between an annual inspection tour of personnel and facilities or reimbursing travel costs for personnel to attend continuing education activities. However, through the PTHE workshop experience, a viable option allowing them to perform both functions was demonstrated.

These health center workshops were followed up with two four-day training sessions for the heads of hospitals and health centers in the Kadey and Mefou respectively. The first one was held in Batouri in November 1980 and the second took place in Esse in December 1980. The specific aim was to increase the knowledge and skills of health facility chiefs to:

- reorganize the health center program around the team concept of staff development,
- collaborate with other agencies;
- plan at least one health education activity;

3.2 continued

-improve consultation techniques for prenatal and children under five care.

Again, trainers were drawn from the UNC field staff, their counterparts, and divisional and provincial health officials.

(iii) Consultation and Technical Assistance

The PTHE Project provided technical assistance to the MOH Training and Continuing Education Service, and the Health Education Service; to the MINAGRI Division of Community Development and to the Ministry of Social Affairs (MINSAF) for their ongoing training activities. The UNC field staff and counterparts worked closely with the training staff of these services in the design and implementation of the conferences and workshops for their personnel.

With the MOH Training and Continuing Education Service, four, six-day in-service training workshops were conducted in four provinces: Center South in May 1980, North in August 1980, West in April 1982, and Littoral in June 1982. An average of 70 health personnel attended each of these provincial workshops which formed part of the Training Service's mandate to offer in-service training to every province in the nation with UNICEF funding. The PTHE counterpart for training is a permanent staff member of the Training Service. After collaboration from UNC field staff for the initial three workshops, she had sole technical and management responsibility for the fourth one. Not one UNC field staff needed to be present because she had become fully capable on her own.

PTHE also collaborated with the MOH Health Education Service in conducting a continuing education workshop for health educators in September 1978 and a national health education conference in July 1982. The Health Education Service had also been given the responsibility of coordinating

3.2 continued

with the MINEDUC to organize a national three-day school health conference in February 1982. The PTHE Project was a member of the planning committee, presented the pilot school health education program component of the Project at the conference itself, and provided two speakers from Togo to present that nation's school health program.

The scale and nature of Health Education Service training events were much wider than any others involving the PTHE Project. While the reading of papers by high level policymakers and the presenting of resolutions at the end provided information to the participants, very little attention was given to the acquisition of new skills. Consequently, PTHE input was most limited in the technical assistance it was able to offer to the Health Education Service, who nonetheless was cognizant of the Project's training capabilities through its participation in the PTHE seminars.

Other Ministries who were aware of the Project's ability and willingness to offer training assistance were the MINAGRI and the MINSAF. They had contact with PTHE as members of the Coordinating Committee and through informal collaboration in the pilot areas between their workers and health personnel. The MINAGRI provincial chief for community development in the East asked PTHE for technical assistance to design, provide materials, and jointly implement a ten-day in-service training course for their 21 rural agents in community health and community organization. Three PTHE itinerant agents, the Kadey Assistant Chief of Preventive Medicine, and two PCV's also attended. It was held in October 1981 in the village of Moundi where the MINAGRI has built a Center for Community Action and Training.

A similar request came from the MINSAF to collaborate on basic training for its rural animators. Thirty-five students from all provinces in Cameroon--some with field experience, some newly recruited--went through the three month training period in Betamba, and were then fielded for a six

3.2 continued

week practicum (with one site being a PTHE health center). PTHE field staff participated in this training in December 1981.

(iv) Visiting Scholars

Four separate visits to UNC/Chapel Hill from Cameroonian health officials had been arranged. While three were primarily for project management purposes, all four visits had training aspects specifically planned to partially compensate for the general lack of public health training among MOH personnel.

The first visit was made by the Chief of the Health Education Service in June 1978, who spent two weeks in Chapel Hill with PTHE field staff to clarify points concerning MOH and UNC roles. It had been hoped that by exposing him to the orientation of the UNC Department of Health Education through individual conferences with faculty and field visits to on-going demonstration projects in rural North Carolina, his input to the PTHE Project would be strengthened. Under his direction, the Health Education Service had been a greater barrier than a vehicle for the Project due to his administrative style, perceptions of priorities, and failure to follow through with decisions he had helped make (see Section 4.2 for a more detailed discussion).

The second and third visits from Cameroonian MOH officials occurred in July 1979 when the Assistant Chief of the Health Education Service stayed for two days while attending a conference in Chicago and the Director of Preventive Medicine came specifically to UNC/Chapel Hill for two weeks. While the justification for their travel was to participate in the selection of a third field technician, a significant amount of time was also spent on orienting them to the basic theory and principles of health education at UNC. Consultations with faculty and practitioners in the field

3.2' continued

arranged. A departmental seminar was also held for the Director of Preventive Medicine as an open forum of exchange and discussion. An important result of the visit for him in particular was the realization that conditions and problems of rural health care in the U.S. were quite similar to those found in Cameroon. He was able to observe and discuss with American public health professionals actively working and involved in developing strategies and methods for solution.

The fourth and final visit from Cameroonian health personnel came as the result of a compromise between the USAID/Yaounde mission and the MOH. When it became apparent during the mid-project evaluation that a long-term degree program in public health for Cameroonians would not be possible due to the amount of time away from their posts, the compromise of short-term training in the U.S. for key PTHE-related personnel from the MOH and other key ministries was reached. Four arrived in Chapel Hill in August 1981 to spend four months at UNC as visiting scholars and were all MOH personnel. Two were the PTHE counterparts (of whom one had just resigned the position), one was the Chief Medical Officer for Benoue Division, and one was on the faculty of the School of Nursing in Bamenda. The latter two had no prior involvement with PTHE whatsoever, which meant that a great deal of special orientation was needed for them.

The selection of the visiting scholars had been the sole responsibility of the MOH. UNC/Chapel Hill had been informed of who they were and when they would arrive only two weeks before the fall semester was to begin. Arrangements were made for their housing, interpreters, course enrollment, and other basic needs. Each was counseled to determine individual programs of study based on their previous training, present responsibilities and interest. Three who spoke very little English were also auditing a special class in English. Field visits in North Carolina, South Carolina, Arizona, and California had also been arranged for them to observe different community-oriented demonstration programs. Both faculty and graduate students of the

3.2 continued

School of Public Health contributed a great deal of time and effort to their learning. For a detailed description and evaluation of their program, see Appendix.

The experience of bringing MOH personnel to the U.S. for short term training as a replacement for the more comprehensive degree program proved to be less than acceptable. For not only is the problem of language and acculturation one that can only be overcome with more time, but the need for follow-up and support under the guidance of faculty is critical to the nurturing of new information and direction. The PTHE Project seriously suffered from the lack of high level MOH decision-makers with a sound background in public health. Unfortunately, four months at the UNC School of Public Health was not enough to ensure it.

3.2 continued

b. Outputs

(i) Presentation of Methodology and Measures

Methodologies for assessing PTHE effectiveness in training activities followed two main strategies, namely, the Quarterly Evaluation Report forms and the Health Center Inventory from this MOH evaluation. These are used in addition to comparison of actual outputs with the targets found in the logical framework.

As described in greater detail in Section 3.1b(i), the Quarterly Evaluation Report form (see Appendix E) was composed of two sections concerning the Health Center activities section, an attempt was made through this instrument to measure health center progress longitudinally through quarterly evaluation of specific health center activities. These specific areas reflect activities deemed pertinent to PTHE goals and objectives in relation to upgrading the existing standards of Kadey and Mefou divisions health centers. Specifically, these areas included (1) personal training (regular meetings of the health center staff, continuing education, etc.), (2) individual patient education, (3) group health evaluation presentation to patient and community members, (4) maternal and child health seminars and (5) hygiene and sanitation improvements in and around the health center facility itself (latrines available for patients, high sanitary quality of the latrine, potable water supply for patients, etc.). The number of points targeted per health center was 45. In other words, if the health center demonstrated excellent achievement of the activities listed above over a three month period, a point score of 45 would be attained.

A second methodology utilized in assessment of PTHE effect at the grassroots level was a comparison of PTHE health centers of those in similar areas not receiving PTHE input. For this purpose the Health Center Inventory (see Appendix I) was developed by an evaluation team composed of UNC/CUSS/MOH members and pretested by UNC/Y and MOH. This instrument was

TABLE 2: NUMBER OF MOH PERSONNEL TRAINED, AND THE NUMBER OF MOH PARTICIPANTS ATTENDING THE SPONSORED TRAINING ACTIVITIES BY POSITION AND LOCATION

September 1, 1978--June 30, 1982

Position	Number of Persons				Number of Participants ¹			
	Mefou ²	Kadey ³	Yaoude	TOTAL	Mefou	Kadey	Yaoude	TOTAL
Chief nurse ⁴ health center or chief doctor of hospital	23	22		45	58	56		114
Itinerant Agent	10	9		19	68	54		122
Other hospital or health center workers	95	39		134	104	47		151
Divisional health authority	4	9		13	26	26		52
Provincial health authority	2	2		4	9	6		15
Nursing school teachers		1	6	7		1	6	7
National health authority			18	18			45	45
TOTAL	134	82	24	240	265	190	51	506

¹Participants are the number of people who attended the various training sessions. One person could participate in more than one training. During this period, there were 14 training sessions.

²Total health personnel in the Mefou number approximately 162 persons.

³Total health personnel in the Kadey number approximately 130 persons.

⁴Four chief nurses in the Kadey (Nguelebok, Mindourou, Boubara, Bandongoue) are also itinerant agents. They are counted only once, as chief nurses in this table.

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TABLE 3: NUMBER OF MOH PERSONNEL AND PERSONNEL FROM OTHER MINISTRIES (AND ORGANIZATIONS) TRAINED AND THE NUMBER OF PARTICIPANTS ATTENDING THE SPONSORED TRAINING ACTIVITIES BY LOCATION

September 1, 1978--June 30, 1982

Ministry or Organization	<u>Number of Persons</u>				<u>Number of Participants</u> ¹			
	Mefou ²	Kadey ³	Yaounde	TOTAL	Mefou	Kadey	Yaounde	TOTAL
MOH	134	82	24	240	265	190	51	506
Representatives of other ministries or organizations	50	36	6	92	65	60	7	132
Peace Corps Volunteers	15	18	2	35	61	47	3	111
TOTAL	199	136	32	367	391	297	61	749

¹Participants are the number of people who attended the various training sessions. One person could participate in more than one training session. During this period, there were 16 training sessions.

²Total health personnel in the Mefou number approximately 162 persons.

³Total health personnel in the Kadey number approximately 130 persons.

⁴Includes 3 volunteers from the Netherlands.

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3.2 continued

(ii) Findings

Relative to the logical framework target outputs for the in-service training component of PTHE, the following results were achieved:

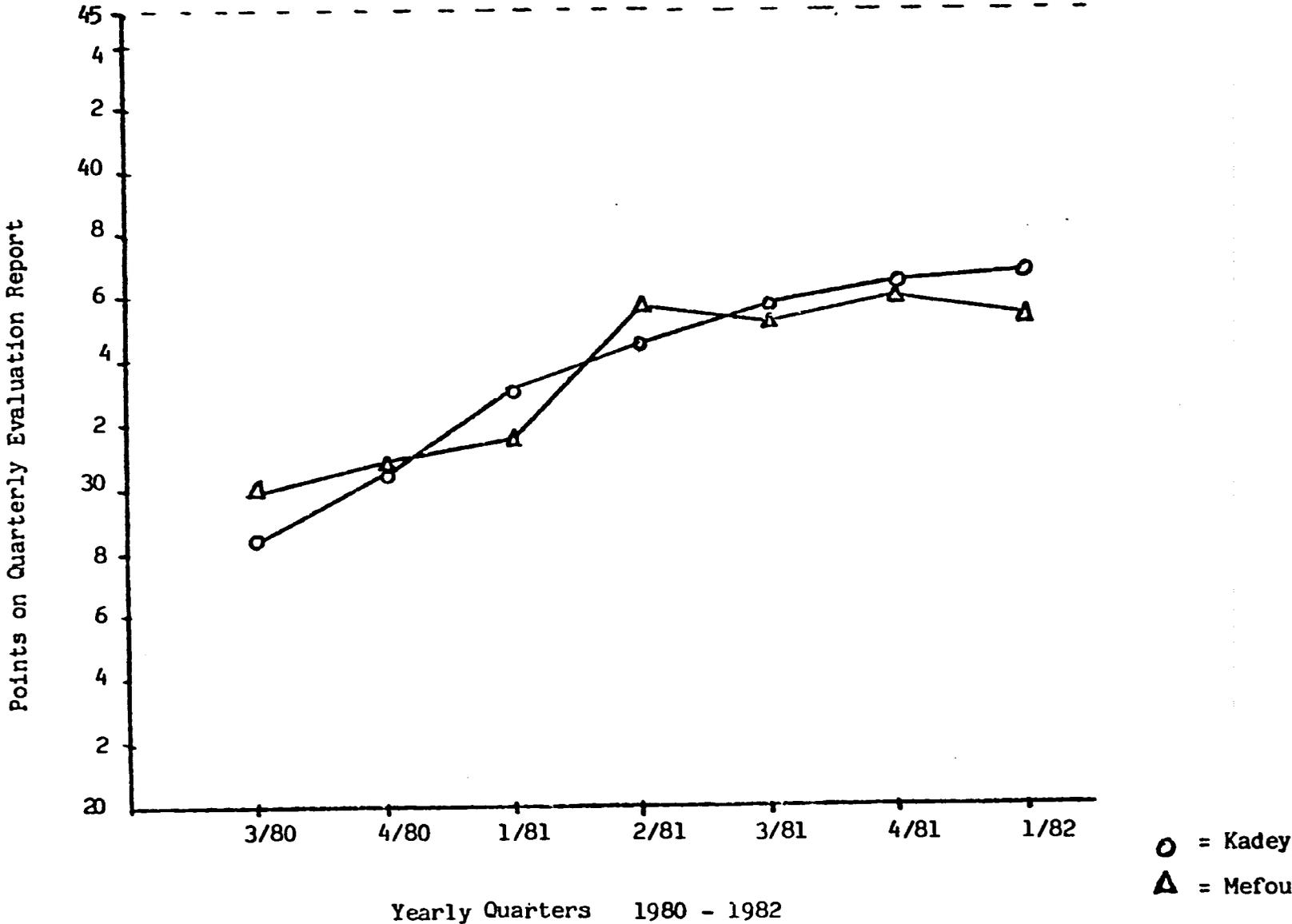
<u>Logical Framework</u>	<u>Actual Output</u>
a. 160 health workers and 30 Peace Corps volunteers trained and implementing health education programs in 16 health centers which are rated as "active."	240 health workers and 35 Peace Corps volunteers trained and implementing health education programs in 18 active health centers.
b. Training design and material developed and used in four MOH continuing education seminars.	Training design and material developed and used in four MOH provincial seminars, two HES seminars.
c. 25 workers from other service trained, of which 8 undertook health activities by June 1982.	92 workers from other service participated in PTHE training sessions, of whom at least 52 undertook health activities by June 1982.

(See Tables 2 and 3)

These figures are based on participant list from the 76 PTHE sponsored training sessions. For MOH personnel, they represent health administrators, faculty of nursing schools, health outreach workers, and the clinical staff of 18 health facilities (hospitals and health centers) affiliated with the Project. Among the 92 workers from other services are primary school teachers, school superintendants, community development agents, agricultural extension agents and social workers. (This figure does not include the 19 community development agents trained during the October 1981 Provincial Community Development seminar in Moundi, Eastern Province; while UNC field had strong input in the design and

Figure 10

Mean Health Center Activity Scores for Kadey and Mefou Divisions By Yearly Quarters: 1980 - 1982.



3.2 continued

operation, the Seminar was sponsored by MINAGRI/CD, and not PTHE).

In terms of sheer numbers, the Project had made a significant impact in training 82% of the health personnel working in the Kadey and Mefou Divisions. Moreover, each health worker had participated in at least two separate in-service training activities, excluding the 16 Evaluation Days and 18 Committee Days held over the four-year period which contained training aspects. Thus, there was a continual process of reinforcement through in-service training for MOH personnel as trainees and trainers.

Mean Quarterly Evaluation Report scores for Health Center Activities by Division are shown in Figure 10 for the period: third quarter 1980 through first quarter 1982. The target number of points per health center was set at 45. Achievement of this maximum point score would be indicative of a health center demonstrating active involvement in those criteria deemed pertinent to improvement of existing health standards in the Mefou and Kadey division health centers.

It is clearly evident from Figure that both the Kadey and Mefou Divisions improved in mean quarterly scores for the 18 month period under consideration. Overall both divisions demonstrated positive net change, 8.5 for the Kadey and 5.4 for the Mefou, in point means, between the beginning and end of the study period. The point range for the Kadey reveals a lower limit mean of 28.2 points and an upper limit mean of 36.7 points while the Mefou demonstrated a lower limit mean of 30 points and an upper limit mean of 36 points.

Results from the second methodology described above of comparing PTHE health center activities with similar matched control groups are displayed in Table 4. The assumption that PTHE health centers would demonstrate

TABLE 4

DIFFERENCE BETWEEN MEANS ON HEALTH CENTER INVENTORY CATEGORIES FOR MEFOU AND KADEY DIVISION HEALTH CENTERS WITH MATCHED CONTROL DIVISIONS

Category	PTHE Division Control Division	Number of Health Centers	Mean	S.D.	t-value	df
1. Health Center activity	Mefou	6	35.67	6.62	3.01 ^a	9.08
	Control	10	26.00	5.45		
	Kadey	6	32.17	5.67	0.52 ^c	11.18
	Control	10	30.00	6.00		
2. Health Center Community Action	Mefou	6	15.33	3.56	2.85 ^a	13.42
	Control	10	9.20	5.01		
	Kadey	6	17.67	3.78	3.14 ^a	13.08
	Control	10	10.70	5.03		
3. Combined Health Center Activity and Community Action	Mefou	6	51.00	6.60	4.39 ^a	12.00
	Control	10	35.10	7.67		
	Kadey	6	49.83	8.80	1.79 ^b	11.71
	Control	10	41.30	9.88		

^aSignificant at .01 level two-tailed test.

^bSignificant at .09 level two-tailed test.

^cNon-significant.

3.2 continued

higher scores than similar matched control groups on the Health Center Inventory (HCI). would assume the form:

$$H_0: u_1 = u_2$$

$$H_1: u_1 \neq u_2$$

Where: u_1 = mean HCI scores for PTHE Health Centers and u_2 mean HCI scores for control group Health Centers.

From Table 4, it is clear that on all three categories of the HCI, the PTHE health centers demonstrated higher mean scores than their control health centers. In terms of the degree to which the health centers varied, both divisions of PTHE health centers (N = 12) differed significantly from their matched control groups (N = 20) at the .01 significance level two-tailed test on the Community Action category. On the combined Health Center and Community Action category PTHE health centers in the Mefou divisions differed from their control health centers at a higher level of significance (.01 level two-tailed test) than the Kadey division health centers which differed from their control group at a slightly lower level of significance (.09 level two-tailed test). Yet on the whole PTHE health centers are shown to differ significantly from their matched control groups.

In considering comparisons of health centers within divisions, the assumption that PTHE health centers would perform equally well, not differing in overall means from each other, and that the control health centers would be equally consistent in performance would assume the form:

$$H_0: x_1 = x_2$$

$$H_1 = x_1 \neq x_2$$

and

$$H_0: x_3 = x_4$$

$$H_1: x_3 \neq x_4$$

Where:

- x_1 = mean HCI scores for Mefou health centers;
- x_2 = mean HCI scores for Kadey health centers;
- x_3 = mean HCI scores for Mefou control health centers;
- x_4 = mean HCI scores for Kadey control health centers

3.2 continued

Table 5 displays these comparisons within divisions: project and control. It is quite apparent that both divisions were internally consistent in terms of mean scores on the Health Center Inventory.

TABLE 5

DIFFERENCE BETWEEN MEANS ON HEALTH CENTER INVENTORY CATEGORIES WITHIN THE DIVISION HEALTH CENTERS AND WITHIN MATCHED CONTROL DIVISIONS

Category	Divisions	Number of Health Centers	Mean	S.D.	t-value	df
1. Health Center Activity	Mefou	6	35.67	6.62	0.98 ^a	9.77
	Kadey	6	32.17	5.67		
	Control (Mefou)	10	26.00	5.45	-1.79 ^a	17.84
	Control (Kadey)	10	30.63	6.00		
2. Health Center Community Action	Mefou	6	15.33	3.56	-1.10 ^a	9.96
	Kadey	6	17.67	3.78		
	Control (Mefou)	10	9.20	5.00	-0.67 ^a	18.00
	Control (Kadey)	10	10.70	5.03		
3. Combined Health Center Activity and Community Action	Mefou	6	51.00	6.60	0.26	9.28
	Kadey	6	49.83	8.81		
	Control (Mefou)	10	35.10	7.67	-1.57 ^a	16.96
	Control (Kadey)	10	41.30	9.87		

^aNon-significant.

3.2 Continued

b. Outputs

(iii) Discussion of Outcomes

The findings relative to logical framework expectations and actual PTHE output speak by themselves. Impressive as the numbers may be, they are limited in value as indicators of training effectiveness. The following discussion of outcomes should answer more critical questions concerning the degree to which the performance of health workers and other workers involved through the PTHE training component.

Findings from the Quarterly Evaluation Report mean scores for health center activities reveal steady progress throughout the period under consideration, and parallel to the regular scheduling of training activities (including quarterly evaluation days). The irregular Mefou curve, peaking during the second quarter of 1981 and falling slightly in the third quarter before returning to peak level during the fourth quarter of the same year, is explainable by two events (and the small sample size - 9 facilities only): third quarter 1981 saw the departure of the state-registered head nurse from Mbankomo for CESSI studies, with no replacement, leading to a steep drop in scores reflecting a limited range of services offered; that same quarter also saw the death of the Soa head nurse early in the quarter, once again, with no replacement until the fourth quarter of the year.

The magnitude of the net changes - +8.5 for the Kadey and +5.4 for the Mefou - is impressive, given the length of period under consideration and given the physical conditions found in many of these centers. By averaging 36 points or better as means scores, PTHE health center necessarily offered regularly scheduled staff meetings/development sessions, patient and group health education with a preventive orientation, and prenatal clinics. Pit latrines and/or clean water were also available to the client population. The target score of 45 would represent the addition of well-baby clinics and better sanitary facilities to the list; in many cases well-baby clinics were not organized due to the lack of necessary basic equipment, such as scales and growth charts. Progress in improvement of sanitary facilities was also more

3.2 Continued

of a problem, i.e. building latrines or provision of clean water or creation and use of refuse pits - this was clear from the Health Center inventory questionnaire. The attitude that state health facilities should only be upgraded by state employees blocked much village participation in these efforts; at the same time, health center staff were not generally enthusiastic about doing this work alone. (In theory, construction companies who receive contracts for these facilities are to include pit latrines, if not water catchment systems with plumbing, in the construction. In practice this is rarely done.)

The findings of the second methodology - the Health Center inventory - clarify the progress made relative to other health centers (non-PTHE) in the same provinces. In Center-South Province, the comparison between Mefou and the control center in Nyong et So and Nyong et Mfoumou, in the areas of health center activities, community action, and overall scores, differences were significant statistically with Mefou PTHE centers clearly outperforming the others. In Eastern province, the Kadey PTHE centers scored significantly higher than the control centers in Lom et Djerem in overall scores and in community action. Differences in scores for health center activities were not significant in Eastern province. A major reason for this would be the presence of the Catholic Relief Service - operated P.L. 480 food distribution program in all of the control centers in the Lom et Djerem and in four of the PTHE centers in the Kadey. CRS ties the food distribution to MCH and health education programs - which accounts for such good scores in these areas (in MCH activities the Lom et Djerem mean score was actually slightly better than the Kadey PTHE mean). Staff development activity pushes PTHE mean scores higher (in the area of health center activities) than the control center but not sufficiently to be statistically significant.

To put scores in perspective: a maximum score of 50 was possible for health center activities (Mefou mean ± 36 , Kadey mean ± 32); a maximum of 25 was possible for community action (Mefou mean ± 15 , Kadey mean ± 18); thus an overall

3.2 Continued

maximum score of 75 (Mefou mean=51, Kadey mean *50). Progress should continue across the range of activities listed in each of the two domains of health center activities (staff development, health education, MCH, and sanitary facilities) and community action (outreach and collaboration with other services) - there remains room for improvement. But PTHE centers do perform better than the control centers and without having benefited from material inputs: PTHE centers were no better stocked in drugs or equipment, nor more fully staffed, than the other facilities of their respective provinces. The critical input was PTHE in-service training, which led, in the cases of Mefou, Esse, Awae, Ngoumou, Ndelele, Bandongoue, Kette, and Boubara, to regularly scheduled staff development activities organized locally with minimal central level input. Possibilities for diffusing these types of local training activity seem excellent if PTHE-type training activities continue at the provincial and divisional levels.

PTHE training and supervision emphasized all of the aspects of health center activities used in the Health Center Inventory. While proposing casual links between a given training session and/or supervision tour and an improvement in extent and/or quality of service may be, at best, arguable, the linkage between improvement of PTHE health center performance (both relative progress over time and in comparison to other health centers) and training/supervision activities is solid.

Training activities were extremely popular with health personnel, both trainers and participants, and served as a motivation factor. Interestingly enough, head nurses from the control centers in the MOH evaluation often expressed the desire to be included, with their staffs, in PTHE-type training activities. While statistics are not now available, impressions from supervisors and head nurses would indicate increasing levels of attendance at preventive/promotive health center activities (health education, MCH) over time in the Project areas as the quality and number of these activities increased.

3.3 Training Institutions Component

a. Inputs

PTHE was to play a major role in the field training programs of several training institutions (although the unrealistic target levels set out in the Project Paper needed to be modified in the revised log frame--see section 2.3 for discussion). A review of PTHE activities, by institution, follows.

CUSS/CESSI (University Centre for Health Sciences/Center for Advanced Training in Nursing)

PTHE's relationship to CUSS/CESSI was initially defined, in part, by the placement of a CUSS faculty member as Chief of Party. The change in Chief of Party made CUSS/CESSI contacts less intimate but not less cordial. Targeted levels of activity for field training of CUSS/CESSI students in the Project Paper took little heed of curriculum, as they included third year medical students along with fourth year in field training. It is the fourth year students who study community medicine, and their program includes a month-long field practicum. CESSI first-year students also are programmed for a month-long field training exercise--and as discussions between PTHE and CUSS began in 1979, the possibility of combining the CUSS/CESSI field training placements in PTHE centers in the Mefou became real. Before PTHE input, fourth year medical students and first year CESSI students were placed in various health facilities in the DASP zones in southern and western Cameroon (DASP was a large scale public health project which was to have operated in five "zones" of Cameroon). Conditions in these facilities were becoming increasingly unsatisfactory for field training, and supervision was very difficult given the wide dispersal of CUSS students. CESSI faced greater problems in this due to more limited resources.

It was agreed for PTHE to provide technical and material support to CUSS and CESSI--technical support in the orientation and supervision of the

3.3 continued

students, material support in acquisition of camping equipment and provision of supplementary vehicles and fuel. (These materials, which became the property of MOH, were later made available for other field training activities.) PTHE participated in the field training sessions of January 1980, January/March 1981, and January 1982. Nine Mefou health facilities (7-8 of them PTHE Centers) each year were selected for field placement.

UNC field staff participated in the preliminary orientation sessions for CUSS and CESSI students. A checklist for students to use in planning and evaluating their field experience was developed with UNC field assistance. Bi-weekly supervision visits to the various health facilities were carried out by UNC and CUSS/CESSI faculty. In 1980 and 1982 CUSS and CESSI students were fielded simultaneously to the same posts. In 1981 there were separate field sessions due to the unusually large fourth year CUSS class. Exact numbers of CUSS/CESSI students who participated in this training are found in the Table.

PTHE participation was greatly appreciated by both students and faculty, and PTHE training site on the whole provided a wide range of training opportunities, especially in community outreach work. The CUSS Director of Community Medicine Training spoke very favorably of the PTHE role in a letter to the Minister of Health written in 1982.

OCEAC (Coordinating Organization for the Fight against Endemic Diseases in Central Africa)

The Project Paper foresaw "intense" PTHE participation in OCEAC training activities. Until late 1980 OCEAC training consisted of regular six-month programs of training for state registered nurses (and at times lower-level nurses) proposed by the member country MOH's. Given this short duration and the program's crowded curriculum, PTHE participation was neither feasible nor solicited. OCEAC students did visit PTHE Centers on

3.3 continued

on day-long field tours, and once participated in a PTHE Committee Day at Oman, near Bikok (April 1980)

Beginning in mid-1980 OCEAC reorganized its training into a two-year epidemiology program designed for state registered nurses. An inaugural class of 20 students began their study in November 1980; seven of these students were Cameroonian, the other being Gabonese, Congolese, and Central African. OCEAC requested PTHE assistance in their training, and gave full responsibility of the health education component (three weeks of classes) to PTHE. Project technicians designed the component and actually took over the class for that period. This component included development of needs assessment/community diagnosis skills, the planning and organization of health education and staff development activities, and field work/demonstrations. OCEAC students responded well to the active training methods and practical orientation of the component. PTHE centres in the Mefou were once again used as training sites. The course design and activities are now in the OCEAC library.

ENISFAY (National Nursing and Midwifery School of Yaounde)

In the Project Paper ENISFAY was placed in a very privileged position relative to other MOH training institutions. Field training had been anticipated to occur each month of the academic year, with groups of 15 students per month, each composed of a mix of nurses, sanitation technicians, and midwives. This work plan would have required a radical reorganization of the ENISFAY curriculum and calendar--which never took place.

In point of fact, this privileged position for ENISFAY reflected the particularly positive relationship which existed between the sub-Director of Preventive Medicine and the Director of ENISFAY at the same time of the formulation of the Project Paper. A change at the Directorate, which

3.3 continued

coincided with project start-up in 1978, changed this relationship drastically. Personal antagonism between the new Director of Preventive Medicine and the Director of ENISFAY replaced the earlier cordial relationship, to the point that PTHE relations with ENISFAY barely existed. Attempts at establishing working relations failed miserably. PTHE sponsored field training for ENISFAY students never took place, nor did the yearly five-day PTHE seminars for ENISFAY faculty foreseen by the Project Paper. A small number of ENISFAY faculty did, however, participate in PTHE seminars in 1978, 1979, and 1981.

In 1981, the National School of Nursing was reorganized, and ENISFAY, which had truly been in many ways a provincial school as well as a national one, was absorbed as a part of the National Institution. Nursing, midwifery, medical technology, and sanitation technology all became separate schools of the Institution.

With the change in Preventive Medicine Directors (and therefore PTHE Project Director) in 1981, ENISFAY interest in PTHE was revived. Both the nursing and sanitation technician programs expressed interest in PTHE participation in field training exercises. Unfortunately scheduling problems ruled this out during the final year of the Project--as well as the reluctance on the part of the new Director to commit Project resources beyond June 30, 1982.

Other Institutions

Given the poor relations with ENISFAY, some attempts were made to establish working relationship with other training institutions under MOH, most of these remaining tentative until the September 1981 Coordinating Committee meeting. It was strongly recommended at that meeting that PTHE contact the MOH training institutions within or associated with the Project zones, with the objective of organizing field training for students during the final ten months of the Project. Contacts were made with the nurses-aid

3.3 continued

training schools at Mbalmayo and Abong-Mbang and with the nursing schools at Bertoua and Yaounde (ENISFAY).

Both Bertoua and ENISFAY responded positively, and each designed proposals, with assistance from UNC field technicians, for field training during 1982. In the case of Bertoua, PTHE technicians actually designed a field training program, and scheduled PTHE participation before the Project Director canceled the activity in March 1982. ENISFAY's proposal was dismissed by the Director since most of the field training would take place after June 30, 1982. Bertoua and ENISFAY train nurses in two-year programs. Responses from Mbalmayo and Abong-Mbang were received too late for consideration.

b. Outputs

PTHE involvement in the basic training of MOH personnel was to focus on the practical aspects of community health through field practicums for CUSS, CESSI, and ENISFAY students and continuing education for the faculty of these institutions. The level of expected outputs from the PTHE projects for the training institutions component was:

- two graduating classes of CUSS and CESSI will have completed field training in PTHE sites.
- one class of assistant nurses will have completed field training in PTHE sites.
- twenty professors from health training institutions will have received PTHE training.

The actual end of project status achieved was three graduating classes of CUSS and CESSI completed field training with PTHE, and seven nursing school faculty members participated in PTHE training activities. This made for a total of 232 students (66 students in March 1980, 97 students in January 1981, 69 students in January 1982) spending three weeks in PTHE health centers of

3.3 continued

the Mefou for their supervised community medicine field practicum. Of the nursing school faculty, six from ENISFAY and one from the Bertoua Nursing School had attended the five-day PTHE seminars. In-service training sessions had not been specifically designed for faculty due to obstacles already described under "Inputs."

For similar reasons, no assistant nurses from ENISFAY received any form of basic training from PTHE. However, 12 assistant nursing students from the Bertoua School of Nursing in the Kadey did participate in the in-service training sessions organized by PTHE in July 1979 for MOH personnel in the Kadey. Although the students were still undergoing basic training, the exposure to and an interaction with health workers in the field served as a positive learning experience for them.

An additional PTHE output which had not been anticipated was three weeks of basic training for 20 OCEAC students in April and June 1981. At OCEAC's request UNC field staff and their counterparts took full responsibility for the health education component of their two-year epidemiology program.

Table 6 represents the total number of students and faculty by institution who participated in PTHE training over the period of four years. It is important to note that of the 264 students, 13 are from Gabon, Congo, and Central African Republic. It should also be pointed out that students trained by PTHE represent the future physicians and nurses who will hold important positions in the MOH infrastructure at the divisional, provincial, and national levels. The potential for PTHE influence on the re-orientation of health workers in the field to be more community focused in the delivery of primary health care will be multiplied through these students as decision-makers, supervisors, and trainers. Through direct observations and practical experience in the health centers with clinical staff, itinerant agents, and

3.3 continued

the communities they serve, medical and nursing students gained both knowledge and skills needed to eventually initiate and support community participation and action strategies among health workers under their jurisdiction. The field practicum in PTHE training sites provided the indispensable field experience to complement classroom discussions of community medicine in fourth year CUSS and first year CESSI programs, and as such was highly valued by CUSS/CESSI students and participating faculty. There is every indication that this yearly activity will continue.

TABLE 6

NUMBER OF FACULTY AND STUDENTS FROM TRAINING INSTITUTIONS PARTICIPATING
IN PTHE PROJECT TRAINING FROM SEPTEMBER 1978 - June 1982

	<u>Faculty</u>	<u>Students</u>
CUSS	0	160
CESSI	0	72
ENISFAY	6	0
BERTOUA NURSING SCHOOL	1	12
OCEAC	<u>0</u>	<u>20*</u>
TOTAL	7	264

*7 were from Cameroon and 13 were from Gabon, Congo, and Central African Republic.

3.4 Primary School Component

a. Inputs

The re-orientation of this component of the PTHE is described in the discussion of the logical framework in Section 2.3. From a teacher-training orientation this component was transformed into curriculum development and development of a teacher's guide to health education in primary schools. The transformation was subsequent to proposals voiced at the PTHE Interministerial Coordinating Committee meeting of 14 December 1979.

In order to achieve this re-orientation, a National Sub-Commission for Health Education in Primary Schools was established by the coordinating Committee through active cooperation between MOH and MINEDUC (Directorate of Preventive Medicine and Directorate of Primary Education respectively). At its first meeting, 29 January 1980 at OCEAC Headquarters, the Chief of Health Education Service (MOH) and the Chief of Training Services and Pedagogical Affairs, (MINEDUC) were elected co-presidents. While membership changed considerably over time, the Sub-Commission maintained full representation of both ministries. The following objectives were set for the Sub-Commission:

- (1) establish goals and objectives for health education at the primary school level.
- (2) design a curriculum for health education based on the above goals and objectives.
- (3) develop and test a teacher's guide for primary school health education.
- (4) share the results of Sub-Commission work and experimentation with relevant services of the national government.

The entire program of the Sub-Commission flowed from these four objectives. A field tour of three divisions by a Sub-Commission team in February 1980 confirmed opinions expressed in the first meeting--that health education was not given sufficient time in the weekly program of

3.4 continued

instruction, and that health education, as presently taught, was very weak in its practical side. To complement the field study, the Sub-commission reviewed health education texts those used in Cameroun as well as others from Togo, Niger and Zaire.

Working through the month of March, the Sub-Commission developed a set of objectives, both general and specific, for health education in primary schools. It was decided, rather than to design a textbook, to produce a teacher's guide to health education with lesson plans to be tested in the PTHE Project zones. A program was designed based on them and subjects to be covered at the various levels. It was also decided, given the orientation to practical aspects of health education and the need to adapt instruction as closely as possible to real conditions, to develop the teacher's guide from the field up. Divisional committees, composed of MOH and MINEDUC personnel, would generate lesson plans from the objectives and themes laid out by the national Sub-Commission. The divisional committee, supplied with documents and working materials, would establish work teams at each grade level responsible for a set of lesson plans. It was the responsibility of the national Sub-Commission to edit the two sets (Kadey and Mefou) or lesson plans into a single teacher's guide.

At that time, health education was not a separate entity in the national program of primary education. Health was combined with civics and the subject was called Hygiene et morale, slotted for 1-1½ hours per week, broken up into fifteen minute sessions. After discussions with the Director of Primary Education (MINEDUC), an experimental timetable was established for the testing of the teacher's guide made up of once-weekly health education classes--one session of 30 minutes per week in Cours Préparatoire (CP) (second grade), and sessions of 45 minutes for Cours Élémentaire (CE) (3rd and 4th grades), and Cours Moyen (CM) (fifth and sixth grades).

3.4 continued

Divisional committees were set up in April 1980 during a field tour of a Sub-Commission team, and in each division there were orientation sessions to discuss the teacher's guide and the conditions for its testing. Each divisional committee was composed of eight members, evenly divided between MOH and MINEDUC personnel, with committee having for co-presidents the divisional Medical Officer and the divisional School Superintendent. The committees established working groups for each grade level to write lesson plans, and also selected pilot schools, four in each division, where the teacher's guide would be tested. Criteria for pilot schools were that the school must be a full six grades, be located in the same settlement or in close proximity (less than 5km distant) to a Project health center, and be associated with an active health committee.

Testing of the teacher's guide in the pilot schools was ideally to be monitored by teams for each school and composed of health and education personnel as well as a representative of the local health committee. To facilitate this monitoring, the Sub-Commission designed an observation form in August 1980 (see Appendix J). Collected observation forms for each lesson presented would be sent by the monitoring teams initially to the divisional committee for comment, and then on to the national sub-commission in Yaounde each quarter of the academic year.

It was hoped that the testing of the teacher's guide could begin during the 1980/81 school year, but this proved to be overly ambitious. Divisional work teams did not complete their lesson plans until early January 1981 due to a number of factors, including personnel changes in the intervening period. The national Sub-Commission began its synthesis of the two sets of lesson plans in mid-January 1981. The choice of organization of the synthesis work was an unfortunate one. The Chief of Health Education Service preferred an initial synthesis of each level (CP,CE,CM) by small work groups, to be followed by an overall synthesis to be carried out by an expanded committee.

3.4 continued

By mid-February 1981 the CE and CM lesson plans had been edited into single draft versions (the CP work team never finished its work). The expanded synthesis committee then began to review lesson plans with the goal of standardizing format and assuring smooth transitions from level to level. In addition, it completed the unfinished CP lessons. This final editing dragged on for months. By September, however, the final version was mimeographed and ready for distribution.

Three-day orientation sessions for presentation of the teacher's guide were scheduled in October at Batouri and Mfou with the teaching staffs from pilot schools and local monitoring team members participating. The guide was presented and discussed, a model lesson demonstrated as well as active teaching methods, and visual aid workshop organized. In addition, the testing procedure for the teacher's guide was discussed fully and practiced. By this time one additional school in each of the divisions had been named, making a total of 10 pilot schools.

Representatives from the central level of the MOH, MINEDUC, and PTHE had planned and conducted these orientation sessions in the divisions. However, the presiding officials were the divisional Chiefs of Preventive Medicine and the divisional School Superintendent with the divisional Territorial Administrative Officers opening and closing the sessions. Their presence and active involvement in the orientation not only increased the credibility of the PTHE school health component and underlined the importance of collaboration between personnel from these two ministries, but also sustained the needed level of participation from these key individuals throughout the critical experimental phase.

3.4 continued

While the system of observation sheets had been devised to aid in any necessary re-editing or revision based on classroom teaching experience, another method was needed to evaluate the impact of the teacher's guide and experimental schedule on pupil knowledge and attitude about health promotion. A simple true-false questionnaire (20 questions for CE, 30 for CM) was devised for pre-test/post-test comparison. This questionnaire and the results of testing are more thoroughly discussed in the Outputs Sections.

The Health Education Service was still processing observation sheets at the close of Project PTHE in June 1982. Responses were being tabulated on each lesson plan for any eventual re-editing. At a National Conference in School Health Education, organized jointly by MOH and MINEDUC in Yaounde in late February 1982, the teacher's guide was well-received. The Minister of Education spoke favorably of the guide and its testing in a Cameroon Tribune interview during the conference. A set of recommendations concerning health education in schools are part of the final report of that conference, still in press.

(i) Methodology and Measures

To determine the effects of the PTHE school health education component on a pupil's health attitudes and knowledge, two evaluative instruments were constructed by UNC/Chapel Hill and finalized by the Sub-Commission (see Appendix K). At the 3rd and 4th grade levels the pre-post instrument consisted of 20 true/false questions (14 behavioral, 6 attitudinal) administered by each teacher of the pilot schools to 238 CE students in the Kadey and Mefou Divisions. At the 5th and 6th grade levels the pre-post instrument was composed of 30 true-false questions (23 behavioral, 7 attitudinal) administered by each teacher of pilot schools to 315 CM students in the Kadey and Mefou Division.

3.4 continued

Thus, the total number of respondents from the four grade levels combined was 553 students.

Four pilot schools participated from each division yielding a total student population for grade levels 3,4,5, and 6 combined of approximately 1286. Thus, the sample to which the pre-post true-false questionnaires were administered represented 43 percent of the total student population for these eight schools combined.

In all cases the PTHE technicians and representatives from MINEDUC and MOH provided on-site instructions to teachers who would administer the questionnaires. Classes from each school were selected at random (if more than one class existed) within the appropriate grade level (3rd, 4th, 5th or 6th) to receive the pre-post questionnaires. Approximately 20 students were selected in alphabetical order from each grade level to receive the questionnaire. The rationale for an alphabetical selection as opposed to a random sample of students was to ensure that the same students would respond to both the pre- and post-questionnaires, thereby providing greater reliability of the measurement instrument.

In terms of the process by which the questionnaires were administered, it was by and large the same throughout the eight schools. However, within three of the 28 classes participating, teachers were found to have influenced students on the pre-test as to how they should answer particular questions. These three classes were eliminated in the data analysis of the school health questionnaires as was one other class which failed to administer the post-questionnaire. Thus, 24 classes of approximately 20 students each were administered the pre- and post-questionnaires yielding a total study population of approximately 480 individuals.

3.4 continued

(ii) Findings

It was hypothesized that once a baseline measure of health behavior and attitudes was established through the pre-questionnaire, all students would demonstrate more positive attitudes toward and a greater knowledge of health promotive behaviors after having completed 7 months of the school health education program. By obtaining the mean number of correct responses to questions on the pre- and post-questionnaires, analyses were performed to determine the significance of a positive increase in mean correct response (using .05 as the level of statistical significance). Thus, the test of hypotheses would assume the form:

$$H_0: u_1 \geq u_2$$

where u_1 = mean correct responses to the pre-questionnaire

$$H_1: u_1 < u_2$$

u_2 = mean correct responses to the post-questionnaire

As shown in Tables 7 and 8 a statistically significant increase (.005 level one-tailed test) in mean correct response was demonstrated by students at all four grade levels in both the Kadey and Mefou Divisions.

Further analysis revealed that within divisions (Table 9) two schools, Trypano and Mfou, demonstrated significantly positive increase in mean correct responses. This may be explained in part by the fact that Trypano and Mfou schools are located in semi-urban districts within the Kadey and Mefou division, respectively. Semi-urban areas would perhaps provide a larger population of students exposed to promotive health attitudes and behavior than in poorer, less well-educated rural areas.

Table 7

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

Test	Number of Classes	Mean	SD	t-Value	df
Pre-	11	278.81	105.95		
Post-	11	316.27	123.61	-3.97 ^a	10

^aSignificant at the .05 level for one-tailed test.

Table 8

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

Test	Number of Classes	Mean	SD	t-Value	df
Pre-	13	306.61	77.67		
Post-	13	350.36	81.70	-5.41 ^a	12

^aSignificant at the .05 level for one-tailed test

Table 9

Difference between mean of Correct response and a Health Questionnaire Administered to 3rd, 4th, 5th, and 6th grades students Trypano and Mfou

School	Test	Number of Classes	Mean	SD	t-Value	df
Trypano	Pre	5	305.40	122.83	-2.97 ^a	4
	Post	5	356.40	147.46		
Mfou	Pre	6	317.50	86.75	-4.59 ^b	5
	Post	6	342.00	94.85		

^aSignificant at .05 level one-Tailed test.

^bSignificant at .05 level one-Tailed test.

Table 10

Difference between means of correct responses and a Health Questionnaire administered to students in 3rd, 4th, 5th and 6th grades at eight schools within the Kadey and Hefou Divisions

Grade	Test	Number of Classes	Mean	SD	t-Value	df
3rd	Pre	5	224.00	66.46	-1.69 ^a	4
	Post	5	242.60	70.32		
4th	Pre	4	257.25	16.46	-1.52 ^a	3
	Post	4	278.75	14.73		
5th	Pre	6	324.33	113.38	-2.97 ^b	5
	Post	6	369.16	139.03		
6th	Pre	9	328.67	86.78	-7.45 ^b	8
	Post	9	361.44	79.45		

^aNot significant

^bSignificant at .05 level one-tailed test

results from this study could be construed as being spurious and not resulting from the treatment effect of the school health program per se. However, because a control group of schools was requested from MINEDUC and denied, the present results represent the best data available, given the administrative and political constraints present in Cameroon, of a novel health education program developed for a selection though representative group of Cameroonian schools.

In addition to the above constraints, and in considering the short length of time in which the program was implemented and evaluated (7 months), positive results, however preliminary, indicated a clear positive movement in health attitudes and knowledge.

The cumulative effect of this positive movement over time, for example from grades 3 to 6, would enhance and sustain the adoption and integration of health promotive behavior and attitudes among students as they progress through school. The overall high post-test scores of students in all grades within the pilot schools would also indicate probable diffusion to other students within the schools would also be carried by those students receiving the program to their homes, thus extending the effect of the PTHE school health program to the community at large.

3.4 continued

Beyond any such set of results, the experimental teacher's guide played an important role in the MINEDUC technical sessions on the national reform of primary education according to two national Sub-Commission members who were in attendance. The Vice-Minister of Education, presided over these policy-setting sessions. Copies of the guide were circulated at the meeting and the experimental program, timetable, and lessons were thoroughly discussed. The MINEDUC National Reform Commission subsequently officially opted for 30-minute health education slots for all three levels, CP - CE - CM, with once weekly sessions for CE and CM and two 15-minute sessions per week for CP. Furthermore, health education/hygiene would no longer be combined with civics in the curriculum. The classes would be devoted entirely to health education.

Questions remain however: What are the possibilities of further testing of the guide, of eventual translation into English, of a more finished version with illustrations, of the production of a pupil's text to complete the teacher's guide? Nonetheless, the level of enthusiasm among primary school teachers, students, parents and MINEDUC officials remain very high. The future of the national Sub-Commission, created out of PTHE, will be clearer once the final report of the National School Health Education Conference is published, and its recommendations officially reviewed by the Ministries of Health and of Education respectively.

The development of this teacher's guide for health education in primary school benefitted from solid and steady collaboration between MOH and MINEDUC personnel from field level up to ministerial level and signified the first time for these two ministries to work together. The process also successfully integrated inputs from MOH, MINEDUC, USAID, Peace Corps and UNC.

3.4 continued

For that alone, it was a very positive experience in Cameroonian development efforts. Health workers and teachers alike strongly expressed their desire to continue this collaborative relationship by attending each other's conferences and workshops in the future.

Where this collaboration suffered slightly, however, was in the area of linkage between the school program and the community organization efforts in Project zones. Widespread, firmly established attitudes that primary schools are "government" as opposed "community" structures have blocked progress here--the pilot schools being somewhat exceptional. Contracts tended to be between IA's, PCV's, and other health staff, rather than between village committee members and school directors/teachers. School health committees, as complementary structures, to village health committees, have only begun to be organized -- and almost exclusively at PTHE pilot schools.

Part of this problem, in conceptual/operational terms was unwarranted confidence in the roles of local PTA's as catalysts toward effective linkage between schools and health committees, due to interlocking PTA-health committee membership. PTA's (Associations des parents d'eleves) are not officially recognized by MINEDUC. Their roles and functions thus are not well defined and vary widely. In addition, PTA's in the Kadey and Mefou remain generally at a very low level of development. Given this state of affairs, it is clear why links were not easily established.

Beyond this, IA's, especially in the Mefou, were rarely comfortable with school health aspects of their work load due to sensitivities concerning their own low levels of formal education. Most gave school health a relatively low priority or where possible handed responsibility for it over to PCV's. Nurses aides, generally, were more interested and more effective among the IA's in this role.

3.4 continued

As a tactic in the strategy of community organization in PTHE, the linkage has solid argument backing it. The problems encountered were very practical ones at the level of implementation. Field worker ability aside, lack of supervision/encouragement at divisional level (once again, with this exception of pilot schools) weakened local efforts. The best results from school health committees could be seen in Binguela and Kambele - communities whose VHC's were not active. In these cases success was due more to highly motivated teaching staffs than to community participation or encouragement. It is interesting to speculate how in these special cases the school health committee could serve as a model and encouragement for a moribund village committee.

3.5 Audio-Visual Center

In the original Project Paper and logical framework, no mention was made of an audio-visual aid production (A-V) center. USAID agreed to supply production materials for such a center, attached to HES, after subsequent talks, and the center was appended to the revised logical framework of 1980 as an output. UNC had no technical role to play in this area. If ever the A-V center had become functional during the life of PTHE, no doubt the UNC field team would have worked to harness the center, at least initially, to Project needs.

On the basis of this addition to the Project, Peace Corps agreed to provide an A-V specialist to assist HES in the organization and development of the center (basically a production workshop), as well as to assist in the training of Cameroonian personnel who would operate the center after this initial phase. In point of fact, two A-V specialist volunteers worked with PTHE and HES: from April 1978-May 1980 and from April 1981-June 1982. Both worked on receiving and cataloguing materials sent by USAID for the center, and in addition provided other services to HES as needs arose. The first PCV helped design the initial plan for the center.

The first PCV was never assigned a counterpart: the two slots described in the revised log frame--an A-V specialist and an artist/designer--were never filled by the MOH counterparts during his term of service and became one of the reasons for which he chose not to extend despite his earlier intentions to do so. After some months of search, a second PCV was recruited as a replacement. He also remained without counterpart for ten months. In February 1982, four unskilled clerks were recruited by MOH and assigned to HES, as trainees for the A-V center. This number dwindled to two by April, and the PCV was given responsibility for their training. However, the PCV terminated his service in June 1982 because of chronically poor relations with the Chief of HES and his own pessimism involving prospects that the A-V center would become functional before the end of his

3.5 continued

tour of service. In short, he felt that he could not effectively serve in his assigned capacity.

Much of the frustration was due to the slow progress in implementation by MOH which was interpreted by some persons as lack of support. As finally devised, the MOH plan for housing the A-V center was to build a small office on land adjacent to the HES in order to free-up space in the HES building occupied by the Sanitation and Public Hygiene Service. With the departure of the Sanitation Service, the HES block would then be renovated along the lines of a dark room and silk-screening facilities, library and cataloguing rooms, and storage for materials. This office building was completed in mid-1981 and shortly thereafter occupied by Sanitation and Maternal and Child Health Services. However, upon completion of construction of the new building, the contractor balked at beginning renovations of the HES block, claiming that the renovations were not in the construction contract and thus not included in his bid. Thus, in late 1981 another call for bids on the renovation work was made. More funds were needed and the administrative process of committing funds and awarding contracts dragged for months. In June 1982, work began on the HES renovation for the A-V center. A projected date of late October 1982 for completion was given. MOH had funded both the new office space and the renovation out of its financial participation in PTHE (fiscal 1980-81, 81/82).

Beginning in early 1979, materials began arriving in Douala from USAID--photographic equipment (film, paper, enlarger, cameras, dark room equipment), silk-screening equipment, poster paper, and art materials--to be transported by MOH to Yaounde. By early 1981, all materials to be sent in this original order had arrived in Douala, thus accounting for the bulk of the \$93,000 material/equipment line in the PTHE budget. Unfortunately, due to delays caused by the paperwork process of getting the materials

3.5 continued

out of Douala (and then from Yaounde airport to MOH), some of the shipment was damaged or destroyed, including a shipment of photographic chemicals and dyes which were destroyed by fire at the port in Douala. Meanwhile in Yaounde, HES had no appropriate place to store the shipment. Temporary storage space near the Central Pharmacy did not protect material from heat and humidity (or rain, for that matter). As might be expected, much of the photography material (film, paper) was beyond expiration date. Silk-screen dyes had dried out while still stored in their tins. A list of materials for re-order and as a complement to the original supply order was written up by the two PCV's. It was decided, prudently, by USAID not to act on the new order until appropriate storage facilities were available.

As stated earlier, PTHE had no real technical role to play in the development of the A-V center. Vehicles from the field office were used now and again to transport freight from Yaounde airport to MOH, or to drive HES personnel round the MOH-Customs--Ministry of Finance circuit in the pursuit of documents. At the May 1981 PTHE seminar, field workers (IA's, PCV's, CD agents) were polled on their A-V needs and preferences by the PCV for HES. It was hoped that the results would be used in orienting future A-V production.

The bottom line is, however, that from 1978 to 1982 and at this writing no A-V center exists. There is no point in speaking of its functioning. While personnel have been recruited for the center, they are unskilled, and presently no longer have someone to train them. Obviously, no management system has been developed for the A-V center, and only one poster was produced by the PCV using the materials and equipment available to be set up on a temporary basis in his office.

Chapter 4

MANAGEMENT ANALYSIS

4.1 Roles and Responsibilities

a. United States Agency for International Development

1) USAID Technical Roles and Responsibilities

USAID had three important technical responsibilities to the Project. They were:

1. to procure the 141 person/months of long-term and short-term technical assistance to the MOH.
2. to advise the MOH Project Director on policy matters.
3. to conduct the mid-project evaluation.

In this section they are dealt with separately.

Technical Assistance

To assist the MOH in implementing the goals and objectives of PTHE, USAID contracted with the University of North Carolina at Chapel Hill for long-and short-term technical assistance to the MOH under USAID contract afr-c-1432 which was signed by USAID and UNC in June 1978. UNC provided 133 months of long-term technical assistance, and 26 months of short-term technical assistance for a total of 159 months of technical assistance in the four year period.

However, USAID/Y had signed the Project Assistance Agreement with the MOH (PROAG) in July 1977 which named October 1, 1977 as the start date for Project PTHE. All other donor agencies began project activities on or about that date. The Peace Corps had already placed 5 volunteers in the Kadey as early as March 1977 and by March 1978 the Peace Corps had placed 12 volunteers at their posts. UNICEF had its motorcycles in the field and the MOH had already assigned counterparts to the volunteers. During the

4.1 continued

one-year delay between USAID's signing of the technical assistance portion of the Project, USAID/Y hired a technician through a personal services contract. Her duties were primarily to maintain lines of communication between the donor agencies and the Peace Corps and MOH personnel already in the field, and to provide orientation/technical supervision to the volunteers. There were not, during this time, effective links between the MOH and activities in the two pilot zones since the MOH had not yet named its project personnel at the ministerial level. The reason was that USAID had not delivered its promised project funds to the MOH, and did not, until April, 1979.

UNC's early efforts at providing technical assistance to MOH experienced early instability both in Chapel Hill and in Yaounde. This was due to the resignation of one of the members of the field party and the somewhat extended period required to bring the field party back to its full strength. From January 1980 through June 1982, however, the UNC field party remained stable. See Section 4.3 for more detail.

Policy Advice To Project Director

While the Interministerial Coordinating Committee had the responsibility of advising the Minister of Health on policy matters regarding the Project, it never in point of fact, functioned effectively in that role. USAID was represented on the committee, and it was initially expected that the Committee would be the mechanism through which USAID technical input to the MOH would be transmitted.

This rather formal and indirect line of communication could never have sufficiently responded to Project needs. As the Minister of Health's designated representative in the Project, it was the Project Director who was the direct link between the Minister, the Project, and USAID. And it

4.1 continued

was in this line that confusion over roles, and reluctance to establish direct contact, conspired drastically to limit the exploitation of this means to resolve outstanding policy issues. USAID-Yaounde often preferred to limit direct communication with the Project Director to standard formal texts, while seeking to communicate through the UNC field team on immediate questions in less formal terms. The Project Director, sensing that direct personal contact with USAID was seemingly not encouraged, also avoided such contacts except in cases of absolute necessity. Because of this, the MOH remained only vaguely aware of USAID guidelines and practices, and very wary of seeking contacts and negotiations to resolve operational questions. The depth of these mutual misunderstandings - MOH of USAID, and USAID of MOH policy - was painfully clear during the USAID/MOH negotiations in April 1980 concerning logical framework modifications and administration policy within the Project.

With the arrival of a more experienced Project Manager at HNPO in January 1981, this situation improved steadily. However, the first two years of problems in the domain were difficult to overcome. It was difficult to dispell Project Director(s)'s perceptions of USAID as a shadowy and somewhat threatening presence in PTHE communication through direct contacts. A better understanding of USAID policy by Project Directors would have assured a more workable and productive grantor/grantee relationship between USAID and Project Directorate as well as between USAID and MOH, wherein directives would not have so often seemed arbitrary, unilateral, and unexpected.

Mid Project Evaluation

The responsibility of conducting the mid-project evaluation was that of USAID/W (AFR/DR) and was coordinated by PTHE's Technical Monitor at that office.

4.1 continued

The evaluation team was headed by a consultant selected by AFR/DR who collaborated with an MOH designate (from the Directorate of Statistics and Planning) and a USAID designate (from the organization of Dutch Volunteers).

The evaluation came 6 months prior to the project mid-point and used data that was at most 12 months old. However, the timing of the evaluation seemed appropriate, in that it left the MOH, UNC and USAID with a generous amount of time with which to implement many of the evaluation recommendations.

UNC was satisfied that the evaluation was thorough and impartial. Its summary of recommendations is presented in the Appendix.

Following the evaluation, USAID followed some recommendations by amending the UNC contract so that the UNC technicians were no longer responsible for the accounting of the MOH administered training funds: the USAID/Y Project Manager assumed that responsibility. USAID also assigned a project manager who remained at post for the final two years of the project. USAID also requested UNC to initiate the recommended socio-anthropological study of the Kadey. However, the recommendation to revise the logical framework and to amend the project agreement accordingly was not followed.

(ii) USAID Administrative Role & Responsibilities

There were three USAID offices involved with the Project throughout its existence. They were:

- Office of Health, Nutrition, and Population/Yaounde
Key Person--Project Manager
- Office of Development Resources for Africa, Washington, D.C.
Key Person--Technical Monitor
- Office of Central Contracts, Roanlym, Virginia
Key Person--Contracting Officer

4.1 continued

The P.P. allocates a limited administrative role to USAID. Overall, administrative responsibility was to be with the MOH Project Director although UNC was expected to provide strong management and administrative skills in support of the MOH in project administration. UNC, however, was charged with being responsible to USAID for on-going daily project management. Other than limited logistical support to UNC, USAID had no formalized administrative responsibilities.

USAID's administrative role was nonetheless quite strong throughout much of the project, and was particularly strong during the project's start-up period. The USAID Mission Director in Yaounde was highly supportive, and quite innovative during the early difficult months of the Project described below.

On May 16, 1978, there was a pre-contract conference in Washington, D.C., which was attended by campus personnel, the USAID/W contracting officer, and the USAID/W Technical Monitor. USAID told UNC that a budget of \$1,900,000 had been authorized for the UNC contract and requested UNC to submit a cost proposal. UNC prepared the cost proposal which was accepted by USAID and on June 7, 1978 UNC was awarded a contract for \$1.9 million. All three technicians were in Yaounde by July 6, 1978. The campus coordinator, arrived in Yaounde on June 27, 1978, and carried a copy of the UNC contract. USAID/Y discovered that all of the funds earmarked for the project had been erroneously placed in the UNC contract by USAID/W whereas USAID/Y had intended that approximately 1.4 million would be the amount of the UNC award; approximately .5 million should have been awarded to the grantee which was the Ministry of Health.

At the Project start date, September 1, 1978, the following conditions existed:

1. The MOH had a formal agreement with USAID, but had not received its grant. Thus the counterparts to the UNC team could not be officially named.

4.1 continued

2. UNC had an additional .5 million dollars which, due to the wording of the contract, could not be spent on the activities the money was intended to support.
3. The UNC field team needed to begin project implementation and to spend contract money on the project expenses.
4. USAID/Y was initially unwilling to proceed with the amendment process, believing that USAID/W was somehow in error, and could or would correct the mistake immediately.
5. USAID/W requested UNC to submit a new cost proposal in October 1978 for \$1.4 million. UNC did so within two weeks and following initial review of the new proposal by USAID/W-contracts, there was a conference in Washington which was attended by the USAID/W Technical Monitor, the USAID/Y Mission Director, and UNC representatives. The new proposal was quickly accepted in principal, but it was not until March 1979 that USAID modified UNC's contract proposal with a budget of \$1.42 million.

It was during this start-up period (June 1978-April 1979) that the USAID/Y Mission Director necessarily played a strong and supportive administrative role with the project, working closely with all parties to get the project underway.

This early involvement by USAID/Y consumed considerably more USAID staff time than had been anticipated in the project paper; and resulted in USAID's playing a much stronger role both in policy and in management than had been foreseen, at least until the mid-project evaluation had been completed. The early months of the project saw a great deal of conflict between the parties, as might be expected, while negotiations between Chapel Hill, Yaounde, and Washington dragged on endlessly. But while there was conflict, there was also very close interaction. The result was that three disparate organizations - USAID, UNC, and GURC learned to work

4.1 continued

together somewhat. For example, USAID permitted a considerable amount of travel during the project's early months. The MOH Project Director and the Chief of the Health Education Service all visited Chapel Hill within the first year of the Project and UNC's Campus Coordinator, Associate Coordinator, and Administrative Officer visited Yaounde. UNC's Chief of Party was able to visit the Office of Central Contracts and AFR/DR. The visits gave all parties a much keener understanding of both the resources and constraints of each other.

The Office of Development Resources' administrative role in the project, if any, was not apparent to UNC. However, the AFR/DR technical monitor's office is the repository of all project reports, and during the project life, AFR/DR's technical monitor was always accessible to UNC. He often provided the campus office with useful administrative advice, and at all times demonstrated helpful interest and concern over project activities.

The Office of Central Contracts had the responsibility of enforcing USAID regulations. Throughout the project, all requests for travel, consultation, and personnel changes required written authorization from this office. This office, like AFR/DR, was usually responsive and helpful to UNC's requests, once a clear, mutual understanding of roles was established.

(iii) Comments

UNC has never clearly understood the reason behind the delays in project implementation discussed in the Administrative section, and so without this information it would be unfair to state that the delayed implementation is a deficiency on the part of USAID. It should, however, be understood in the beginning, all of THE Project funds were erroneously included in the UNC contract. The effect of this on the MOH's relationship with USAID has not been evaluated but it did cause an undue amount of emphasis on money in the beginning.

4.1 continued

A second USAID deficiency was its staff instability throughout much of the project. During the four years of the project there were three Chiefs of HNPO and five Project Managers. The Chief of HNPO, who had coordinated the writing of the Project Paper and negotiated the Project Agreement, left Yaounde the month before the field operations began. During the first year of the Project, while it was experiencing considerable start-up problems, there was no HNPO at all, when leadership was needed the most. Instead, there were three project managers at that time, one of whom was a state department intern. The HNPO Chiefs and Managers each had markedly varying perceptions of what the Project was intended to accomplish.

A third deficiency was the relationship between USAID and the MOH. USAID's daily contact with the Project was through the UNC technicians. When USAID did communicate directly with the MOH Project Director, it was often without prior consultation with the UNC team. As a result, there were often misunderstandings.

An example was the question of honoraria and per diem for MOH personnel and other UNRC personnel. Honoraria and per diem were occasionally allowed by USAID and were occasionally not allowed. This particular issue was never satisfactorily settled and always appeared to be determined by the personal perceptions of the project manager at the moment. Thus, the MOH Project Director never appeared to his colleagues to be in very much control of the Project.

b. Ministry of Health

Primary responsibility for the PTHE Project could only be assumed by MOH, and this is clearly stated in the Project Paper. MOH was to provide "overall Project direction," and "MOH personnel for training." In the original design, the Minister of Health or a designated representative would assume responsibility for the Project through an interministerial Coordinating Committee composed of representatives of MOH services, other ministerial departments, and various agencies involved in PTHE (including USAID). In addition, the Minister was to name a Project Director, responsible for direct supervision of Project staff and activities, and who was to serve as President of the Coordinating Committee.

Behind this, MOH was to provide three technicians to the Project, just as there were to be three USAID sponsored technicians from UNC. At the Kadey and Mefou divisional levels, the Preventive Medicine Section Chiefs and their assistants were to serve as project coordinators and supervisors respectively. At field level, the entire corps of health personnel in the two divisions were also seen as the MOH contribution to PTHE, although among health personnel PTHE activities were often seen exclusively as the responsibility of itinerant agents.

In the Project Paper specific responsibilities were defined for the Minister, the Coordinating Committee, and the Project Director. However, no specific responsibilities were assigned to the others - neither the MOH technicians (counterparts), divisional level coordinators and supervisors, nor itinerant agents. Job descriptions were drafted at various times for the latter three functions, none of which carried the necessary authority to define roles, and the counterpart role continued to be only indirectly defined by the roles assigned to the UNC field technicians.

Specifically then, the Minister of Health (or his designated represented) was to assume overall responsibility for establishing policies

4.1 continued

regarding project activity. The Coordinating Committee was to have the major responsibility for advising the Minister on policy matters regarding aspects of the PTHE project, and to report, through its president, directly to the Minister. The Project Director, a "staff" person designated by the Minister, was to implement and coordinate the project with direct supervisory responsibility for the technician staff, and serve as president of the Coordinating Committee.

Obviously, not all of the responsibilities or functions were, or could be, made explicit in the Project Paper, and implementation brought modification of even those made explicit. In the case of management of Project funds specifically, the Director of Project, created a post in his office of financial assistant which was filled by a Ministry of Finance personnel.

As the Project evolved, roles and responsibilities changed in their operational expression. The Minister of Public Health named the Director of Preventive Medicine as Project Director in 1978. In early 1979, two MOH technicians were named as PTHE counterparts--the Assistant Chief of HES for community organization, and the Assistant Chief of Training and Continuing Education Service for training. No third technician was ever named. Divisional coordinators were named in late 1978. While there were itinerant agents working in Project areas even before actual Project start-up, they were not officially named until December 1979 by ministerial service note.

Formal organigrams reflect, at best, a desired design of management, supervisory and communication lines. The specific role descriptions and definitions of responsibilities fare little better. In operation, the MOH technical and administrative roles took very different forms in contrast to the Project Paper design.

4.1 continued

The role of the Minister (or his designated representative) could probably never have been detected from observation of PTHE over its four-year life. In practice, this role became confused with and subsumed in, the role of Project Director. It can be said that over time the Minister had exceedingly little direct contact with PTHE--much less an active role to play.

The Coordinating Committee, which by consent, was to meet every six months subsequent to its first meeting April 26, 1978, finally met but three more times during the Project. As it was organized, it was a very unwieldy advisory board: there were officially 35-40 members representing various levels of GURC ministries and MOH services, as well as associated agencies. Often these designated members sent delegates in their place, which led to reluctance to discuss policy and extremely cautious behavior relative to commitments to PTHE. (Distribution of progress reports well in advance of the meetings seldom met its objective of reducing presentations and increasing informed discussion.) Thus, Coordinating Committee meetings served rather to inform members of Project activities, past, present, and future. Very little policy review and recommendation came out of the Coordinating Committees, with the notable exception of the Primary School Health Education Sub-Commission proposed at the second meeting (December 1979).

In point of fact, the MOH team--director and technician staff--generally viewed the Coordinating Committee as an encumbrance, an intrusion on the administration of the Project. Few, if any, members of the Coordinating Committee resented this limiting of their role, and little was done to combat the loss of an active role in PTHE policy-making. Other factors conspired against regular meetings even on a semi-annual basis, and thus, after the third scheduled meeting (May 29, 1980) only one other took place on September 3, 1981.

4.1 continued

And so MOH technical and administrative responsibilities at central level became strongly concentrated in the Directorate of Preventive Medicine. This in itself would not necessarily have been an unfortunate turn of events, but this concentration assured that PTHE, administratively and politically within the MOH, would rise or fall with the fortunes of the Director of Preventive Medicine--that his relationship to the Minister, to other Directors, and to the Preventive Medicine Section Chiefs, would determine his success in coordinating PTHE activities. And this real personalization of the management of PTHE was several times magnified in the perceptions of PTHE shared by MOH functionaries outside of the Project.

This real, and perceived, personalization led to strained relations with the Chief of HES, the Director of Health Services, and the Director of ENISFAY. The Chief of HES felt that he was excluded, as in fact he was for most of the 4 years, from PTHE planning, programming and activities, and that his assistant, the community organization counterpart, made little effort to inform him of Project operations. Antagonistic relations with the Director of Health Services and Director of ENISFAY severely limited cooperation with such crucial services as Training and Continuing Education (despite the presence of a PTHE counterpart) and Nursing Care, and virtually ruled out the ENISFAY component of the PTHE training program (as detailed in the original log frame). The change in Directors in March 1981 did little to change the image of PTHE within the MOH, which was already well-established.

Indeed, despite fairly strong ministerial support, especially following the Presidential Cabinet shuffle of mid-1980, PTHE was unable to benefit fully from this support due to the deteriorating Director-Minister relationship. A change at the Directorate had been rumored since the naming of a new Minister of Health. During the interim the Director became increasingly timid, and PTHE rarely entered into his discussions with the Minister.

4.1 continued

The new Director assumed office in an atmosphere of criticism of his predecessor's coordination and management of bi-lateral projects. Given this state of affairs, it was not unexpected that he oriented himself more towards a role of close monitoring and conservative policy-making, as opposed to one of forward-looking dynamism. Unfortunately, at that point in the life of PTHE (the second half of its third year), the transition to full GURC responsibility for Project continuation and extension should have been a priority, and as such would have required active participation by the Director in innovative PTHE policy-making.

These same problems received another expression at the level of counterparts (MOH technicians). The naming of a counterpart for training became a theater for struggle between the two directorates (Preventive Medicine and Health Services), as the Training and Continuing Education Service is in the Directorate of Health Services, yet it was the Project Director (Preventive Medicine) who was to propose the technicians. Thus in four years three different technicians served as training counterpart.

In the case of the community organization counterpart, a different set of problems arose. The technician, with a doctorate in public health, was not at all convinced of the effectiveness of community organization as a health education strategy, and once named, functioned rather as the Director's "eyes and ears" in the Project, with decision-making power far beyond the technician's role. He was not ineffective in this role (although the community organization program suffered for it) given his close relationship to the Director and Minister. The changes of 1980 and 1981 brought an end to this influence and power, and by August 1981, he formally resigned from PTHE. No technician was ever named to replace him, as the acceptance of his resignation by the Minister never occurred. And so the UNC community organization technician remained without a counterpart during the

4.1 continued

entire final year of the Project. The Chief of HES, who initially replaced his assistant as the new Director's closest advisor on PTHE, successfully argued against the counterpart role, preferring an integration of PTHE into his service. In March 1980 a midwife with some public health training, newly assigned to HES, was given responsibility for community organization activities in the Service. In the final analysis, the community organization program of PTHE received very little MOH technical input from central level during the fourth year of the Project, a crucial year for assuring continuity and diffusion.

At divisional level, MOH technical input and management was steadier despite changes in personnel, some confusion over roles, and logistical problems for supervision. By mid-1981, the Kadey division had organized its own distribution system of monthly allowances for fuel and minor repairs for itinerant agents and PCV's, and a regular schedule of supervision was set up. The reassignment of the Divisional Project Coordinator in January 1982 out of the Project zone disrupted the supervision schedule, which was never re-established. It is worthy of note that a UNICEF-donated Land Rover, to be used by the Preventive Medicine Section Chief, became unusable for supervision purposes after a year, and from 1979-1981, the section chief was basically without transportation. A UNICEF motorcycle, donated to the assistant chief, the Project supervisor, was rarely used for supervision purposes while it was in good repair.

The Mefou faced similar difficulties in logistical terms, and no regular schedule of supervision was ever established. Unlike the Kadey, the Project supervisor was not given a motorcycle and a UNICEF Land Rover, promised in 1978, never found its way to Mafou. A well-worn Land Rover was assigned to the Preventive Medicine Section in late 1981.

4.1 continued

In both divisions, Preventive Medicine staff, especially the Project coordinator and supervisor, enthusiastically participated in PTHE training activities and actively contributed to training designs as their skills increased. Changes in personnel at divisional level, and the virtual freeze on PTHE training activities during the second half of 1981, conspired to block the steady progress made in decentralizing the design and organization of in-service training activities down to divisional level. The enthusiasm, and growing abilities, were not lacking. A five-day session planned, organized, and designed by the Kadey divisional section for late November 1981 was cancelled at the last minute due to administrative problems at the provincial level; the subsequent reassignment of the Project coordinator made rescheduling all but impossible.

Field level performance, in technical and management areas, varied according to several factors. Performance measures are more thoroughly evaluated in Chapter 3. The contributions of CUSS-trained doctors at Esse, Ngoumou, and Ndelele were particularly noteworthy, as were the day-to-day efforts of the itinerant agents, often under difficult physical and administrative conditions.

One cannot overemphasize the importance of a solid support system, from the field up, for this kind of public health activity. And it is indeed in this area that one finds a regrettable weakness in MOH management and technical input. From provincial level upward support for PTHE field activities was often fragmented, irregular, and poorly articulated. The strong message of ministerial support did not filter down, nor did it often find material expression. This became clear in lack of response to expressed needs and to reports, little or no positive feedback on local accomplishments, and long delays in following up on promises of material or technical support. Certainly few bureaucracies could receive high

4.1 continued

marks in this subject of responsiveness, but the situation in PTHE changed little despite much discussion of these problems at quarterly evaluation meetings and at national seminars.

4.1 continued

c. UNC Field Office/Yaounde

Technical and administrative responsibilities of the UNC field office must be viewed from two angles--responsibilities toward MOH and USAID, as stipulated in the Technical Assistance Contract, and toward UNC/Chapel Hill, as the PTHE home base office.

The Technical Assistance Contract specified eight basic activities for UNC;

- (1) Develop an appropriate operational framework for the major participating agency to plan, carry-out and evaluate the practical system of health education activity.
- (2) Develop and implement organizational and training programs for formation and support of village health committees.
- (3) Develop and implement practical training of health education at the university level.
- (4) Develop and implement an in-service training program in health education for current health workers.
- (5) Develop and implement health education component training programs for new health workers.
- (6) Provide health education training for workers from other sectors.
- (7) Provide an evaluation strategy for the entire project.
- (8) Keep accounts of expenditures of all training provided under this project and submit to RDO/Yaounde the necessary vouchers.

One might add to these the submission of required reports. These formal responsibilities, the discussion of which are the substance of this final report, are joined by another set of responsibilities expressed in terms of specific tasks for the technicians and Chief of Party. It is these responsibilities and accompanying roles which can be discussed in this section.

Job descriptions as found in the Project Paper often find operational expressions which differ significantly from the original design.

4.1 continued

For the two technical field positions, health education/training specialist and health educator/community organization specialist, the differences were relatively slight. In both cases, the actual roles played evolved from the direct supervision and coordination role described in the Project Paper to much more of a technical support role, with the responsibilities of supervision and coordination increasingly in the hands of MOH personnel. This was consistent with the doctrine that PTHE was an MOH/USAID Project for which UNC provided technical assistance. However, responsibilities were added to the list as field conditions required. Notable among these were administrative ones related to the keeping of training expenditure accounts and to transport/logistics.

The requirement to keep accounts of expenditures of training funds, for submission to the USAID Resource and Development Office, seemed to run counter to the premise of PTHE being an MOH project. And yet due to this requirement on UNC field staff, MOH did not develop its own system of accounting for these funds until mid-project. Thus, the UNC Training Technician, virtually alone, was obligated to manage the PTHE training funds. As MOH took more responsibility and once a new financial management system was developed, this responsibility gradually disappeared from her list. But initially this function absorbed a large amount of technician time. UNC contracts office was strongly opposed to assumption of this role by UNC staff and, on reasonable notice to AID and MOH, ordered UNC personnel not to continue these responsibilities.

While provision of motorcycles by UNICEF was foreseen in the Project Paper, no system of fueling and maintenance had been planned either by USAID or MOH. Thus from start-up until October 1980, the UNC Community Organization Technician was obliged to manage the USAID ad-hoc funded system--including scheduling of bi-monthly refueling (delivery of fuel to health

4.1 continued

centers), establishing fuel allotments, storing and distributing UNICEF--donated spare parts, and reimbursing repair bills submitted by field workers. Once again, MOH took over these responsibilities but not before they had taken up a significant amount of technician time.

The Chief of Party role certainly manifested the greatest variance between the Project Paper description and actual operations. Technical aspects--planning, development of research activities, evaluation, and indeed technical assistance--became overwhelmed by administrative ones. In addition to managing the UNC field office, as foreseen, the Chief of Party was forced to take on other administrative responsibilities, including the financial one of ultimate responsibility for PTHE funds: the Chief of Party was signing checks and monitoring Project funds through the UNC bank account. This was contrary to UNC faculty regulations, and was discontinued in 1980, but only after UNC forced the hand of MOH in taking responsibility. Liaison activities increasingly crowded out technical ones; the Chief of Party assumed liaison roles not only between UNC and USAID, and between the Director of Project and the Coordinating Committee, but also between the Project Director and USAID. As it became clear that the local hire bookkeeper could not be trusted, the Chief of Party also took over that role, for all practical purposes.

Through all of this, these expedient and necessary, but often inappropriate, activities detracted from technical support efforts. Beyond that they conspired to further muddle the image of PTHE management, leading to confusion in roles between Project Director and Chief of Party, and between MOH, UNC, and USAID.

But as the months passed, MOH assumed more responsibilities, and roles were sorted out in the wake of the mid-project evaluation, the field office was able to devote much more time to technical support activities.

4.1 continued

Consultations increased and the sphere of Project influence grew: technical input was provided for MOH provincial training seminars, for Peace Corps training, for the OCEAC epidemiology program, for the CD Eastern Province seminar, for Social Affairs animatrice basic training program at Betamba, and for the National Conference on School Health Education (these in addition to regular PTHE training and supervisory activities). UNC field office was also requested to provide technical assistance to the Catholic Relief Service North Cameroon Rural Health Education Project and to CARE programs in the Margui-Wandala, in the areas of training activities and evaluation design. MOH, through the Training and Continuing Education Service, received technical assistance from UNC field technicians in its reformulation of the nurses' aide training curriculum. All of these in addition to more informal consultations with primary school teachers, CD agents, OCEAC students, ENISFAY instructors, and other MOH personnel. Many of these activities are more fully discussed elsewhere in this report (see sections 3.1, 3.2, and 3.3).

Deficiencies, almost all of them in the administrative sphere, were not lacking and were pointed out, although at times unfairly, in the Contractor Performance Evaluation Reported (CPEER). The first such report covering the period from July 1978 to July 1980 gave negative ratings in the areas of "responsiveness to AID directives," "adherence to work schedule," "timely submission of required reports," By the next report period (July 1980 to December 1981) all of these received satisfactory ratings. Negative ratings in the first two areas could be attributed largely to the communication problems and confusion of roles which early on plagued PTHE, and which strained field office relations with USAID project managers.

Untimely submission of reports was indeed a serious deficiency during the first eighteen months of PTHE, and this was related to field personnel

4.1 continued

shortage and to home-field communication problems. Bi-annual and annual reports were required as well as projected work plans. The effort to incorporate strong home office input into these reports initially produced delays in submission. The delays were subsequently eliminated.

"Relations with cooperating country nationals" is also an area of evaluation in the CPER form; in both reports superior ratings were received. UNC field did indeed establish and maintain exceedingly good relations, despite often difficult conditions, with MOH and other departments of GURC.

The above discussion concerned UNC field office roles and responsibilities vis-a-vis MOH, USAID and other GURC departments. But internal administration of the field office also deserves attention, and is needed to complete the picture of field operations.

UNC field office was to be the operational arm of UNC in Yaounde responsible for documentation, for daily operations, for clerical and logistical support of field activities, and for management of UNC resources locally. The field office saw more than its share of office management problems. Inexperience and incompetence of the clerk/typist and bookkeeper initially hired caused serious problems in the efficient running of the office. Correspondance, documentation, and accounts suffered the worst for this. Beginning with the third year of PTHE, much more competent staff were on board. It should be noted that local hire never surpassed seven in number, including watchmen.. Overall, during the life of PTHE office performance was satisfactory at best, with a long period of mediocrity.

In the area of vehicle maintenance (PTHE was supplied with two Toyota Landcruisers and one Renault R-12) performance was superior. Mechanical difficulties were relatively rare; both Toyota's logged over 100,000 km

4.1 continued

each, and the R-12 over 65,000 km. Driver performance was also commendable especially in view of the often horrendous road conditions.

Working relations between UNC field and UNC/Chapel Hill suffered for communication problems. Delays in correspondence were often discouragingly long--often three weeks merely for transit. A system of bi-weekly telephone calls could never replace close analysis of documents and question, followed by written comment and reactions. Worst of all, the MOH office for PTHE had no telephone--making the calls even more inconvenient and time consuming. Beyond this the field office never could develop the effective planning capacity to work well within the constraints of such delays and necessarily longer lead times. This limited the degree to which UNC/Chapel Hill could contribute timely technical input. The Contractor Performance Evaluation Report of December 1981 tended to criticize the home office solely for this deficiency. In point of fact, blame must be equally shared where it is justified.

d. UNC/Chapel Hill Home Base Team

The University of North Carolina School of Public Health, through the Department of Health Education, was to be responsible for recruiting, hiring, and supervising project technicians in the field. UNC/Chapel Hill was also to provide professional and administrative support to them, including provision of short-term professional consultation, for achieving PTHE project goal and objectives.

4.1 continued

The UNC/Chapel Hill core personnel were a Project Coordinator, an Associate Project Coordinator, an Assistant Project Coordinator, and an Administrative Officer. The Coordinators were faculty members of the Department of Health Education and the Administrative Officer was a University staff member.

(i) Technical Roles and Responsibilities

As the PTHE contract university, UNC/Chapel Hill was accountable for the quality and effectiveness of field operations in developing a nationally coordinated training system of practical health education responding to the needs of rural populations. Therefore, the overall technical role of UNC/Chapel Hill was to supervise and support the activities of its field technicians based in Cameroon. Specifically, UNC/Chapel Hill was to:

- develop and maintain the appropriate activities of the UNC Department of Health Education in support of the Project and the field staff in Cameroon.
- anticipate needs and respond to technical requests from the field staff.
- elicit contributions from UNC faculty and assume responsibility for its timely transmission to the field staff.
- assist in the design of training, community organization, and evaluation activities.
- coordinate visits made to UNC by PTHE field staff, Cameroonian officials, and others associated with the Project.
- provide on-site consultation from UNC/Chapel Hill home base staff and other professionals when assistance, support, and routine close contact were indicated by PTHE needs in the field.

4.1 continued

The Assistant Project Coordinator had full-time responsibilities, whereas the Project Coordinator and Associate Project Coordinator provided a minimum of 42% of their time to this Project. Her role was to manage and coordinate the daily work of all staff attached to the Project. In addition to the specific technical activities cited above, she was to:

- coordinate the review of all correspondence from the field staff and ensure both immediate acknowledgement and substantive response at the earliest date possible.
- supervise the maintenance of maps, charts, and graphs for monitoring the continuous progress of the PTHE toward projected short and long term objectives.
- send relevant publications, conference proceedings, and documents related to health education priorities and actions to the field staff.
- oversee and coordinate preparation, timing, content, and distribution of all formal reports required of PTHE.
- maintain relations and contact with other international development projects in the Chapel Hill area and the U.S. with special reference to programs of service, demonstrations, training, and research in Africa.

Throughout the four years of the PTHE Project, the UNC home base staff met together as a team on a weekly basis giving full attention to the progress and needs of the Project. Correspondence and phone calls from the team were discussed in detail with each staff member offering further insight or suggestions to be relayed to the field. Specific requests for technical and management assistance were accorded particular importance during these meetings by outlining specific actions to be taken during the week to ensure an adequate response by mail or in the next phone call to Yaounde. Quite often the requests from the field required contacting other faculty members in the Department of Health Education or on the wider UNC

4.1 continued

campus for professional consultation. Having readily available access to this pool of expertise was a definite advantage for the UNC home base team in providing technical support to PTHE. Moreover, each member of the UNC/Chapel Hill project staff brought to PTHE a personal network of international health and development contacts that collectively spanned worldwide--from the Peace Corps in Washington to the MOH in Togo, from the School of Public Health in Ibadan to WHO in Geneva, from the Nursing School in Moncton Canada to the University of the West Indies. It was not unusual for those sources to be tapped generously and gratuitously in providing technical support of the highest quality possible to PTHE field operations.

Professional journals, texts, manuals and reports were systematically reviewed for relevant technical material to be sent to the field staff. The home base office also had some documents translated into French or multi-copied for immediate use in PTHE training sessions. Similar services were performed in Chapel Hill for official PTHE reports to be submitted in French and English to USAID and MOH.

Being an academic training institution, UNC/Chapel Hill also saw the value of the PTHE Project as a learning experience for academicians, practitioners, and students with a special interest in international health and development. Graduate students in health education have worked as PTHE Project research assistants with funding provided by the School of Public Health throughout the four year period. The strategies and methods used in PTHE have been presented and discussed in relevant courses offered by the School of Public Health. Analysis of the PTHE experience have been presented at professional conferences. An intensive four-week short course for health officials from English and French speaking African countries has been developed and offered on an annual basis as a direct result of the PTHE Project experience. In short, the UNC/Chapel Hill home base staff had expanded their technical role and responsibilities beyond the limitations

4.1 continued

of the contract agreement to not only bring attention to the significance of a pilot project, but also to stimulate new ideas and feedback for strengthening the quality and effectiveness of UNC technical assistance.

Five faculty members from UNC/Chapel Hill provided direct consultation to the PTHE Project in Cameroon, upon requests from the field staff, the MOH and USAID/Yaounde. Services from three outside consultants were also requested by the field and filled by UNC/Chapel Hill. The temporary duties included an ethnographic study of the Kadey, development of the school health component, the design of an evaluation scheme, and the development of health center workshops (see Section 4.3 for a detailed list.)

These short-term technical contributions fulfilled project needs in most cases, and adequately in all. The presence of new faces with fresh ideas and energy was revitalizing for the PTHE staff and counterparts who through the intensity of the daily operations needed additional perspectives and feedback on the Project as a whole. The benefit to UNC faculty members of observing field activities and meeting with key MOH personnel was obvious when they returned and continued to make productive contributions.

(ii) Administrative Role and Responsibilities

UNC/Chapel Hill had full responsibility for personnel and financial needs of the UNC/Yaounde field office as well as the home base office. However all personnel activities, actions, and expenditures initiated by the campus team required concurrence from USAID and the University. For the Project Administrative Officer this meant preparing and sending two sets of documents needing authorization from two administrative systems each with its own pace, language, and requirements for prior approval from the other. Masterful planning and coordination were frequently necessary to receive mutual concurrence on time. In addition to this responsibility, the Project Administrative Officer was to:

4.1 continued

- handle all logistical and administrative arrangements for contract related travel.
- process monthly expenditure reports for project staff.
- establish a financial and personnel management information system between the UNC/Yaounde and UNC/Chapel Hill offices.
- supervise the UNC/Chapel Hill secretary.
- provide administrative and management support to UNC/Yaounde through on-site visits as indicated by need in the field.
- process all documents related to Project Personnel, matters including, staff research assistants, and consultants.

The flexibility of the Administrative Officer who was capable and willing to travel to the Yaounde field office for extended periods was a key factor in resolving communication and management problems between USAID, MOH, and UNC.

A system of weekly phone calls between Chapel Hill and Yaounde was established during the first two years of the Project and then reduced to bi-weekly calls for the last two years. These calls would occur directly after the home base staff meetings so that the field technicians could have direct communication with each UNC project member in Chapel Hill. Rarely would the calls be less than 45 minutes in duration to sufficiently coordinate technical, management, and personal inputs from project staff in Yaounde and Chapel Hill. Issues dealt with ranged from requests for office supplies and short-term consultation to the resolution of communication conflicts and the choice of health education methods to be implemented.

The functioning of project support staff in Chapel Hill had its advantages and disadvantages. Distance from field operations was an obvious problem in that close working relationships with the MOH and USAID/Yaounde were difficult to develop; and the ability to respond quickly to project related needs, while greatly improved through regular telephone communication,

4.1 continued

was still less than desirable. The advantages, however, more than struck the balance. The recognized role and responsibilities of UNC in PTHE placed the home base staff in a particularly effective position to negotiate or discuss PTHE issues with high level decision-makers in the MOH and USAID infrastructure. The act of sending a letter, making a phone call, or traveling from Chapel Hill to address specific project related questions ascribed higher priority and greater urgency to the action needed. This leverage was not often used to avoid its abuse.

Additionally, when UNC home base staff did visit field operations their distance from the daily pressures and demands of the Project enabled them to observe subtleties in the execution of and conditions surrounding PTHE strategies and methods. These differences often would have important influence on the outcomes. Feeding these observations back to the field technicians and their counterparts and subsequently redesigning project activities accordingly proved to be extremely beneficial to field operations.

Finally, but not least important, being an integral part of a major university and school of public health, the home base staff had access to a wealth of resources in providing technical and administrative support to the Project. Libraries, computers, fiscal management and clerical services, biostatisticians, epidemiologists, social and behavioral scientists, medical and public health professionals, and other international health projects on campus were available to and tapped by the PTHE home base team.

(iii) Comments

UNC/Chapel Hill suffered from two major deficiencies when the Project began in 1978 which were to constrain project inputs for nearly two years. The first was communication problems between UNC/Chapel Hill and three USAID

4.1 continued

offices: AFR/Development Resources in Washington, Contracts Office in Washington, and USAID/Yaounde. This led to an eleven month delay in releasing funds from the UNC contract to USAID/Yaounde for training program expenditures, and thereby requiring the PTHE field technician for training to divert 10-35% of her time in disbursing the monies for training and maintaining a fleet of motorcycles. There was also a significant three month delay involved in notifying UNC/Chapel Hill of the rejection of a candidate proposed for field technician for community organization and a one and a half month delay in notifying acceptance of the school's second candidate. This obvious gap in personnel meant the loss of important technical assistance in developing community organization strategies and methods for PTHE.

The second major weakness of UNC/Chapel Hill was an inadequate file of qualified technicians for francophone Africa. With the mutually agreed upon resignations of the Chief of Party and the Assistant Project Coordinator, both within the first seven months of field operations, a significant amount of time was spent in recruitment. This led to the need for one of the field technicians to assume the responsibilities of Acting Chief of Party with minimal attention given to her original role. The UNC/Chapel Hill Project Administrative Officer was sent to Yaounde for six weeks to assist her which in turn stretched to resources of the home base office given the absence of an Assistant Project Coordinator.

A Health and Training Specialist was hired on a half-time basis to fulfill the coordinating function at UNC/Chapel Hill until an Assistant Project Coordinator was hired in September 1980. The cause in delay was due in part to the inadequate file of qualified candidates, however, responsibility can also be found in the early confusion between USAID/Washington and USAID/Yaounde concerning the budget. USAID/Yaounde objected to the approved agreement between UNC and USAID/Washington to sub-contract the

4.1 continued

services of the Assistant Coordinator who had extensive prior experience in Cameroon and other French speaking African nations, but was a full-time employee of the Research Triangle Institute in North Carolina (See Section 4.3). It had been expected that he would play a major role as the anchor of the home base team with the most direct experience and knowledge of Cameroon. The loss of his input in August 1978 was serious set-back for UNC home base operations. Recruiting a replacement was further hampered by renegotiations between USAID/Washington and USAID/Yaounde concerning the project funds granted to the MOH as specified in the Project Agreement but which had been included in the contract award to UNC by oversight (See Section 4.4). Consequently, UNC could not recruit and hire an Assistant Coordinator in good faith until these negotiations were finalized.

UNC/Chapel Hill did develop an enlarged resume file of persons qualified to work in French speaking countries as technicians and administrators. It has been continually updated and as of January 1980, the field staff and home base staff remained at full and consistent capacity. A pool of short-term consultants were also readily identified from this file.

4.2 Communication Structure

a. Communication among USAID, MOH, UNC

Each of the three major agencies with a principal investment in PTHE is a separate bureaucracy with a complex communication system of its own. The task of grafting PTHE communication needs onto these three existing systems became a preoccupation for the management team throughout the life of the Project. The preceding discussion in Section 4.1 on the roles and responsibilities of each organization addresses management questions of who is accountable for what. However, it is the question of how it is to be communicated, by whom, to whom, and when which is treated in this section.

Figure displays in diagram form the various lines of communication, the nature of the communication, and its frequency between principal PTHE Project parties. This diagram was developed by the mid-project evaluation team in direct response to a scope of work question: "Assess project communication between/among UNC Chapel Hill, UNC field team, AID/Washington, AID/Yaounde, MOH, Peace Corps, and other donors."

USAID/Washington's AFR/Development Resource Office had direct links with PTHE home base team; while UNC's Contracts Office in Chapel Hill had direct links with USAID Contracts Office; and the USAID Missions Health Nutrition and Population Office (HNPO) in Yaounde had direct links with AFR/DR in Washington. The communication to and from USAID/Washington dealt solely with contract administration and approval of orders such as travel authorizations and budget transfers. Telephone calls and cables were the predominant means used. On several occasions UNC/Chapel Hill intervened in the communication between the USAID/Yaounde and USAID/Washington by informing one or the other office that a cabled authorization had not been received or had not been sent.

◆ LINES OF COMMUNICATION BETWEEN
PRINCIPAL PTHE PROJECT PARTIES◆

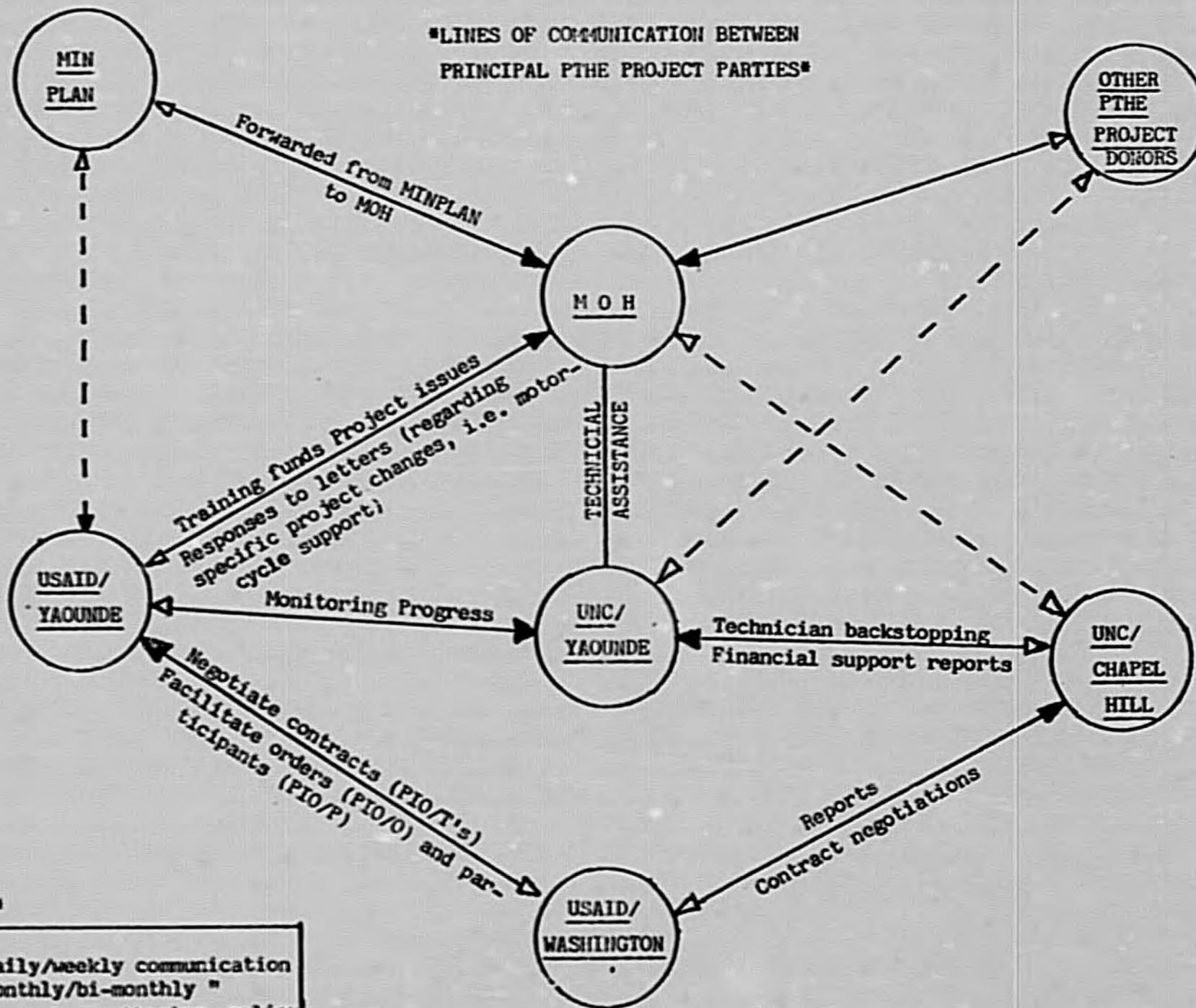


TABLE 11

◆ KEY ◆

- Daily/weekly communication
- - - Monthly/bi-monthly "
- ➔ Support, monitoring, policy approval
- ▷ Reporting responsibility

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4.2 continued

In every case the precipitating factor in UNC's decisions to intervene directly was to ensure the timely arrival of authorization needed for PTHE field operations.

USAID/Yaounde not only had direct links with USAID/Washington but also with the MOH, the UNC/Yaounde field staff, and the Ministry of Economic Affairs and Planning (MINPLAN). The communication between USAID/Yaounde and the MOH predominantly dealt with issues of inputs as specified in the contract signed by these two parties. Official correspondence, minutes from meetings, and informal discussions devoted much attention to the administration of training funds transferred from UNC to the MOH, and the MOH contribution of financial and personnel resources to PTHE as an indicator of MOH commitment. However, due to the centralized nature of decision-making within the government of Cameroon, the MOH could not finalize agreements with USAID without proper authorization from the MINPLAN. Therefore, USAID/Yaounde did communicate directly but less frequently with the MINPLAN to negotiate contract changes and policy issues affecting PTHE. To avoid causing confusion within the Cameroonian decision-making process, USAID/Yaounde informally agreed to have the MOH review all official correspondence addressed to the MINPLAN before it was actually sent.

Communication between USAID/Yaounde and the UNC/Yaounde field staff was essentially to monitor PTHE progress. Reports were made by UNC/Yaounde every six months, official meetings were held on an as-needed basis, and informal interactions took place daily at the USAID Mission Office. While the contact between USAID/Yaounde and UNC/Yaounde was direct and frequent, it was generally haphazard and hierarchical in nature. The HNPO Chief would often make decisions, pass it to the Project Manager who would then in turn communicate the decision to the UNC field staff.

4.2 continued

At times the Project Manager would inform the HNPO Chief of the UNC field staff's reaction or the Chief of Party would directly speak with the HNPO Chief. A well planned mechanism in which the HNPO, UNC/Yaounde, and the MOH Division of Preventive Medicine would meet regularly together to discuss the progress of PTHE was never established. The mid-project evaluation team had strongly recommended that such a group meet monthly as a coordinating sub-committee of critical donor agencies. The idea was supported only by UNC.

The field staff's relationship with the MOH was the strongest and most positive among all the possible linkages formed during the Project. The PTHE team approach bringing UNC and MOH personnel together as counterparts was a major reason for the relative ease and openness of communication. Within the MOH organizational lines the PTHE Project was considered by the first Director of Preventive Medicine to be directly under his division as a separate service among the existing six he supervised. Written PTHE progress reports were submitted directly to the Director and PTHE was officially represented at internal MOH meetings by the Cameroonian counterpart for community organization who was also the Assistant Chief of the Health Education Service, although his commitment to and understanding of PTHE was too weak to entrust him with this role, or the Director of Preventive Medicine himself who was also Project Director.

However, when the Director of Preventive Medicine was changed in 1981, his replacement no longer considered PTHE as a separate service but rather an integral component of the Health Education Service. The intent was to better facilitate the transition of PTHE responsibilities from the UNC and USAID to the MOH which would have been an effective strategy, if the counterparts and activities of PTHE had been

4.2 continued

originally concentrated within the Health Education Service. However, this was not the case due to some serious barriers described in greater detail under "comments". The result of this change was less direct communication from the UNC field staff to the new Director of Preventive Medicine and less effective representation of PTHE Project progress to the MOH in general, and to the Minister of Health who had been newly named in 1980.

Communication between UNC/Yaounde and its home office in Chapel Hill was initially hampered by a time lag of ten to fourteen days for mail. A system of weekly trans-atlantic phone calls was instituted in late 1979 which greatly improved the situation until technical problems with telephone cables in Yaounde eliminated the UNC/Yaounde office phone. Nonetheless, bi-weekly phone calls were placed to make requests for technical back-up from Chapel Hill, to give progress reports on PTHE activities, to plan site visits from UNC consultants, to clarify management issues, and to coordinate financial accounting matters. It was the responsibility of the Assistant Coordinator in Chapel Hill to fulfill the liaison role between UNC/Yaounde and UNC/Chapel Hill by responding to requests from the field, monitoring the progress of the Project, and providing technical assistance in the field when the need arose.

UNC/Chapel Hill directly communicated with USAID/Washington and its field staff frequently. On rare occasions would the MOH receive a phone call or correspondence from UNC/Chapel Hill. The operating principle of communication for UNC/Chapel Hill was that USAID/Washington would adequately inform USAID/Yaounde and that UNC/Yaounde would adequately inform the MOH of decisions, actions, and suggestions made in Chapel Hill.

4.2 continued

For those cases in which the communication system did not function as expected, UNC/Chapel Hill did make direct contact with the MOH and USAID/Yaounde.

UNC/Chapel Hill did not have direct links to other donor agencies such as UNICEF and the Peace Corps. Only the MOH and UNC/Yaounde communicated with them to negotiate their various contributions to PTHE. This "missing link" in the system created a very real weakness for the Project and is discussed under "Comments".

The MOH had communication lines with all the principal PTHE Project parties except USAID/Washington. As stated earlier, it was the Division of Preventive Medicine which handled all matters for the MOH concerning PTHE. The rationale for placing the Project within this Division, rather than within the Division of Health Services, was because PTHE activities would be more prevention oriented than curative. However, in the contract agreement between USAID and the MOH, the PTHE counterpart for training was to be assigned for the MOH Service for Training and Continuing Education which is under the Division of Services. Of the training institutions participating in PTHE, CUSS and CESSI are under the MINEDUC, ENISFAY is under the MOH Division of Health Services, and OCEAC is a separate international institution with no government-related status. Thus, it was essential for the Project that the Division of Preventive Medicine maintain open communication with these key parties which are outside of its official jurisdiction. The Coordinating Committee, chaired by the Director of Preventive Medicine, was one mechanism established by PTHE to bring together all the participating governmental and non-governmental agencies every six months. Aside from these meetings, there was no other formal means for the Division of Preventive medicine to communicate on a regular basis with the primary and secondary contributing agencies.

4.2 continued

b. Comments

It needs to be recognized that the complexity of the communication system just described is not unique to the PTHE Project. While technological advances have significantly reduced problems of distance and access, they do not overcome the communication barriers of conflicting decision-making styles of conflicting perceptions of priority. Given any effort on the scale of PTHE requiring collaboration from several large organizations, there are bound to be barriers and breakdowns in communication. Some can be avoided or reduced while other cannot. The following communication constraints experienced by PTHE fall under both categories.

The single most significant difficulty, which could have been easily remedied, was the awkward and uncomfortable role that the UNC/Yaounde field staff, was forced to play as an intermediary for USAID-MOH communications. The PTHE field staff had made a conscious policy to never conduct project activities or make decisions affecting PTHE without the physical presence and full participation of an MOH representative. This was very important to the process of institutionalizing the Project into the MOH. However, the pressure from USAID/Yaounde to only meet with the UNC field staff, either prior to a meeting with the full MOH and UNC Project staff or for the UNC staff alone to discuss the matter further with the MOH, undermined to some degree the PTHE aim of developing MOH ownership. The result was that key MOH personnel including the Director of Preventive Medicine, the Chief of the Health Education Service, and the PTHE counterpart for community organization believed that UNC field staff were indeed USAID representatives who acted and spoke on behalf of the Agency. In an effort to counterbalance their image to MOH on one hand and to demonstrate their concern to USAID on the other, the field staff frequently took an advocacy stance on behalf of the MOH in their

4.2 continued

communication role of intermediary. From USAID/Yaounde HNPO's perspective the UNC/Yaounde staff were not only ineffective as a communication link to the MOH, they were not to be trusted. Consequently, relations between HNPO staff and UNC staff were strained and cautious throughout the first three years of the Project. With the arrival of a new HNPO Chief, communication did improve but not enough to overcome the set precedent.

Monthly meetings of the HNPO Chief, the Project Manager, the Director of Preventive Medicine, and the Chief of Project as a critical decision making body recommended by the mid-project evaluation team would have been a major step toward improving communication. However, by this point neither USAID nor the MOH considered it to be of high priority. MEDCAM, an even larger technical assistance project, was being negotiated between the two organizations at this time and the procedure was not going well (MEDCAM was ultimately rejected by the government of Cameroon). In retrospect, if these monthly meetings had been instituted when PTHE field operations had begun in 1978, this communication problem could have been minimized if not totally avoided.

Another constraint which could have been reduced concerns the unsatisfactory level of communication with other donor agencies, specifically UNICEF and the Peace Corps. The only direct points of contact for them were with the MOH and the UNC/Yaounde staff. The one formal mechanism available to them for PTHE involvement was the Coordinating Committee which only met every six months. Both the Peace Corps and UNICEF did express their dissatisfaction with their level of involvement to the mid-project evaluation team.

4.2 continued

As agencies making critical contributions to PTHE in terms of motor-cycles, spare parts, and personnel there needed to be direct and on-going communication with them from USAID/Yaounde and UNC/Chapel Hill. Placing the responsibility of negotiating input from other donor agencies on the MOH and UNC/Yaounde, who needed to concentrate on project implementation, was unreasonable and unfeasible.

With sound evidence that donor agencies were no longer able to honor their original commitments, USAID and UNC did not establish a procedure for renegotiating new commitments as soon as possible. As a result, the UNC field staff and the MOH were placed in the position of going to the donor agencies "with hat in hand" as project planning and implementation progressed. They were essentially successful in gaining commitment from the Peace Corps in part due to personal relationships between the staff members, but were not able to receive more than 20 of the 200 motorcycles from UNICEF.

It is doubtful whether the formation of a Donor Agency Subcommittee to the larger Coordinating Committee would have sufficiently alleviated the communication problem. As a task force for monitoring the usefulness of agency input to PTHE activities, it would have been helpful. As an arena for negotiating agreements, it would have been inappropriate for the level of decision-making that would be required. The HNPO Chief and the UNC/Chapel Hill Project Coordinator, who would be the key people needed, did not normally attend Coordinating Committee meetings. Moreover, the Coordinating Committee itself did not prove to be as effective and efficient as had been hoped. Its role was to be that of an advisory body to the PTHE Project but in actuality functioned as a group of high level decision-makers who were called together to receive progress reports on PTHE activities. For an analysis of the Coordinating Committee see Section 4.1b, Roles and Responsibilities of the MOH.

4.2 continued

A barrier which could not have been anticipated or resolved was the internal MOH conflict inherited by PTHE from its direct affiliation with a Director of Preventive Medicine. As a matter of historical grievances, competition, and personal differences, the Project's first Director of Preventive Medicine did not communicate well, if at all, with the Director of Health Services, the Chief of the Health Education Service, or the Director of ENISFAY. While the Director himself was very supportive and interested in the Project's village level activities, he was extremely reticent about integrating PTHE into these agencies or services with which he had an adversarial relationship. This situation essentially paralyzed PTHE development at the training institution level and slowed down its pace at the village level for the first 2½ years.

With the change in Directors came a corresponding change in PTHE-MOH relationships. Former foes became distant friends and former friends were no longer affiliated with PTHE. The most blatant example was the resignation of the Assistant Chief of the Health Education Service as the PTHE counterpart for community organization. The new Director and the Chief of the Health Education Service preferred having the entire Service rather than a specific individual assigned as the counterpart. These changes in orientation and relationship made it very difficult for UNC to establish a working communication system with the MOH after having invested 2½ years in developing one which was radically altered. Nonetheless, it was accomplished, which was evidenced by the public support given to the PTHE approach by the past and present Ministers of Health. The most effective link for keeping the Minister informed was through the PTHE counterpart for training.

Logistical and technical barriers to communication were the absence of an office phone for the UNC/Yaounde field staff and the absence of an Assistant Coordinator in Chapel Hill for the first two years of the Project.

4.2 continued

Concerning the first obstacle, the UNC field staff spent an unnecessary amount of time and energy negotiating the use of agency phones or waiting for calls from Chapel Hill to come through. Moreover, UNC/Chapel Hill could only contact its field staff directly through prearranged times or by leaving messages with other parties. It was extremely frustrating when immediate action or response was needed.

Not having a full-time Assistant Coordinator in Chapel Hill to act as a liaison between field staff and their home office at the time when field operations had to get off the ground made for a choppy start. (see section 4.3) Compounded by the fact that the key USAID/Yaounde and MOH personnel who had any knowledge about PTHE were no longer accessible, the field staff received minimal technical support during its first year of operation. Despite an Associate Coordinator, an Administrative Officer and two outside consultants to Yaounde, no single person was actually responsible for monitoring the day-to-day activities until September 1980.

4.3 Personnel Management and Accountability

This section reviews the Project's history of personnel management focussing on USAID, UNC, and MOH separately.

USAID's responsibilities in the area of Personnel Management were:

- (i) to assign a USAID direct hire employee to the position of project manager of PTHE within the HNPO of USAID/Yaounde mission
- (ii) to assemble the mid-project evaluation team and assign duties to it.
- (iii) to approve/disapprove the assignment, nomination and salary of UNC long- and short-term technicians.

The MOH's responsibilities in the area of personnel management were:

- (i) to assign a person to the position of Project Director who would implement and coordinate the project and who would have direct supervisory responsibility for the UNC technical staff.
- (ii) to authorize health workers in the pilot division to participate in project activities and to assign "itinerant agents" at the health center level to implement PTHE community organization activities.

UNC's responsibilities in the area of personnel management were to:

- (i) provide long-term technical assistance to PTHE by hiring project staff with USAID approval, and to provide logistical support to a three-person field team which was to be based in Cameroon.
- (ii) provide long-term technical assistance to PTHE with a UNC campus staff which would make the considerable resources of the University available for technical backstopping to the field team.
- (iii) provide short-term technical assistance as needed.

a. USAID

USAID assigned four different project managers during the first two years to PTHE, let alone intermittent acting project managers. There were

4.3 continued

three HNPO chiefs, none of whom overlapped in time with his predecessor. Instability of USAID staff assigned to PTHE was a major impediment to cooperative and consistent project management among the three critical organizations. Technical direction and progress were too frequently hampered by the absence of key USAID decision-makers and the need to orient them to project needs.

USAID staff continuity was at its very weakest in the first year of project implementation. The USAID/HNPO chief who had been responsible for bringing PTHE into existence left Yaounde in August 1978 for another assignment. There was no one to replace him until July 1979. During the same period there were three project managers, none of whom was willing to assume a leadership role. In May 1979, the PTHE project manager relinquished USAID's responsibility for approving/disapproving UNC's nominations for field party personnel. Instead, it was given to the MOH Project Director, who traveled to Chapel Hill in June 1979 to select the candidate for a vacant field position. After the MOH Project Director had made his choice, the new HNPO chief came on board at USAID and asserted that USAID would not approve the Project Director's choice. USAID/Yaounde delayed communicating that decision for a painful four months. There can be no doubt that the relationship between USAID and the MOH had been needlessly damaged.

In addition to the high rate of staff turn-over and lack of overlap, there was the diverse orientation and expectations of each USAID staff assigned to the Project. They tended to use projects in other countries with which they were familiar as a frame of reference. One manager appeared convinced that PTHE was essentially a latrine building project, another saw it primarily as an introduction to family planning while another saw it as a nationwide training project. As a result, the UNC field

4.3 continued

team spent a considerable amount of time away from technical responsibilities, orienting USAID to the Project.

The responsibility for assembling the mid-project evaluation team was given to three parties, with USAID/Y retaining the authority to approve/disapprove its composition. AFR/DR was asked in November 1979 to identify an external source to lead the mid-project evaluation and nominated a candidate almost immediately. MOH and USAID/Y each were to select a team member. There followed approximately four months when UNC, the MOH and AFR/DR believed that the evaluation was imminent but virtually no action occurred during this period. The reasons for the delay remained unclear to UNC.

Whereas it was USAID/Y's responsibility to authorize UNC's nominations of long and short term technicians for PTHE, it was the office of Central Contracts' responsibility to approve/disapprove the technicians' salaries which had been proposed by UNC. USAID/W Central Contracts did disapprove proposed salaries for all three UNC technicians due to differences in criteria used for determining salary levels for university faculty appointments. This resulted in a long appeal process while the technicians were actually at work.

USAID's formal process for approving long and short term assistance involved the following steps:

Formal initiation was always proposed to the office of Central Contracts by UNC Central Administration. USAID Central Contracts requested AFR/DR's approval first, then transmitted UNC's request to USAID/Y by cable, which would respond to USAID/W by cable. USAID/W would in turn send a letter to UNC authorizing the proposed technical assistance.

4.3 continued

Eventually UNC and USAID/Y developed a costly though satisfactory means of shortening the time required for the approval process by trans-atlantic telephone calls. In maintaining telephone communication with the mission, both UNC and the Mission could provide each other with enough information to know the status of the request. Usually two calls were required. The first was to let USAID/Y know that a request was coming. The second was for UNC to know the cable number of USAID/Y's response. In most cases UNC had to use this information to assist USAID/W in locating the cable. Due to regulations, USAID/Y could not transmit a cable directly to UNC.

b. MOH

Any discussion of personnel management on the MOH side must take into account the wider number of considerations present in MOH actions; it would be overly optimistic to expect a national bureaucracy to act always in favor of Project needs in two divisions (of 44). However, mobility of personnel in and out of PTHE, and in and out of central posts, was certainly far greater than anticipated. One of the assumptions of the revised logical framework (boxes c4-no.3) is "Project personnel will be maintained in their posts."

Given the decentralization policy of GURC, and other individual career factors, this assumption could not be easily maintained at field level, especially in health center head nurse positions. However, as one rises in the hierarchy, more central level influence can be exerted to maintain MOH personnel in post, if indeed there is a will to exert such influence. Stability in the key posts--Project Director, counterparts divisional coordinators and supervisors, and itinerant agents--was necessary to help assure Project continuity and accountability, both in administrative and psychological terms. Four years of a pilot project require a level of commitment which personnel turnover can rapidly erode.

4.3 continued

The rate of turn-over within MOH was by no means a secret when the PP was written. Thus, besides a ministerial commitment to keep key project personnel in place, a ministerial letter was circulated in early 1978, to provincial and divisional level officials requesting that transfers of personnel out of Project areas be eliminated except in cases of extreme necessity during the life of the Project. Despite this, and due to several factors, MOH Project personnel changed significantly during years 1978-82.

Central Level

The Director of Preventive Medicine was changed in March 1981, which meant that PTHE also changed Project Directors. Little time was allotted to a smooth transition, and this guaranteed a long dormant period before Project activities could be cranked back up to acceptable levels. In July 1981 the financial assistant to the Director was recalled to the Ministry of Finance; once again the transition was less than smooth, with accounts remaining tangled until October 1981 when an official replacement was named. Neither of the replacements held strong commitments to PTHE, and both faced problems in other areas of the Preventive Medicine Directorate.

In many ways the question of counterparts--the MOH technicians--suffered from another problem of widely differing perceptions. MOH technicians are not spoken of as "counterparts" in official Project documents; USAID/Yaounde pushed for this role definition as a means to guarantee Project integration into relevant MOH services. Within MOH these positions (only two of which were ever filled) were seen rather as slots for a whole set of exceptional opportunities--for field work, increased income, and further training overseas--and thus, positions closely tied to existing patronage systems. MOH did not name counterparts officially to the Project until January 1979 (due in part to delays in the disbursement of USAID funds to MOH). Since that time three different people occupied the training technician slot. The community organization technician slot was virtually unoccupied during the final year of the Project. The resignation of

4.3 continued

the Assistant Chief of HES as Project counterpart was never officially accepted, nor was he requested to resume his activities. Both the Chief of HES and its Chief of Training Service came to resent the "counterpart" role of MOH technicians, preferring broader collaboration with their services as opposed to with one member of their services.

Divisional Level

Despite clear cut texts (circulated in 1978 and again in 1981) defining the posts of divisional coordinator (Chief of Preventive Medicine) and supervisor (Assistant Chief of Preventive Medicine), confusion was permitted to prevail, and personnel changes were numerous. During the life of the Project four different CUSS-trained doctors occupied the post of Chief of Preventive Medicine in the Kadey, one of them refusing to relinquish his post in the Project when he was named Divisional Chief of Health Services. Thus for nearly two years, while the Directorate did nothing to clarify matters, the Divisional Chief of Preventive Medicine for the Kadey did not function as Project coordinator while his assistant continued to function as supervisor. In the Mefou, the acting Chief of Preventive Medicine (in post since 1974) was not named Project coordinator, but rather functioned as supervisor; the post of Coordinator was occupied by the divisional Chief of Health Services for three of the four years of the Project--until a CUSS graduate was officially named Chief of Preventive Medicine, with his predecessor becoming his assistant. That post--Assistant Chief of Preventive and Rural Medicine--pointed up clearly the inability of the Preventive Medicine Directorate to effectively work with other departments of MOH. Both the Mefou and the Kadey were forced at various times to function without official Assistant Chiefs of Preventive Medicine, since MOH text required that a state-registered nurse occupy the post, and yet no move was made to slot such a nurse for the post. In both cases, other nurses performed the duties of the assistant chief, and very effectively, but without official recognition or authority.

4.3 continued

Itinerant agents were the only field-level personnel to be considered "Project" personnel by MOH, despite the crucial role in Project activities played by head nurses. Therefore, there was not much fluctuation in the ranks of IA's, especially following the Service note of December 1979 naming 18 IA's. Eventually four more were (unofficially) added to the Kadey in 1981. One IA from the Kadey succeeded in gaining admittance to the sanitation technician's school in Yaounde (ENISFAY) and so was replaced at the same time as the new IA's were named.

Head nurses changed quite a bit more often--of the eighteen PTHE centers/hospitals, fourteen saw changes during the life of the Project, ten of these involving transfers.

Questions of supervision and support systems are discussed elsewhere in this report. However, another problem of personnel management never quite resolved concerning incentives to remain in PTHE posts. In a bureaucracy that grants rewards to seniority and through success in professional competition (needed for further training and thus for advancement), there was little to hold personnel in place besides the promise of on-the-spot in-service training (not used in calculating level of technicality for advancement) and increased job satisfaction. There are not insignificant rewards, but often become light in the balance relative to locational advantages of other posts or a return to school. Only among itinerant agents did a strong esprit de corps develop, and this was not truly due to MOH efforts.

Difficulties in holding key personnel in place are considerable--witness the regular changes at USAID/Yaounde in PTHE project managers. Beyond this, morale incentives--congratulatory letters at the very least--were exceedingly little used, and a near total absence of material incentives, by MOH in its management of Project personnel.

4.3 continued

c. UNC

With the singular exception of UNC's nomination of a community organization technician to replace the position vacated by Dr. Candy (who became Chief of Party) USAID/Y was always supportive of UNC's nomination to fill or change field staff positions. UNC requested and received, without delay, permission to change the first Chief of Party, and to move the former community organizing technician to Chief of Party. As the recruitment and hiring organization, UNC did, however, encounter difficulties in receiving USAID/W approval for proposed salaries. It should be noted, however, that USAID/W did eventually approve salaries that were approximately what UNC had proposed.

The UNC long-term technicians were all hired as full time members of the faculty of the University. Thus, in proposing salaries to USAID/W, the technicians' salaries had already been approved by the Chairman of the Department of Health Education, the Dean of the School of Public Health, the Chancellor of the University of North Carolina, and the Board of Trustees of the University of North Carolina. As a large state agency, UNC/CH, in other words, has well-developed guidelines which are used in establishing salaries and additionally has watch dog regulations imposed on it both by the state of North Carolina and by the US Department of Health and Human Services. Even so, USAID counterproposed salaries for the community Organization Technician which was less than a secretary's salary at UNC (\$15,000). When USAID revised the Chief of Party position to specify that the qualification for the position included the degree of Medical Doctor, it counterproposed a salary for that position which was clearly unacceptable for what an M.D. should expect. In appealing USAID/W's salary proposals the UNC staff felt that UNC was being treated as if it was a small consulting firm instead of a large, financially conservative state agency.

4.3 continued

USAID's contract with UNC listed the following key positions on campus for PTHE: Campus Coordinator and Assistant Campus Coordinator.

When the Campus Project Coordinator made his initial visit to Cameroon (June 25, 1978) he was advised that the key person named in the contract, an Adjunct Assistant Professor of UNC/Ch, could not occupy the position of Assistant Coordinator. The reason given was that as an employee of the Research Triangle Institute of Research Triangle Park, NC, he was actually working with the Project through a subcontract between RTI and UNC. USAID/Y felt that the cost of that subcontract was excessive. Thus, UNC was essentially without an Assistant Coordinator from the very beginning, even though USAID/W had already approved, in writing, every detail of that subcontract. In supporting USAID/Y's stated, although unwritten, decision, UNC ran into difficulties with USAID/Contracts immediately as USAID/Contracts was extremely reluctant to approve the nullification of a contract which that office had negotiated.

UNC could not immediately recruit and hire a replacement for Assistant Coordinator because at the same time that USAID/Y had disapproved the RTI subcontract, USAID/Contracts was requiring UNC to renegotiate the entire budget. As UNC no longer knew the amount of money which would eventually become available, it was unable to make the salary commitment required to fund the position. Instead, UNC committed the time of the Chairman of the Department of Health Education to PTHE, using the title Associate Campus Coordinator, and was not able to consider a replacement for Assistant Coordinator until UNC had an approved budget, which was not until April 1979.

During the period June 1978 through April 1979, the PTHE home base staff spent a total of 2.25 months in Yaounde to support the field team in spite of the fact that campus personnel resources had become severely strained.

4.3 continued

During the Associate Coordinator's January 1979 visit to Cameroon, the decision was made that the first Chief of Party was philosophically incompatible with host country, UNC field team, and UNC campus personnel. The Associate Coordinator consulted privately with all parties concerned, then wrote USAID/W in early February for permission to replace her. USAID/W requested and obtained concurrence from USAID/Yaounde prior to providing the Associate Coordinator with written authorization on February 15, 1979, to replace her. Subsequently, UNC began a worldwide search for two positions: Chief of Party and Assistant Campus Coordinator, and began conducting interviews of qualified applicants.

UNC/CH identified a qualified candidate who was a medical anthropologist, and a nurse who had two tours of duty in Africa. Her French was at the level required for teaching in a francophone University.

Prior to UNC's nominating her through the proper channels, the UNC/Chapel Hill Project Administrative Officer hand-carried her resume to Yaounde for examination by USAID, the Project Director and the field team. The project Director was politely negative to UNC's nominee for Chief of Party. Since she met the specifications, USAID asked the MOH Project Director to describe the qualities he expected the Chief of Party to possess. He listed "medical doctor" as the principal criterion, whereas the project paper required the Chief of Party to hold a doctorate in Health Education, or some other health specialty. USAID passed these criteria on to UNC and informed UNC that the Project Director would come to Chapel Hill to interview the candidates and select the new Chief of Party. UNC had no medical doctors among its applicants because UNC had not advertised for medical doctors. When the Project Director came to Chapel Hill it was clear that he wanted the first community organization technician to be Chief of Party and suggested to UNC that the medical

4.3 continued

anthropologist be hired as the Assistant Coordinator. Upon agreement from all parties, UNC asked USAID/W to amend the contract. With the decision for Dr. Candy to become Chief of Party, the position to be filled became that of Community Organization Technician.

The Director identified a candidate to be well-suited for the position of Community Organization Technician. UNC agreed with the Project Director's decision because UNC believed that USAID actually had given the Director the authority to select the field personnel with whom he would be working.

In point of fact, USAID was willing to overlook the Project paper's specifications for Chief of Party and approved UNC's nomination. However, USAID was not willing to approve the Project Director's choice for Community Organization Technician. It should be noted that there was a staff change at USAID/Y during this process such that the USAID/Y Project Manager who authorized the Project Director's trip in the first place was not the person who had to approve/disapprove the Project Director's choice.

USAID's decision to reject the nomination was very slow in coming. No one knew what decision was to be reached for four months.

UNC entered a second world wide search and began interviewing candidates in November 1979. The Community Organization Technician was interviewed in November 1979 and nominated. USAID approval did not come until one month after that. He was in the field and working in January 1980.

From January 1980, the UNC field party remained stable and was generally regarded as a highly effective team.

As in all USAID contracts, short-term like long-term technical assistance requires both Mission approval and USAID/Central Contract

4.3 continued

approval. This system of approvals is time consuming and cumbersome. Because USAID/Contracts apparently never disapproved any UNC request which had been approved by the Mission, there does not appear to be any reason for these two sets of approvals other than the fact that the regulation exists. In every case, UNC had to enter into direct telephone communication with the USAID Mission to facilitate the approval process. It would have been highly desirable if the USAID Mission had been permitted to communicate officially with UNC. The School of Public Health has its own telex as does the USAID/Y. Both agencies could have had rapid printed word exchanges but were, instead, required to always use Washington as an intermediary in spite of the fact that Washington's actual role was minimal. The management of short-term technical assistance was complicated, and it was in trying to implement them that UNC and USAID/Y would have benefited from direct communication.

UNC's short term Technical Assistance, were as follows, with comments comments on each.

Joan Fiator 11/79 - 1/80 School Health.

An employee of the Transcentury Corporation, Fiator is an American, already in residence in Cameroon. Implementation required UNC to execute a subcontract with the Transcentury Corporation, needing detailed approval by Washington and Yaounde. Communication through channels was inadequate for effective implementation. Cables from Washington to Yaounde often omitted critical information.

Marilyn Westphal 11/79 - 3/80. TDY Replacement for Medevac'd Technician. An employee of the Peace Corps (Washington), Westphal was seconded to UNC through an Interagency Personnel Agreement, an incredibly complex document which had never before been seen by USAID/Washington. UNC had total familiarity with agreements of this sort.

4.3 continued

H. Jack Geiger 12/79. Overview.

The Arthur C. Logan Professor of Community Medicine at City University of New York, Dr. Geiger was the founder of the Community Health Center Movement in the United States and is the senior authority in Community Health in the U.S. academic community. His visit was for the purpose of strengthening PTHE concepts among the various interested parties in Yaounde.

Eugenia Eng 1/80 - 4/80. School Health

A UNC employee who had worked with PTHE from the beginning.

Eng's TA was implemented efficiently. She developed the school health component with the MOH, MINEDUC, and PTHE Project Staff.

Karen Gridley 5/13/80 - 7/12-80. Planning.

A consultant, Gridley's TA was implemented smoothly. Her assistance was to work with UNC, MOH and USAID as an external source to revise the logical framework and help develop Project plans for the last two years.

Tony Whitehead 1/1/81 - 2/28/81. Ethnographic Survey.

Whitehead, an anthropologist on the faculty of HEED, UNC/Ch, was sent to Cameroon to conduct an ethnographic study of two sectors of the Kadey. This study had been proposed by UNC in March 1978 but was not given full MOH/USAID support until the mid-project evaluation had also identified the study as an urgent need--both for PTHE and for the proposed MEDCAM Project. Communities studied were Timangolo (Gbaya/Haura-Fulani/Bororo) and Blendissola (Kaka Ngbwako). A report was produced by the team who carried out the field work.

Preston Schiller 8/1/81 - 8/31/81. Internal Evaluation.

The PP calls for MOH to develop its own system of evaluation and Schiller, like Eng and Whitehead, was part of the UNC campus team. Schiller assisted MOH to develop this capability. The

4.3 continued

consultation was planned in advance but USAID/Y gave MOH very short notice causing a slight delay in the naming of the counterpart. Schiller's report was somewhat delayed but was considered valuable.

Engenia Eng 10/3/81 - 10/25/81. School Health.

As Project Assistant Coordinator general oversight and conducted in-service teacher training and orientation for field testing the school health curriculum in 10 pilot schools.

Babazou Simboou 8/82. School Health

Anani Draie. 8/82. School Health

Messrs. Simboou and Draire, of the Togolese Ministry of Education were provided to the School Health Conference by UNC as speakers. The Director of the MOH Health Education Service made the request to UNC.

In addition to the above specific consultation, John W. Hatch (coordinator) and Guy W. Steuart (Associate Coordinator and Chairman) provided general over-sight and guidance visits as follows:

Hatch	6/25/78 - 7/31/78
	3/24/80 - 4/3/80
	4/20/82 - 5/1/82
Steuart	1/10/79 - 1/23/79
	10/22/80 - 11/7/80
	4/4/82 - 4/12/81
	5/1/82 - 5/5/82

The field team often stated that there was a need for a fourth technician to provide administration. UNC sent the Project Administrator, Paul Seaton, to Yaounde when the need was critical during the periods 5/9/79 - 7/9/79; 11/14/79 - 12/14/79 and 5/8/82 - 6/3/82.

4.4 Financial Management and Accountability

a. Ministry of Health

The USAID grant of approximately \$600,000 to the MOH for training did not materialize until April, 1979, and the MOH was unable to utilize its grant money until September, 1979. It was not until March, 1980, that the MOH had the responsibility of accounting for its own grant. Never in the life of the Project did USAID and the MOH work out a mutually satisfactory way of disbursing, expending or account for grant funds.

1. During the first year (September, 1978 through September, 1979), the MOH used money which had been advanced to it by UNC (non-USAID) funds. The central administrative offices at the University of North Carolina was understandably highly reluctant to do this and did so each time only after lengthy negotiations with UNC's home base staff who transferred the funds to the UNC field team who were required to be personally accountable until the money was returned to UNC after close after-the-fact examination by the USAID/Y comptroller. In disbursing these non-USAID funds for MOH activities, the UNC team could only do so on a worse-possible scenario basis and were required to spend much of their time during a training cycle sitting at a table and counting out money to participants. The UNC technicians twice requested the UNC Administrative Officer to travel to Yaounde to assist them and to explain UNC's discomfort over the situation which existed. There were several occasions when UNC absolutely refused to any more state revenues to Yaounde and the technicians acquired loans from Cameroonian banks to finance Project training activities.

2. When the USAID grant to the MOH finally appeared, in April 1979, the MOH Project Director had been so affected by the technicians' nervousness over money, and at the same time so dependent upon their handling it, that he refused to disburse funds unless it was in a commercial bank account which required a UNC technician's co-signature. This effectively relieved MOH of accountability. However, the UNC Administration quickly realized

4.4 continued

that if one of its employees had signatory power over a GURC bank account, UNC had the ultimate responsibility. Thus, if USAID did question MOH expenditures USAID could easily collect an MOH disallowance from a U.S. institution. In March, 1980, the UNC Administration ordered the Chief of Party to remove her authority from that bank account, leaving the MOH Project Director personally accountable. On the other hand, USAID would not permit the grant money to be handled by the MOH's existing financial structure. In late 1980, a solution was worked out. The grant funds remained in a commercial bank account signed jointly by the Project Director and the Director of Studies, Planning and Statistics of the MOH.

b. University of North Carolina

The University of North Carolina at Chapel Hill is the largest recipient of research grants and contracts in the Southeastern U.S. as well as being a major USAID contractor. It has a well-established system of contract management. When UNC signed the PTHE contract, the University assigned one of its state administrators who was specialized in USAID contracts to the Project to provide financial and administrative management. A University contractor to the USAID has a standardized set of USAID regulations called "Cost Reimbursement Contract with an Educational Institution" (AID 1420-23a) which establishes USAID policy very clearly.

All campus based activities were financed routinely through the existing UNC system and reported as expenses to Washington through the standardized practice of grant reporting. No UNC expenditures are ever examined, except by internal audit, until after the end of a project when they are examined by auditors of the Department of Health and Human Services. The constraints that a reputable USAID contractor must impose upon itself under an after-the-fact system of accountability are extremely rigid and conservative.

4.4 continued

More than half of the UNC grant of \$1.455 million was expended in Cameroon. Money was transferred by telex from North Carolina to a commercial bank account in Yaounde which had been established under the name "University of North Carolina - Project PTHE." Through guidelines from the UNC Administrator, the money was used to support the following costs:

1. housing and utilities
2. furnishings
3. salaries and fringe for local hire
4. fuel and maintenance of vehicles
5. office supplies
6. communications

The funds, when spent, were returned to UNC in the form of paid receipts (in CFA) which were accounted for and stored in Chapel Hill.

It would have been desirable, particularly from the field team's point of view, if USAID/Y could have at least approved the field expenditures which were reported, on a monthly basis, before the paid receipts were returned to Chapel Hill. Instead, Chapel Hill had to report the total of these expenditures back to Yaounde in dollars.

Because the field technicians were responsible for over \$700,000 to a state agency, and not trained in financial management or contract administration, they required considerable support and guidance from the UNC Project Administrative Officer who spent a total of 3 1/2 months in Yaounde over the four years of the Project. It would have been more desirable perhaps, if USAID rather than UNC, could have provided the technicians with logistical support. Logistical support from a state university 9,000 miles distant becomes quite complicated.

4.4 continued

After initial, and expected, start up problems, a system developed between UNC and its field staff of financial reporting. The only insoluble problem was that of unreliable mail. All financial reports to Chapel Hill were photocopies and often illegible. The UNC Administrator made his final trip to Yaounde in May, 1982, to collect the original receipts, also to conduct a complete audit of transactions over the life of the Project to reconcile differences with AID/Y/MOH donor agencies and to Project financial obligations associated with winding down, and to report the expenses on the illegible photocopies through the UNC system.

4.5 DONOR AGENCY INPUTS

a. UNICEF

UNICEF input, according to the original logical framework, was to be 200 motorcycles, an unspecified amount of construction material, and visual aids. However, at a meeting of PTHE/UNICEF in March, 1979, certain conditions to UNICEF participation became clear. UNICEF operates in Cameroon through an agreement with GURC, it argued, and thus could not commit materials to PTHE specifically, but only through MOH. MOH was to submit an overall list of projects and needs in a given fiscal year upon which UNICEF could establish its level of participation i.e. a national plan of action was needed in which PTHE needs could be placed. At that meeting, it was also stated by UNICEF that previous correspondence referring to a contribution of 200 motorcycles was "informational" and did not constitute a commitment on UNICEF's part. A number of conditions to be met by MOH in order for UNICEF to consider further contributions included an action plan for PTHE 1979/80, an evaluation of previous activities, better coordination with other services, and adequate personnel in the field. Beyond this March 1979 meeting, the areas of UNICEF participation evolved somewhat differently, and needs separate discussion.

Motorcycles: Twenty SUZUKI 120 cc motorcycles arrived in Douala in late January, 1977; about half of these were distributed in July, 1977, to IA's and PCV's in the Kadey. The remainder were distributed to IA's and PCV's in both the Mefou and Kadey in April, 1978, coinciding with the arrival of a second group of PC volunteers. Requests for more motorcycles went unanswered until at the March 1979, meeting. UNICEF set out the following conditions for provision of motorcycles:

- 1) the number requested must be justified.
- 2) the make/model of motorcycles requested must be justified.
- 3) a list of needed accessories (helmets, spare parts, pumps, etc.) must be established.

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4.5 continued

UNICEF also urged that a garage for motorcycle repairs be set up by the MOH in Bertoua or Batouri. This became a further condition in January 1980 for delivery of motorcycles. The project of an MOH-financed garage was discussed and explored for months before quietly dying in late 1980. (It would have been financed out of the MOH contribution to PTHE and stocked by UNICEF with parts and tools). In addition, UNICEF required a maintenance system for the motorcycles to be established and operated by MOH. MOH responded with a monthly indemnity system which began in October 1980. By late 1980, UNICEF officials admitted (unofficially) that no motorcycles could be delivered in fiscal year 1980-81 under any circumstance and that prospects for 1981-82 were no better, due to shrinking UNICEF budgets and the 15% ceiling on the transportation component of UNICEF's budget in Cameroon. They offered bicycles or mobylettes.

Final UNICEF motorcycles contribution:

20 motorcycles--delivered in late January 1977.

2 steel boxes of spare parts (shared with CD) delivered in late June 1979.

Other Transport: UNICEF did provide Land Rovers for the Preventive Medicine section chiefs in Batouri and Mfou. A UNICEF Land Rover was delivered to Batouri in late 1977. By mid-1979, it was no longer road worthy and funds were not available for major repairs. Thus, in three years of the Project's four, no vehicle was available for supervision in the Kadey. Another UNICEF Land Rover was destined for Mfou in late 1979. In point of fact, it never left MOH. A well-worn Land Rover arrived in its place (the MOH replacement for the UNICEF gift) in late 1981.

Construction Materials: The MOH Chief of Sanitation Service had taken responsibility for a national plan of actions hydrauliques from which UNICEF would figure its contribution in cement, reinforcing bars, pipe, roofing tin, and tools. It was discovered, however, that neither Kadey nor Mefou were

included in the national plan. A rush was made to collect shopping lists, plans, estimates for water source improvements in the PTHE divisions which were then transmitted through HES (mid-1979). Nothing ever came of this. The Chief of the Sanitation Service claimed in early 1980 that the materials UNICEF had delivered were, for the most part, lost to rust, moisture, or theft in Douala port and that no other materials were forthcoming. And so, PTHE saw none of the promised construction materials.

Visual Aids: Although little of this ever reached PTHE field workers or health centers, UNICEF did contribute flannel boards, tape recorders, crayons, "etc." to MOH through HES. Flip charts used in Project areas were supplied by PTHE and the Peace Corps.

b. OCEAC

The original logical framework spoke of "consultants, training programs and office space." OCEAC participation in PTHE never reached those levels. Consultations, very informal ones, were rare and did not involve PTHE field personnel. OCEAC did not train any PTHE personnel nor participate in any of the training sessions. PTHE, rather, provided training opportunities for OCEAC students, and Project technicians were responsible for the health education courses in their 2-year epidemiology program. Office space was provided for the first the years of the Project before MOH gave PTHE permanent quarters, and office machinery was often shared during and after that two-year period, as were vehicles on rare occasions.

c. PEACE CORPS

The Peace Corps' association with PTHE actually predated the start of the UNC technical assistance contract, having fielded volunteers in the Kadey in 1977 in anticipation of Project start up. In four subsequent years, Peace Corps supplied over 560 person months of service--33 volunteers (29 health educators, 2 A-V specialists, 2 sanitation specialists). Beginning in 1980, Peace Corps supplied motorcycles for volunteers. Of the health

4.5 continued

educators, three extended their terms of service by a year: one remaining in post in Ndelele, one staying on as PCV leader/training associate, and one staying on as monitor for HES of the pilot primary school health program. Among the health educators, there were eight early terminations, and one among the A-V specialists.

Volunteer performance necessarily varied, but it is useful to discuss changes in PCV role over the life of PTHE.

The PCV role was first seen as that of a counterpart to IA's, sharing the same responsibilities. PCV's would work closely with IA's in village communities, often as a team separate from the health center. This led to a great deal of confusion among head nurses and local supervisors, as it was not at all clear who was to supervise community activities. Attempts at integrating the IA-PCV team into the health center team often met strong resistance or were misunderstood by the PCV's. Behind much of this was the lack of a clear understanding of the relationship between UNC field office, as technical assistance, and MOH and Peace Corps. And through it all, there was a noticeable drift away from the health education/community organization direction toward a more limited sanitation orientation for field work.

It is likely that lack of UNC and MOH input to PCV training was in large part responsible for confused directions and ambiguous roles. By 1980, the need was felt widely that the PCV role should be officially redefined, and the training of the next group of volunteers (arriving July 1980) be reorganized to reflect the new role definition. After long discussions with MOH field supervisors, PC, and project technicians, a new job description was developed for PCV's in PTHE. The new job description was really a reorientation back to health education, with a wider field of action than just the village health committee program. PCV's were to be freed from their counterpart role to IA's by more effectively dividing

4.5 continued

their time between health center and community outreach activities. Health center activities would include not only patient and group health education sessions, but also staff development activities. The experience of PCV's in Mbankomo and Esse had shown rich possibilities for staff development programs at health centers and hospitals, working in close association with the head nurse/doctor. It was, in fact, this last link which had failed to solidly ground the PTHE training strategy in the divisions: national and divisional level seminars, and even health-center workshops had to be followed up by regular locally organized training activities at health facilities for their staffs.

With the arrival of the third and final group of volunteers in July 1980, the reorientation began in earnest, with UNC field technicians and the PCV leader doing much of the design of the training. This complemented their earlier technical training sessions conducted in Chapel Hill--for the first time PCV's destined for PTHE service in Cameroon were able to discuss the Project and learn about it from UNC during stateside training. Once fielded (September, 1980), these ten PCV's (including 2 sanitation specialists, one for each division) performed much more closely to Project design. Mfou, Bandangoue and Awaé especially saw their PTHE programs expanded and their effectiveness greatly improved--not just in community outreach, but in the range of health center activities.

The classic conflicts of Peace Corps service--the short duration of participation relative to Project life, the need for job satisfaction within that short term as opposed to longer term goals--need not be discussed here. It is important to note that among donor agencies, Peace Corps met its commitments and often went beyond them--helping with logistics at national seminars, supplying health education materials and visual aids, and aiding in supervision. And volunteer performance generally received high marks from supervisors, colleagues, and villagers.

Chapter 5
Recommendations

5.1 Recommendations to The Ministry of Health

It appears that the MOH has a range of choices in regard to continuation and extension of PTHE strategies and methods. It could continue the Project at present levels of effort while continuing to refine strategies and methodologies. It may wish to identify the more successful components in terms of potential health benefits and replicate these on a broader basis. The Ministry may also consider revising some PTHE strategies based on input from its own evaluation of the Project. As the report of the MOH evaluation is not presently available, and its recommendations are not known, there are a number of recommendations which UNC technical assistance from Chapel Hill and from the field, would propose.

They are presented here and are organized under two major headings. The first set of recommendations are related to the diffusion of PTHE strategies and methods to other parts of the Cameroon, and are categorized by Project components. The second set of recommendations concerns the future development of efforts by the GURC to integrate primary health care and community development.

a. Improvement and Extension of PTHE Activities To Other Parts of Cameroon

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 be-

5.1 Continued

come more community oriented in practice and the role of their supervisors is to support the team approach to service delivery.

3. The support of the GURC needs to be demonstrated by official texts concerning the itinerant agent role: a job description and per diem to cover over-nights related to outreach activities, and means of transport. Fuel needs to be provided to the divisional Chiefs of Preventive Medicine to enable them to make the essential support and supervision.

4. 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.

5. 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.

6. 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.

7. Existing PTHE health centers in the Kadey and Mefou should be continued and further strengthened with personnel and finances to maintain the momentum of staff development and community outreach.

8. Other "pilot" health centers in additional divisions should be established to continue the steady and systematic extension of community oriented primary

5.1 Continued

health care rather than a fragmentary and superficial attempt to cover an entire region or country at once.

9. The selection of new "pilot" health centers should be based on the degree to which adequate tangible resources, support, and supervision can be provided to the staff, and particularly, to the itinerant agent.

10. A monthly report feedback system should be further developed if the practice of monthly reports by itinerant agents is to be maintained and extended to other divisions.

11. The use of a quarterly checklist from which points can be calculated as a tool for monitoring and assessing progress in terms of health center activities and community action. It is easily filled-out by health workers, require minimal levels of formal education, and data analysis assumes the most basic arithmetic skills. Its use, however, should be complemented with Evaluation Days to fully exploit its value as a planning and feedback instrument for the health workers.

12. The use of mopyettes, such as Peugeot 154, seems best for itinerant agent work, relative to questions of cost, security, and ease of repair.

13. As a follow-up to the National Seminar of July 1982, divisional Chiefs of Preventive Medicine should conduct surveys of their division to identify what is already being done in terms of community organization before deciding how best to integrate this strategy into the outreach efforts of health and other services.

Training

14. The trainers guide, developed through PTHE, should be further tested and expanded in the field by the MOH Training and Continuing Education

5.1 Continued

Service to develop training plans with specific objectives for each level of health personnel.

15. 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.

16. The training techniques introduced through PTHE such as role play, case study, small group discussion, and structured exercise should be continually used in in-service training activities for all levels to expose trainees and trainers alike to more active and learner-centered methodologies.

17. 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.

18. The MOH should initiate and encourage other ministries to collaborate on in-service training sessions by inviting their personnel to participate as trainers and trainees. The MINAGRI and MINEDUC should receive special attention to strengthen the already established collaborative relationship with the MOH.

Training Institutions

19. MOH should continue to invest in the Mefou Division Health centers to maintain appropriate field training sites for students.

20. MOH should designate a qualified trainer to work with nursing schools' directors and faculties to design feasible field training programs for each school.

5.1 Continued

21. The Training and Continuing Education Service of the MOH should follow-up the specific requests from the Assistant Nursing School in Abong-Mbang and Mbalmayo for technical assistance in organizing field training for their students.

22. The Training and Continuing Education Service should continue collaboration with CUSS and CESSI, and the MINSAF Rural Animator Training Service for their students' field training.

23. The Training and Continuing Education Service and the Health Education Service should continue collaborating with OCEAC in the development of its health education component for the 2-year epidemiology program.

School Health Education

24. 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.

25. The A-V production center at HES, once operational, should establish visual aids for primary school classroom use as a high priority, with subjects to be taken from the Teacher's Guide outline.

26. Yearly sessions, at the beginning of each school year at divisional and/or sub-divisional levels, should be organized for existing pilot schools to improve school health education methodology, giving special emphasis to relations between the school and the community and the school health committee.

27. 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.

5.1 Continued

b. Future Development of Effort by The GURC to Integrate Primary Health Care and Community Development

28. The Cameroon people are rich in traditions and known for strong family units, mutual aid societies, and youth and women's organizations. These units should be studied for their potential contribution to the reduction of morbidity and mortality related to preventable disease.

29. A structure exists whose potential has not been tapped -- the rural co-operatives (SOCOODER, CENADEC, SOCOOPED). 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.

30. Presently overlooked, but of increasing importance, are the number of retired health workers -- from ward servants to nurse - residing in rural areas. They potentially are a positive force for community health action, and in many cases could be particularly useful in establishing and monitoring village pharmacies or networks of family pharmacies.

31. Efforts should continue to encourage closer association of village health or development committees with their local primary schools. Potential benefits despite stubborn problems are great, in improving school environment and in putting health education into practice. This could be best accomplished through sub-divisional level campaigns.

32. Given the range of field workers in action at village and sub-divisional levels (MOH, MINAGRI, MINSAF, MINEDUC), MOH technical input for CD and MINSAF training is essential, just as CD trainers would be useful for the nurses aide community health program.

5.1 Continued

33. 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.

34. 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.

35. 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.

36. In-country resources such as the University and the General Delegation for Technical and Scientific Research should be encouraged to contribute to the design of programs to integrate community health development.

37. Continuing education must receive a high priority to maintain optimum levels of staff development, and particularly among frontline workers, with regularly scheduled village seminars a necessity. These could be organized by MOH in collaboration with the MINAGRI training centers.

38. 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.

5.2 Recommendations to USAID

Development projects often concentrate on a specific quantifiable objective, such as growing 25% more wheat or constructing fifty wells and ten schools, to the neglect of developing skills essential not only to the immediate project but to increasing the capacity of people to achieve self-reliance. Such skill development is central to the process of community organization and development as a strategy of health education. Several recommendations follow from this line.

1. USAID should collect and analyze research findings from all its demonstration projects to determine those characteristics that seem most strongly related to success in such programs.
2. To increase returns from diminishing external resources, USAID should consider the potential for development which exists within traditional helping systems such as family groups, women's organizations, and mutual aid societies.
3. Experimentation with several approaches to the same objective is justified, with projects of smaller scale, in order to develop a body of experience to guide program design and assistance.
4. 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.
5. Subsequent to this, a phased introduction to the project approach should begin at the lower ministerial levels, such as Chiefs of Service and below,

5.2 Continued

to establish a strong cadre of decision makers who will constitute a critical mass of technical managers and trainers or whom future program development will depend.

6. Intensive training of personnel in the field should focus on carefully selected and strategically placed pilot areas to serve as a central focus for further diffusion, and as training centers for students and new personnel assigned to the pilot areas.

7. 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.

8. 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.

9. 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.

10. 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 6

CONCLUSION

And so concludes the story of PTHE from the UNC point of view. While the bilateral technical assistance has officially ended, the theories and principles which guided the Project remain strong in presence and intact in practice. At times, PTHE was humbled by the complexities involved in on-site application of these theories and principles, however, the experience has proved to be a move in the direction that must be taken if the people of the United Republic of Cameroon are to experience significant improvements in health status in the future.

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?

"We tell them, but they won't listen" has been reiterated time and time again by health professionals. Why they don't listen is indeed a difficult question. And while the answers are likely to be as varied and complex as the respondents themselves, they are the central core of a project like PTHE.

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

6 continued

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.

The introduction of a panacea of interventions to ensure project success in the conventional sense was not the aim. Rather, the PTHE Project trained Cameroonian health workers to implement those very specific and sophisticated community organization techniques which have been shown to reduce health risks among populations in other parts of the world. The measure of project success would, therefore, be the extent to which communities and professionals have progressed together in their ability to design and implement health promotion and development projects as equal partners through self-help efforts and the redistribution of existing resources. In these terms, PTHE trained health workers at the village level, health center level, and divisional level succeeded. 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

6 continued

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. The Project's failure to have done so has resulted in a high level of enthusiasm and momentum generated among villagers and health workers in the pilot divisions to continue and expand PTHE activities being greeted by a ministry who won't listen."

Therefore, as Project technicians and coordinators who have been humbled by but elated with the four year experience, we strongly encourage the continuation of the PTHE approach within the MOH even if resources constraints dictate a reduction in effort. 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.

We also know that organizational boundaries within and between government 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.

We value the experience of PTHE in that it has enabled us to meet and work with cadres of dedicated and motivated health workers many of whom

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gave unselfishly of their time and energy to improve the human condition. We also wish to acknowledge their contribution to our own personal comfort and professional growth and experience. The opportunity to have worked with other ministries has been to our advantage as well and we are impressed with their commitment to national development and their openness to innovative ideas. Most of all, the sheer reality of the willingness and ability of the human community to strive for their own betterment was proven once again by the enthusiastic response from the people of the Kadey and Mefou Divisions to the PTHE challenge to become involved. The essential components required for health-related development are alive and well in Cameroon.

APPENDICES

Appendix A

List of Names

Ministry of Health

Minister of Health:

Mr. P. Fokam Kamga

Mr. A. Eteme Oloa

Projector Director:

(Director of Preventive Medicine)

Dr. J. R. M'Bakob

Dr. P. C. Mafiamba

Chief, Health Education Service:

Mr. Elias Joe

Assistant Chief, Health Education Service

(& Counterpart for Community Organization)

Dr. Edmond Ndjikeu

Chief, Sanitation & Public

Hygiene Service

Mr. Samuel Ngalle Edimoh

Mr. Jean Ngoka

Mr. Francis Ntuba

Director of Health Services:

Dr. Simon Atangana

Chief, Training and Continuing

Education Services:

Mr. Ignace Tchoumba

Dr. Ephrem Mba

Counterpart for Training:

Miss Emily Nkwanyuo

Mr. Jean Charles Ngombo

Madame Lucienne M'Bom

Director of ENISFAY:

Madame Damaris Mounloun

List of Names continued

Provincial Delegates:	Central-South East	Dr. Denis Bomba Nkol'o. Dr. Daniel Mouchili
Provincial Chief, Preventive Medicine and Public Hygiene Service:	Central South East	Dr. Emmanuel Tchekanda Dr. Owona Essomba Dr. Emmanuel Dame Dr. Emmanuel Tchekanda
Preventive Medicine Section Chief:	Kadey: Mefou:	Dr. Pierre Nkopchieu Dr. Emmanuel Dame Dr. Pierre Onna Dr. Lucien Monthe Mr. Martin Medjoto Dr. Afane Ela
<u>Ministry of National Education</u>		
Vice Minister		Mrs. Dorothy Njeuma
Director of Primary Education		Mr. Joseph Ndzino Mr. Beling Koumba
Chief of Training Service and Pedagogical Affairs:		Mr. Wilfred Ntoko
University Center for Health Sciences		
Assistant Director		Dr. Dan N. Lantum
Chief of Public Health Unit		
Professor of Community Medicine		Dr. Thomas Nchinda

List of Names continued

Center for Advanced Nursing Training

Director:

Ms. Alice Collomb

Community Medicine Lecturer:

Ms. Myriam Jato

Ministry of Agriculture

Community Development Directorate

Director

Mr. Andrew Ndonyi

Chief of Training Service

Mr. Martin Lontouo

Mr. Jean Marie Minkoulou

Provincial Section Chief,

Eastern Province

Mr. Janvier Bouoto

Ministry of Social Affairs

Director of Rural Animation Program,

Chief of Training Service

Mrs. Henriette Mvondo

International Organizations

World Health Organization

Representative

Dr. Robert Dackey

Dr. Georg Quincke

UNICEF

Program Coordinators

Mr. Ian Hopwood

Ms. Kathia Fisch

Mrs. Angeline Songomali

OCEAC

Secretary General

Dr. Louis Sentihles

Training Director

Dr. Pierre Eozencu

List of Names continued

USAID

USAID/Yaounde

Mission Director:

Mr. James Williams
Mr. Ronald Levin

Chief, HNPO:

Dr. Albert Henn
Dr. Richard Brown
Mr. Ray Martin

Project Manager:

Mr. Richard Thornton
Ms. Eilene Oldwine
Mr. Doug Palmer
Ms. Erna Kerst (Acting)
Mr. Ray Martin

USAID/AFR/DR

Technical:

Mr. Russ Anderson
Mr. Sid Chambers

UNC

UNC Field Officer/Yaounde

Chief of Party:

Dr. Ethel Martens (9/78-5/79)
Dr. Darryll Candy (5/79-6/82)

Technician for Community Organization:

Dr. Darryll Candy (9/78-5/79)
Mr. Michael Davies (1/30-6-82)
Ms. Nancy McCharen (9/78-6/82)

Technician for Training:

List of Names continued

UNC Campus Based Team

Campus Coordinator:	Dr. John W. Hatch (6/78-9/82)
Associate Campus Coordinator:	Dr. Guy W. Steuart (6/78-9/82)
Assistant Campus Coordinator:	Dr. Raymond Isely (6/78-8/78)
	Ms. Eugenia Eng (4/80-9/82)
Health Training Specialist:	Ms. Eugenia Eng (6/78-4/80)
Anthropology Specialist:	Dr. Tony Whitehead
Evaluation Specialist:	Dr. Godfrey Hochbaum
Community Organization Specialist:	Dr. Alan Steckler
Community Organization Specialist:	Mr. Leonard Dawson
Administrative Officer:	Mr. Paul Seaton (10/78-9/82)
Research Assistant:	Mr. Robert Costantino (4/79-8/81)
	Mr. James Herrington (9/81-9/82)

APPENDIX B

ORIGINAL LOGICAL FRAMEWORK

PRACTICAL TRAINING IN HEALTH EDUCATION 631-009

To increase the ability of the rural population and other underprivileged groups to participate in development activities

1. Organization of Village Leadership to address village priorities.
2. Knowledge and Utilization by villagers of multiple government services.
3. Participation by villagers in planning of CURC service programs.

1. Annual Reports of Committees, activities and projects from government and other field workers.
2. Annual Reports from government and private agencies on volume of services provided villagers.
3. Annual Reports from project participants (Agencies and Institutions) on village participation in program planning and use of services.

1. Poor health is a limiting factor to socio-economic development.
2. Villagers will take advantage of increased opportunities to participate in program planning.
3. CURC continues to encourage village participation in general socio-economic development.

To develop and implement a nationally coordinated practical training system of health education activities responding to the needs of the rural population and other underprivileged groups in Africa. Initial project activities will take place in the Nifou and Zafé districts of Cameroon.

- Conclusions that will indicate purpose has been achieved and of project status.
1. Coordination by IOM/C of practical training programs conducted by WHO/CUSS, OCEAC and EHSIFAY
 2. Integration of health into other socio-economic programs in villages!
 3. Modification of educational objectives by institutions involved to match reality of village life.
 4. Continuous reassessment of project impact on villages of service provided.

1. System of reporting and planning between participating bodies
2. Health and other sector workers planning village projects together
3. Village committee and field worker reports
4. Review of WHO/CUSS, OCEAC, and EHSIFAY curricula for practical training
5. Periodic feedback of villagers perception of project value.

1. Coordinated and integrated action is more efficient than independent and isolated action.
2. Impact on villages is more positive and effective through coordination
3. Villagers will understand the relationship among various development activities
4. CURC will continue to support project and will incorporate findings and goals of project in national planning
5. Future health personnel for Africa should acquire practical experience in the environments in which they will eventually work

- Output:
1. Program of village health committees
 2. Program of teacher in-service training
 3. Program of coverage for health and other workers
 4. Program for OCEAC mid-level workers
 5. Program for CURC students
 6. Program for EHSIFAY students and faculty.

- Magnitude of Outputs:
1. 788 village health committees
 2. 120 Field level workers trained and working
 3. 511 Primary School Teachers trained
 4. 160 Health Workers recycled
 5. 100 Mid-level nurses trained
 6. 400 Professional level CUSS students trained
 7. 311 EHSIFAY students trained
 8. 10 EHSIFAY faculty trained
- Total persons trained 1,614; Total villages served: 78; Total population served: 270,000

1. Coordinating committee reports
2. Training program reports
3. On-site observation
4. Review of Plans, documents, and schedules
5. Periodic conferences.

1. Inputs implemented in a timely manner
2. Continued cooperation and support
3. Project technicians will have relevant expertise

A.I.D.

- Technicians: Instance Team: 144 M/M
- Recycle Program: 10,000/Days
- Scholarships: 63 M/M
- Health Education Conferences (4)
- Mid Project Evaluation
- Commodities: 3 vehicles + POL
- Personnel: 26 Volunteers
- Scholarship, Consultant Services, Supplies
- CURC: 20 motorcycles, construction & additional materials
- EHSIFAY: Faculty Support
- CURC: Consultant Services, Training Program and Facilities
- WHIC: Personnel and Budget Support

Implementation Items (Type and Quantity)

1. Technical Assistance Contract	\$1,263,000
2. Recycle Program	80,000
3. Scholarships	340,000
4. Commodities	52,000
5. Health Conferences	40,000
6. Mid-Project Evaluation	25,000
initiate 18 mos. after project technicians report in Cameroon	
7. Contingency	103,000
8. Installation	147,000
TOTAL AID	\$ 2,040,000

AID PROJECT BUDGET
 AID CONTRACT OFFICE
 File, etc.

1. Continued availability of funds
2. Current training programs continued
3. Suitable candidates identified for training

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APPENDIX C

REVISED LOGICAL FRAMEWORK

Best Available Document

A.1. Goal
 To increase the number of health-related development activities identified and undertaken by rural populations.

A.1.1. PURPOSE
 To develop and implement a nationally coordinated practical health education training system which responds to the needs of rural populations.

C.1. OBJECTIVE
 1. Effective program of village health committees implemented in the Keady and Mefou

2. Effective in-service training program for health and other workers operational in the Keady and Mefou

3. Program of practical training for CBS/CBSI and other health training institutions operational.

4. Expanded health education program developed for primary school
 5. Audio-visual workshop constructed, equipped, and operational.

D.1. INPUTS
UNLAD
 Technical assistance
 Field Team - 344 P/M
 UNLAD Budget - 117 P/M
 Local XRP - 178 P/M
 Training
 In-Country
 U.S.
 Committee
 Other Costs

UNLAD/NGO Personnel
 Project Coordinator, Technical Assistant, Supplies Manager, Audio-Visual Specialist, Artist, Personnel at health center, department provided, national level
Training Seminars/Workshop Construction
 Office Space

A.2.
 1. Village leadership organized to implement program for health improvement according to local priorities.
 2. Villagers increase use of specific public services within the Ministries of Agriculture, Education, Health and Social Affairs such as rural engineering and community development.

B.2. E.O.L.S.
 1. Interagency Coordinating Committee meets regularly to review all aspects of practical health education training system.
 2. PRHE methods (sit, needs assessment, planning, training design, active participation, team work, trainer follow-up) are utilized by key services in the Ministry of Health.
 3. A national plan for an expanded practical health education program in primary schools.
 4. Materials developed by the audio-visual center are being distributed nationwide.

C.2.
 1. a. 40 itinerant agents trained and in the field with means of transportation by 6/82.
 b. 240 committees established, of which 80% are rated as "active" by 6/82. (Refer to rating scale)

2. a. 160 health workers and 30 Peace Corps volunteers trained and effectively implementing program of health education in 16 health centers by 6/82.
 b. Training materials/design developed and utilized by PRHE in 8 KCM in-service training program by 6/82.
 c. 25 workers from other services trained, of which at least 8 utilize training to undertake specific health activities.

3. a. 2 graduating classes of CBS/CBSI will have completed field training in PRHE sites by 6/82.
 b. One graduating class for "instructors" will have completed field training in PRHE sites by 6/82.
 c. 20 professors from health training institutions will have positive practical experience training by 6/82.
 d. 2 teachers from 8 pilot schools receiving in-service training by 6/82.
 e. Teachers instruction manual developed by 6/82.

3. a. Workshop constructed by 12/80.
 b. Audio-visual personnel hired by 12/80, including 1 P/M, 1 Commission audio-visual specialist, and 1 Commission artist.
 c. Management system within health Education Service in place, including procedure for processing requests and re-ordering supplies.
 d. 20 health education posters/ brochures printed by 6/82.

D.2.
UNLAD (as revised 1980-4-Appendix D)
 Technical Assistance \$1,172,100
 Contract 8 214,250
 Training 8 124,000
 In-Country 8 98,000
 U.S. 8 73,850
 Committee 8 12,850
 Other Costs 8 20,000,000
TOTAL: \$2,000,000

UNLAD/NGO Personnel - 1 year
 Approx. \$2,178,000
 1979/80 (\$49,560,000 CFA)
UNLAD
 Training, Seminars/Workshop Construction \$8,700,000 (CFA)
 Committee 1,500,000
 Construction 12,500,000
 Garage 2,000,000
 Office Space 1,400,000
TOTAL: 20,000,000
 1980 Total request \$2,000,000 (CFA)
 1980 Total request \$4,000,000 (CFA)

A.3.
 1. Annual reports from Territorial Administration regarding self-help development efforts based in each semi-profecture.
 2. Annual reports from Government and private agencies on volume of services provided to villagers.

B.3.
 1. Meeting reports
 2. Reports from key services including: Training and Continuing Education Service and health training institutions. Site visits of training sessions.

3. Review of program plans and documents.
 4. Reports from the Health Education Service.
 5. For all DOP: UNLAD Evaluations: 1-1980/11-1981/11-1982.

C.3.
 1. a. KCM/Health Education Service Reports
 b. Training program reports
 c. Health evaluation reports
 d. KCM/Health Education Service reports
 e. Monthly reports of itinerant agents
 f. Site visits.
 2. a. Training program reports
 b. In-service evaluation reports
 c. Site visits
 3. Training reports from other KCM services.

4. Training program reports
 5. Reports from health centers and itinerant agents.
 6. Reports of PRHE and CUB training reports.
 a. Site visits.
 b. Review of training reports.
 c. Site visits.
 6. Training program reports.

7. a. Training reports.
 b. Site visits.
 c. Review of manual.
 8. Operation of site.
 9. Budget review.
 6. Documentation from Health Education Service.
 7. Examination of audio-visual aids.

D.3.
 1. UNLAD accounts and records.
 2. UNLAD accounts and records
 3. KCM accounts and records.
 4. Other agency accounts and records.

B.4.
 UNLAD will continue to support local initiatives both politically and through provision of services.

1. UNLAD will incorporate findings and results of the Project in national planning.
 2. Villagers will take advantage of opportunities to organize to solve health related problems.

C.4.
 1. KCM will incorporate results of the Project from the Keady and Mefou districts into national health planning.
 2. On-going cooperation will be maintained in the PRHE between the Project and all KCM services.

3. Continuity of personnel involved in the PRHE will be maintained (KCM, UNLAD, P/UNLAD).
 4. On-going cooperation will be maintained between KCM and UNLAD.
 5. Health training institutions continue to recruit community field training for their students.

6. Professors are available for training.
 7. Availability of funds and other inputs at critical moments so as not to hinder attainment of outputs.
 8. Project Personnel will have the necessary skills (KCM, UNLAD, P/UNLAD).
 9. On-going operation of existing training program.
 10. Appropriate evaluation will be identified for in-service or UNLAD and field placement.

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APPENDIX D

CLEANEST VILLAGE CONTEST JUDGING SHEET

215

FICHE DE NOTATION - CONCESSION

Nom de la Famille _____

Nom du village _____

Centre de Santé _____

1. Source d'Eau

Cette famille se procure de l'eau dans une source notée à _____

Le conteneur d'eau est propre et couvert _____

TOTAL _____

2. Latrine (Un point pour chaque réponse positive)

1. Latrine d'au moins 4 mètres de profondeur _____

2. Dalle _____

3. Dalle définitive _____

4. Trou avec couvercle _____

5. Trou de 30 x 10 cm de secteur _____

6. Abri _____

7. Latrine située à au moins 50 mètres de la source d'eau _____

8. Latrine éloignée de pas plus que 8 mètres de la maison _____

9. Latrine propre _____

10. Latrine utilisée _____

TOTAL _____

3. Fosse à ordures (Un point pour chaque réponse positive)

1. Présente _____

2. Pas remplie à plus de 50 cm du bord _____

3. m.² de secteur _____

4. Ordures couvertes avec de la terre _____

TOTAL _____

4. Enclos pour bêtes (excluant les volailles)

Cette famille a des bêtes _____

Les bêtes sont dans un enclos _____

.N.B. : S'il y a des bêtes en liberté (hors de l'enclos),
enlever 5 points du total.

5: Propreté générale de la concession (Un point pour chaque
réponse positive) _____

1. Maison crepie _____

2. Maison peinte _____

3. Cour débroussée _____

4. Cours balayée _____

5. Cour débarrassée d'animaux errants (sauf volailles) _____

TOTAL _____

Total des points de la concession _____

(Moins 5 pour les bêtes errantes) _____

TOTAL _____

DATE _____

Noms des membres du jury : _____

FICHE DE NOTATION - SOURCE D'EAU

Localisation de la source _____

Nom du village _____

Centre de Santé _____

Marquer un (1) point pour chaque réponse positive.

1. Source Aménagée (Date d'aménagement _____) _____
2. Aménagée avec des matériaux définitifs _____
3. Rigole de protection présente et nettoyée _____
4. Rigole d'évacuation présente et nettoyée _____
5. Un minimum de 5 litres d'eau coulant du tuyau par minute _____
6. Accès à la source nettoyée _____

TOTAL _____

16

DATE _____

APPENDIX E

QUARTERLY EVALUATION FORM

FICHE D'EVALUATION TRIMESTRIELLE

Période de _____ à _____
 Centre de Santé _____ Méfou _____
 Kadey _____
 Nom du Personnel : Chef de Centre _____
 Agent Itinérant _____
 Volontaire du C.P. _____
 Nombre Total de personnel au Centre de Santé _____
 Nombre Total des villages à desservir par ce Centre de Santé : _____

7. ACTIVITES DU CENTRE DE SANTE	1er mois	2 ^{ème} mois	3 ^{ème} mois	Ann
1. REUNION DE TRAVAIL				
a. Le personnel du Centre programme, au moins 2 fois par mois, des réunions afin d'améliorer leurs rôles aussi bien que les services du Centre ?	2 pts	X each month		6
b. Les réunions de travail sont-elles faites au moyen des contacts individuels selon le besoin de temps en temps ?	1 pt.	X each month		3
2. EDUCATION INDIVIDUELLE DU MALADE				
a. La plupart des conseils sont-ils orientés vers la prévention ?	2 pts	X each month		6
b. La plupart des conseils sont-ils orientés vers le traitement ?	1 pt.	X each month		
3. EDUCATION EN GROUPE				
a. Le personnel prépare t il et présente t-il des causeries au sujets de la santé aux malades au moins 2 fois par semaine ?	2 pts.	X each month		6
b. Des causeries sanitaires sont-elles présentées de temps en temps ?	1 pt.	X each month		
PROTECTION MATERNELLE ET INFANTILE				
a. Consultations des femmes enceintes ?	2 pts	X each month		6
b. Consultations des nourrissons ?	2 pts.	X each month		6
AMENAGEMENTS SANITAIRES				
a. Latrines aménagées, utilisées et entretenues ?	2 pts	X each month		6
b. Aménagement d'eau potable disponible, entretenu ? au centre	2 pts.	X each month		6
c. Construction d'une latrine en cours ?	2 pts.			
d. Aménagement d'un point d'eau en cours ?	2 pts.			
e. Autres aménagements réalisés pendant le trimestre en cours ?				
(Lesquels) 1. _____				
2. _____				
3. _____				
	2 pts. X project			
	TARGET score: 45 220			

Best Available Document

II. ACTION COMMUNAUTAIRE (à remplir pour chaque village contacté)

1. Nom du village : _____

Population approximative : _____

POINTS AFFIRMATIVE réponses	1er mois	2 ^e mois	3 ^e mois	MAX.
a. Notables villageois contactés ?	2 pts	X each month		6
b. Enquête communautaire et analyse de la hiérarchie de l'autorité villageoise faites ?	3 pts	X each month		9
c. Les besoins ressentis des villageois sont-ils recensés ?	3 pts	X each month		9
d. Comité installé dans ce village, s'occupant des questions sanitaires ?	3 pts.	X each month		9
e. Comité installé se réunit-il au moins 2 fois par mois ?	2 pts X each month or meeting/month = 1 pt each month			6
f. Comité installé avec des projets sanitaires achevés pendant le trimestre en cours ? (Lesquels) _____	2 pts	X each project		
g. Comité installé avec des projets sanitaires en cours ? (Lesquels) _____	2 pts	X each project		
h. Comité installé avec des projets agricoles ou alimentaires achevés pendant le trimestre en cours ? (Lesquels) _____	2 pts	X each project		
i. Comité installé avec des projets agricoles ou alimentaires en cours ? (Lesquels) _____	2 pts.	X each project		
j. Ecole primitive où le programme d'éducation sanitaire est-il dispensé ?	1 pt	X each month		3
k. Ecole participant dans la réalisation d'un projet communautaire ?	1 pt	X each month		3
l. Ecole avec une association de parents d'élèves active ?	1 pt.			1
m. Existence de services de l'école, régulièrement entretenus ?	2 pts.	X each month		6
n. Existence d'un notable à l'école ?	2 pts	X each month		6
o. Ecole avec un projet sanitaire en cours ? (Lequel) _____	2 pts	X each project		
p. Ecole avec des projets agricoles ou alimentaires en cours ? (Lequel) _____	2 pts	X each project		

ACTIVE = ≥ 38 pts.

a + b + c + d + e monthly meeting + no project = 38
(credit would separately)

Best Available Document

III: LIAISON

	1er mois	2 ^e mois	3 ^e mois	pts
1. Comité est en contact avec les responsables des services ou organismes suivants :				
a. _____	X	$(\frac{1}{3} + \frac{1}{3} + \frac{1}{3})$	= 1	
b. _____	X	$(\frac{1}{3} + \frac{1}{3} + \frac{1}{3})$	= 1	
c. <i>(contacts had to be maintained throughout the quarter to receive points)</i>				
d. _____				
e. _____				
2. Les services et organismes suivants participent aux activités du Comité				
a. _____	X	$(\frac{2}{3} + \frac{2}{3} + \frac{2}{3})$	= 2	
b. _____				
c. <i>(participation had to be maintained throughout the quarter to receive points)</i>				
d. _____				
e. _____				
3. Les autres Centres de Santé suivants, participent aux activités du PTRA +				
a. _____				
b. _____				
c. _____				
d. _____				
e. _____				

N. B. : + Remplir une autre fiche pour chacun des Centre de Santé.

LIAISON points were added to the total on review and

APPENDIX F

MOH VILLAGER QUESTIONNAIRE

COPIE

QUESTIONNAIRE

Numéro 20065

LA POPULATION

Département _____ Village Djanguel Chef de village oui M
 non F

1) Est-ce qu'il y a un comité de santé dans votre village ? oui non

Si oui, est-ce que vous êtes membre du comité oui non

Si oui, depuis combien de temps existe-t-il, ce comité de santé ?

un an deux ans trois ans plus de trois ans

Si oui, que fait ce comité ? (N.B. l'enquêteur cochera la (les) réponse (s) donnée(s)).

Journées de propreté

Aménagement des points d'eau

Education sanitaire

Construction de latrines

Pharmacies familiales

Autres (à préciser) _____

2) Est-ce qu'il y avait une journée de comités dans votre secteur (zone) oui

Si oui, dans quel village ? Où ? (NB l'enquêteur cochera la réponse donnée) non

KADEY

Ngoulemekong

Dongali

Kambéle Chantier

Alouma

Dimako

Oundjiki

Autre _____

MEFOU

Dzouzok

Andock

Nkolmending

Autre _____

22/

Si oui, que fait-on au cours de cette journée de comités ?

(NB l'enquêteur cochera la (les) réponse(s) donnée(s))

séance d'éducation sanitaire

aménagement d'un point d'eau

construction d'une dalle de latrine

distribution des médicaments

autres à préciser _____

3) Est-ce que votre village a participé dans le Concours du Village le mieux assaini ?

oui non

Si oui, est-ce que vous même, vous avez participé au Concours pour le prix de la meilleure concession ? oui non

4) Y a-t-il un centre de santé que votre famille fréquente ? oui non

Si oui, lequel ? _____

Si oui, y a-t-il des séances d'éducation sanitaire à ce centre de santé ?

oui non

Si oui, quels sujets sont discutés ? (NB l'enquêteur cochera la (les) réponse(s) donnée(s))

l'hygiène corporelle

les maladies et leur protection

la nutrition

l'hygiène du milieu

la P. M. I.

Autre (à préciser) _____

5) Est-ce que le comité de santé aide à améliorer les conditions de vie dans votre village ? oui non

6) Est-ce que l'agent itinérant aide à améliorer les conditions de vie dans votre village ? oui non

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7) Est-ce que vous participiez aux activités du comité de santé ?

oui non

Si oui, quelle est votre participation ? (N.B. l'enquêteur cochera la (les) réponse(s) donnée(s))

assistance aux réunions participation active
(investissement humain)

participation matérielle inspection d'hygiène

autre (à préciser) _____

APPENDIX G

VILLAGES INCLUDED IN SAMPLE

VILLAGES A ENQUETER

(questionnaire - chefs de villages et population)

KADEY (20)

MEFOU (20)

Bandongoué

Bandongoué
Daliguéné S.A.K.
Dimako II
Zembélé

Awae

Awae I
Ebolewa
Mewoudou
Mvolo

Batouri

Dimako
Anoë
Kolkélé
Kambélé Chantier

Esse

Esse village
Nkolombonde II
Nsimi
Ebolnkok

Ketté

Bossia
Nambora
Ndzambi
Oundjiké

Evindissi

Abang-Mindi
Andock
Nkolmekok
Ntouessong I

Mbang

Djampiel
Kosso
Molabo
Moloundou

Mfou

Obout A
Béguélé
Dzouzok
Meven

Ndélélé

Banga
Sone
Alouma
Yola

Ngoumou

Nkongzok II
Nkongmeyos III
Ebolbourn II
Nkongbibega

- Enquête à mener par 10 maîtres d'école dans chaque département (2 par centre)

— Echantillon : Kadey : 20 villages (2 centres x 4 villages)
Méfou : 20 villages (5 centres x 4 villages)
5 villageois/village (chef + 2 membres du comité dont une femme si possible et 2 qui ne sont pas membres)

= 200 réponses

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APPENDIX H

ITINERANT AGENT QUESTIONNAIRE

I. Itinerant Agent Questionnaire

A. Personal Data:

1. Name AMIC NGELE M. Michel
2. Sex M
3. How old are you? 40
4. Are you married? Yes No Other
If yes, how many wives do you have? 2 (ff)
5. Does your wife (s) work outside the home? Yes No Other
If yes, what type of work outside the home does your wife do?
Wife ff 1 (longest marriage) _____
Wife ff 2 _____
Wife ff 3 _____
Wife ff 4 _____
6. How many children do you have? 7
7. What religion do you belong to? Catholic
8. What ethnic group (or tribe) do you belong to? ETENGA
9. What is your family (or lineage or clan) name? ✓
10. Where do you live most of the time, that is, what is your address?
BIKOK
11. Do you live some other place some of the time? Yes No
Other
If yes, where is that? MBADOUOU II (7 mi. from BIKOK)
12. How long have you lived in BIKOK? 12 years
13. Where did you grow up? MBADOUOU II
14. How many years of formal school do you have? 13 (level of 5th)
15. What other kinds of training do you have? For example, nursing, first aid, etc.

<u>1st</u> aid	<u>Graphic</u>	<u>Yacoubi'</u>
health education, itinerance	<u>2 months</u>	<u>CLCAC</u>

16. How long have you been an aide sergeant? 4 (if years or
in months if less than 2 years)

17. What other types of work did you do before becoming an aide sergeant,
and how long did you work at each occupation? itinerant

OCCUPATION	LENGTH OF TIME
(always a health worker)	

D. Social Support

18. Do people often come to you for advice and help?

4 Yes _____ No _____ Other

If yes, what type of advice and/or help do people come to you for?
Of those items that people come to you for help, rank them according
to which one you are consulted for most frequently.

a. sickness or illness	<u>2</u>
b. marital or courtship problems	<u>6</u>
c. family problems	<u>6</u>
d. job information or help	<u>6</u>
e. religious consultation	<u>6</u>
f. legal or political help/information	<u>3</u>
g. other (specify and rank.)	<u>sanitation 1</u>

19. About how many times per week do people come to you for advice or help?
(Circle appropriate number.)

- a. less than one time per week
- b. one to two times per week
- c. three to four times per week
- (d)** five to six times per week
- e. six to seven times per week
- f. eight to nine times per week
- g. ten or more times per week
- h. other

20. What kind of people come to you for help?

a. Men? x Yes _____ No _____ Other _____

b. Women? x Yes _____ No _____ Other _____

c. Do (ethnic group) come to you for help?

x Yes _____ No _____ Other _____

(Ask for each ethnic group.) ETENGA only ethnic group

In the IA's home community and the region he or she serves

D. Do (occupational group) come to you for help? ✓

_____ Yes _____ No _____ Other _____

(Ask for each occupational group in IA's home area and the region served.)

21. Why do you think people come to you for advice and help? ✓

22. Have there been times that you feel that you can't be of much help when you are asked?

_____ Yes x No _____ Other _____

If yes, what type of help or advice and why?

(Based on answer to # 18 a)

Problem

Why

a. sickness or illness _____

b. marital or courtship problems _____

c. family problems _____

d. job information/help _____

e. religious consultation _____

f. legal or political help/information _____

g. other (specify) _____

23. Has anyone ever come to you for advice or help, do you ever refer them elsewhere?
If yes, to whom or where and why?

Problem	Whom or where referred	Why such referral
a. illness/sickness	<i>head ^(nurse) nurse or Doctor (n/c)</i>	<i>best qualified</i>
b. marital or courtship		
c. family		
d. job information/help		
e. religious consultation	<i>curat or priest</i>	<i>best qualified</i>
f. legal or political help/ information	<i>party representative</i>	<i>best qualified</i>

24. Do you ever go to anyone for help or advice in the following problem areas?
If yes, to whom and why?

Problem	Whom sought	Why this person
a. illness related		
b. marital/courtship		
c. family related		
d. work related		
e. religious relates		
f. legal/political		
g. other (specify)		

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c. Network Associations

25. Give the names of organizations or groups that you belong to, the criteria necessary to get into this group or association, what office do you hold in this organization, and where do most of the members reside?

Name of group	Membership criteria	office held	Residence of Membership
PTA	parent of pupil	counselor	BIKOK
savings society	—	President	BIKOK
UNC	party militant	JUNC delegate (youth section)	BIKOK

D. Itinerant Agent Activities

26. How long have you been an itinerant agent? 6 (in years, or months or less than 2 years.)

27. What communities do you serve as an itinerant agent?

Bikok center

Nkolmeku

Nkolngok II

Alen

Ebougou Menyou

Oman II

Mbadaumou I

Kouibou

Abang

11. Tell me in how many of these communities has a village Health Committee been organized, when they were organized, if each still exists, the types of projects each have attempted, if each project achieved its goal, and if not, why not. (Continue on back of page if necessary)

Place of village with VHC	Date initiated	Still in existence yes or no	Types of projects initiated	Project's goals achieved?	If goal is not reached, why not? Write in appropriate project number and letter
1. Bivok village	1.29/1/76	1. yes	1a. 1b. 1c.	1a. 1b. 1c.	
2. Nkolmeden	2. 01/2/76	2. yes	2a. 2b. 2c.	2a. 2b. 2c.	
3. Nkolngak II	3. 18/1/78	3. yes	3a. 3b. 3c.	3a. 3b. 3c.	
4. Alen	1.21/1/78	4. yes	4a. 4b. 4c.	4a. 4b. 4c.	

5) Elchajir Mengyu	12/12/73	yes
6) Oman II	10/12/75	yes
7) Abdulouman I	07/10/78	yes
8) Koulibou	25/10/78	yes
9) Abang I	24/09/75	± yes

APPENDIX I

HEALTH CENTER INVENTORY FORM

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FICHE D'INFORMATION DES CENTRES

DE SANTE/HOPITAUX

Centre de santé/hopital _____ Dept. de _____

Nom du Chef de Centre _____ Grade _____

Nombre total de personnel _____

Nombre total de personnel ayant participé
dans un séminaire ou recyclage dans le
cadre du Projet PTHE _____

Nom et fonction de la personne
qui remplit ce questionnaire _____ date _____

Nous vous prions de répondre à toutes les questions. Pour la plupart de ces questions, les réponses possibles sont données ; il suffit de cocher (avec un /x/) la réponse appropriée pour votre centre/hôpital. Pour d'autres questions, nous voudrions plus de précisions ; vous verrez la place réservée à ces précisions. Vos réponses devraient être basées sur les activités des derniers six mois (depuis Septembre 1981)

SCORING 0 - 1 - 2

ACTIVITES DU CENTRE DE SANTE/HOPITAL

1. Réunions de travail

- A) Les réunions de travail, dans votre centre, sont-elles organisées :
- une fois/trimestre /2 une fois/mois /2 toutes les deux semaines /2
chaque semaine /2 de temps en temps /1 jamais /0
- B) Y a-t-il un compte rendu rédigé pour ces réunions de travail ?
- toujours /2 de temps en temps /1 jamais /0

2. Formation permanente du personnel

- A) Y a-t-il des séances de recyclage organisées à l'intention de votre personnel dans votre centre ?
- une fois/an /1 une fois/six mois /1 une fois/trimestre /1
une fois/mois /2 une fois/semaine /2 jamais /0
- B) Quels sujets sont traités au cours de ces séances de recyclage ?
- sujets cliniques /1 santé communautaire /2
techniques d'éducation sanitaire /2 autre (à préciser) /1

(3) leur faites des visites médicales toujours 2 de temps en temps 1
jamais 0

(4) donnez des conseils aux mères toujours 2 de temps en temps 1
jamais 0

D) Est-ce que votre centre/hôpital bénéficie du Programme CRS ? oui
non

6. Aménagements sanitaires au Centre

A) Présence d'une latrine pour :

les malades seuls 1 le personnel seul 1
malades et personnel 2 absence de latrines 0

B) la latrine est-elle propre et entretenue ?

toujours 2 de temps en temps 1 jamais 0

C) Y a-t-il de l'eau propre au centre pour :

le personnel seul 1 les besoins de service 1 les malades 2
le personnel et les besoins de service 1 pas d'eau propre au centre 0

D) Comment les ordures et les déchets du centre sont-ils détruits ou évacués ?

fosse à ordures au centre 2 incinération 1
voirie 2 pas de système d'évacuation 0

II. ACTION COMMUNAUTAIRE

1. Séances éducatives dans la communauté

A) Est-ce qu'il y a des sorties du personnel du centre dans les communautés voisines ?

une fois/semaine 2 deux fois/mois 2 une fois/mois 2
selon les besoins 1 jamais 0

B) Les séances d'éducation sanitaire, sont-elles organisées dans les villages ?

chaque jour 2 une fois/semaine 2 deux fois/semaine 2
selon les besoins 1 jamais 0

C) Qui fait le travail d'organisation communautaire ?

l'agent itinérant 1 chef de centre 1
l'agent itinérant et le chef de centre 2
le personnel 2 personne 0

This question was suggested due to similarity (a bit?) response

D) Quels sont les résultats de ce travail d'organisation communautaire dans votre secteur ?

	Combien	
latrines aménagées et utilisées	<input type="checkbox"/>	_____
points d'eau aménagés	<input type="checkbox"/>	_____
enclos pour bêtes	<input type="checkbox"/>	_____
fosses à ordures	<input type="checkbox"/>	_____
comités de santé actifs	<input type="checkbox"/>	_____
(ou comité de développement)		

2. Visites domiciliaires

A) Est-ce qu'il y a un programme de visites domiciliaires ?
 chaque jour 2 une fois/semaine 2 deux fois/mois 2
 selon les besoins 1 pas de programme 0

B) Quel est le motif habituel de ces visites ?

inspection d'hygiène	<input type="checkbox"/> 1	pour livrer une convocation	<input type="checkbox"/> 0
la P M I	<input type="checkbox"/> 2	pour les causeries	<input type="checkbox"/> 2
les soins aux malades	<input type="checkbox"/> 1	autres motifs (à préciser)	1

3. Collaboration avec d'autres services

A) Est-ce que la collaboration existe avec d'autres services ?
 toujours 2 selon les besoins 1
 lors d'une invitation 1 quand il y a des problèmes 1 jamais 0

B) La collaboration existe entre la Santé Publique et

les maîtres d'écoles primaires	<input type="checkbox"/> 1	les moniteurs agricoles	<input type="checkbox"/> 1
les missionnaires/catéchistes	<input type="checkbox"/> 1	pas de collaboration	<input type="checkbox"/> 0
les assistants du Développement Communautaire	<input type="checkbox"/> 1		
autres (à préciser)	1 / réponse		

C) Quels sont les résultats de cette collaboration ?

amélioration de l'éducation sanitaire dans les écoles primaires	<input type="checkbox"/> 1
surveillance médicale des élèves	<input type="checkbox"/> 1
aménagement des latrines aux écoles primaires	<input type="checkbox"/> 1
création des marchés de vivres	<input type="checkbox"/> 1
aménagement des routes	<input type="checkbox"/> 1

création des champs collectifs	<input type="checkbox"/> 1
campagnes contre la divagation des bêtes domestiques	<input type="checkbox"/> 1
construction des foyers communautaires	<input type="checkbox"/> 1
aménagement des points d'eau	<input type="checkbox"/> 1
autres (à préciser)	_____

I	health centre activities target score:	50
II	community action target score:	<u>25</u>
	overall target score	75

réponses	centres																			M			
	BANDJOLIE	BATOURI	GENÈTIRE	BOUENGA	KOTTE	MOANG	MINIBOU	MOULELE	MOULELE	M	BELEBO	BELEBO	BOUENGA	BOULI	DENE	DANE	BOUENGA	BOUENGA	MOUREN		MOUREN	MOULO	M
I Activités de centres																							
1 activité par le journal (question 1 & 2)	11		8	11	6	6	3	12		8,1	2	10	12	4	6	1	5	5	4	2	10	5,2	
2 activités scolaires (question 3 & 4)	10		10	10	12	10	7	9		9,7	8	9	9	6	14	9	9	12	12	9	10	9,7	
3 (question 5)	10		8	10	10	9	4	11		8,9	11	12	11	3	8	10	10	11	9	10	10	9,5	
4 aménagement extérieur (question 6)	4		1	6	2	0	0	7		2,9	2	8	6	1	5	8	3	8	1	1	2	4,3	
score	35		27	37	30	25	14	39		29,6	23	39	38	10	33	28	29	36	26	22	32	28,7	
cible: 50																						50	
II Action communautaire																							
1 activité communautaire (question 1 & 2)	12		6	10	6	6	5	9		7,7	8	10	6	0	8	5	5	3	8	3	5	4,8	
2 collaboration avec d'autres (question 3)	12		8	9	9	9	6	10		9	3	7	10	6	9	2	3	3	6	5	6	5,45	
score	24		14	19	15	15	11	19		16,7	3	17	16	6	17	7	8	6	14	8	11	10,3	
cible: 25																						25	
notes globales	59		41	56	45	40	25	58		40,3	26	56	54	16	50	35	37	42	40	30	43	39	
cible: 75																						75	

Best Available Document

réponses	AKONG	AKAF	BIKOK	MEFOU	EVINDI	MEANKOMO	MFOU	NDI	NGILMOU	SEA	M	DZENG	GBOGO	KUMARI	NDI	M								
I. Activités de centre																								
1. activité pour le personnel (question 102)	4	11		13	8	12	13			1	8,7	9	2	10	4	7	3	5		4	2	10	9	6,1
2. réception activités (question 104)	12	13		11	11	12	8			6	10,4	11	10	12	3	11	8	9		7	12	11	9	9,4
3. P.M.I. (question 5)	6	11		10	7	11	9			2	8	6	7	6	0	6	7	4		8	8	9	7	6,2
4. aménagement activités (question 6)	5	6		7	2	6	6			3	5	5	0	0	6	6	2	2		4	2	4	6	3,4
score	27	41		41	28	41	36			12	32,1	31	19	28	15	30	20	20		23	24	34	51	25
cible: 50																								50

II. Action Communautaire																								
1. activités communautaires (question 100)	8	3		9	9	5	5			5	6,3	5	0	9	0	0	8	0		7	0	9	4	3,8
2. réalisations activités (question 3)	8	7		11	9	10	8			4	8,1	9	5	0	1	1	9	6		4	7	6	3	4,6
score	16	10		20	18	15	13			9	14,4	14	5	9	1	1	17	6		11	7	15	7	8,45
cible: 25																								25

notes globales	45	51		61	46	56	49			21	46,7	44	24	37	16	31	37	26		34	31	49	38	33,4
cible: 75																								75

540

APPENDIX J

SCHOOL HEALTH CURRICULUM OBSERVATION FORM

FICHE D'OBSERVATION DES LECONS
D'EDUCATION POUR LA SANTE
DANS LES ECOLES PRIMAIRES DU CAMEROUN

Ecole :

Maître :

Date :

Nbre d'élèves :

Garçons

Filles

Total

Classe :

1°) Sujet de la leçon :

A. Est-ce que cette leçon était prévue dans le programme pilote ?

oui non

B. Si non, pourquoi était-elle traitée ?

C. Selon le livre du maître, quel était le but de cette leçon ?

2°) A. Quel matériel éducatif était amené en classe ?

B. Etait-il employé efficacement ? oui non

C. Etait-il approprié ? oui non

D. Avez-vous des suggestions ? oui non

Si oui, lesquelles ?

3°) Quelles méthodes pédagogiques étaient employées ?

Causeries _____ Travaux Pratiques _____

Démonstration _____ Visite sur le terrain _____

Autre (à préciser) _____

4°) Vocabulaire :

A. Le vocabulaire était-il adapté au niveau de compréhension de la classe ? oui non

B. Si non, quels étaient les mots à changer ou à éliminer ?

C. Faites des suggestions

5°) Quel est le moyen de contrôle utilisé par le maître ?

Démonstration Pratique _____

Interrogation orale _____

Interrogation écrite _____

Entretien _____

Autre (à préciser) _____

6°) Est-ce que la leçon était comprise par les élèves ?

Très Bien Bien Assez Bien Non

Justifiez votre réponse.

7°) Participation des élèves :

Très active Active

Passive Nulle

8°) Le but de cette leçon était-il atteint ?

oui non

Justifiez votre réponse

9°) Durée de la leçon : _____ Minutes

10°) A DEMANDER AU MAITRE : quelles sont été les sources d'information pour la préparation de la leçon ?

11°) Remarques et Suggestions du Maître :

12°) Remarques et Suggestions de l'Observateur :

Signature de l'Observateur :

Enseignant

Infirmier

Agent itinérant

Volontaire du Corps de la Paix

Membre du comité de santé

Autre (à préciser) _____

APPENDIX K

STUDENT KNOWLEDGE AND ATTITUDE QUESTIONNAIRES

**PROGRAMME PILOTE DE L'EDUCATION SANITAIRE
DANS LES ECOLES PRIMAIRES
EXAMEN DIAGNOSTIQUE : COURS ELEMENTAIRE**

Ecole : _____

Enseignant : _____

Classe : _____

Pour chaque phrase suivante, il faut répondre "oui" ou "non".
Vous allez décider si la phrase est vraie ou fausse.
Si la phrase est vraie, vous allez encercler le mot "oui"
Si la phrase est fausse, vous allez encercler le mot "non".

Par exemple :

Le chien a quatre pattes : oui non

C'est vrai que le chien a quatre pattes, donc vous devriez encercler "oui" comme ça :

Le chien a quatre pattes <u>oui</u> non

1. Pour un enfant comme moi, un bon petit déjeuner est le café et le gâteau sucré.
oui
non
2. La cola et les bonbons ne sont pas bons pour les dents
oui
non
3. Les aliments qui m'aident à grandir sont les fruits, les œufs, le lait, les légumes, et les haricots.
oui
non
4. C'est dangereux d'utiliser le bic pour nettoyer les oreilles.
oui
non
5. Le microbe entre dans le corps par la bouche, le nez, les yeux, et les oreilles.
oui
non
6. Je dois nettoyer les dents avant de manger.
oui
non
7. Les vaccinations me protègent contre certaines maladies.
oui
non

8. Quand je mange, la nourriture passe par l'estomac.

oui
non

9. Le paludisme vient des moustiques.

oui
non

10. Si je mange la nourriture touchée par les mouches, je pourrai tomber malade.

oui
non

11. L'hôpital et le dispensaire sont des lieux où l'on soigne les malades,

oui
non

12. La latrine empêche la pluie et les mouches de porter les selles au village.

oui
non

13. Si je bois l'eau bouillie ou filtrée, je pourrai tomber malade.

oui
non

14. Il faut laver les plaies avec de l'eau et du savon.

oui
non

15. Un enfant ne peut rien faire pour éviter les maladies.

oui
non

16. Un enfant sale reste en bonne santé

oui
non

17. Il faut beaucoup d'argent pour rester en bonne santé

oui
non

18. Je suis responsable de ma propre santé

oui
non

19. Il vaut mieux prévenir les maladies que les guérir.

oui
non

20. L'éducation sanitaire est importante pour les grandes personnes, mais pas pour les enfants

oui
non

PROGRAMME PILOTE DE L'EDUCATION SANITAIRE
DANS LES ECOLES PRIMAIRES
EXAMEN DIAGNOSTIQUE : COURS MOYEN

Ecole : _____

Enseignant : _____

Classe : _____ Date : _____

Pour chaque phrase suivante il faut répondre "oui" ou "non".
Vous allez décider si la phrase est vraie ou fausse.
Si la phrase est vraie, vous allez encercler le mot "oui".
Si la phrase est fausse, vous allez encercler le mot "non".

Par exemple :

Le chien a quatre pattes oui non

C'est vrai que le chien a quatre pattes, alors vous devriez encercler "oui" comme ça :

Le chien a quatre pattes <u>oui</u> non

1. Les mouches portent beaucoup de maladies.
oui
non
2. En utilisant une latrine, j'aide à prévenir les maladies.
oui
non
3. Les aliments infestés par les mouches sont dangereux pour ma santé.
oui
non
4. Les maladies des poumons et du cœur peuvent être causées par les cigarettes.
oui
non
5. Je devrais prendre les médicaments seulement quand mes parents me les donnent.
oui
non
6. La nourriture que je mange passe par l'œsophage et entre dans les poumons.
oui
non
7. La bière et le vin pourraient empêcher le cerveau de bien travailler.
oui
non

8. Le meilleur moment pour nettoyer mes dents c'est juste avant de manger.

oui

non

9. Quand je coupe mon doigt, je dois le laver avec du savon et de l'eau

oui

non

10. C'est une bonne idée d'utiliser un bic ou une allumette pour nettoyer les oreilles.

oui

non

11. Il faut soigner les dents seulement quand elles font mal.

oui

non

12. On prend la nivaquine pour traiter les vers intestinaux.

oui

non

13. Les moustiques peuvent porter le paludisme.

oui

non

14. La tuberculose est une maladie des poulmons.

oui

non

15. Les déchets non protégés peuvent causer des maladies intestinales.

oui

non

16. Si j'enlève autour de ma maison des objets cassés comme des bouteilles et des boîtes de conserves, je préviens le tétanos.

oui

non

17. Pour rester en bonne santé, je dois manger beaucoup de nourriture non variée.

oui

non

18. Les aliments qui aident à former des dents fortes sont le café et le pain

oui

non

19. Si on est vacciné contre la rougeole, on sera protégé contre la rougeole et la variole.

oui

non

20. Une latrine sans danger doit être au moins à 4,5 mètres de profondeur.

oui

non

21. Une personne qui dépose les selles partout facilite la transmission des oeufs de parasites.

oui

non

22. Une des conséquences du manque d'hygiène dans la communauté est l'épidémie.
oui
non
23. Il y a un comité villageois dans mon village qui s'occupe des problèmes sanitaires.
oui
non
24. Je suis trop jeune pour suivre les règles d'hygiène pour rester en bonne santé.
oui
non
25. Quand je vais chez les vendeuses, je n'achète pas les aliments non-protégés.
oui
non
26. Quand je tombe malade, ce n'est pas ma faute.
oui
non
27. Les villageois ne peuvent rien faire pour résoudre les problèmes d'hygiène au village.
oui
non
28. Pour prévenir les maladies, il faut beaucoup d'argent.
oui
non
29. L'éducation sanitaire m'apprend comment éviter les maladies.
oui
non
30. Je suis capable d'améliorer et de maintenir ma propre santé.
oui
non

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APPENDIX L

EVALUATION REPORT OF VISITING SCHOLARS PROGRAM

FINAL REPORT
of the
CAMEROON VISITING SCHOLARS PROGRAM

Fall Semester 1981
University of North Carolina
School of Public Health
Department of Health Education

I. BACKGROUND

The PTHE mid-project evaluation report (see Gridley et al, 1980, p. 19) recommended that the monies which were originally allocated for upper level health education training at the WHO School of Public Health which moved from Yaounde to Cotonou, Benin, be used to provide 20 middle and upper level Ministry of Health (MOH) personnel with 2-4 weeks of training in preventive health education by the UNC/Chapel Hill staff before September 1981 either in Yaounde or in Chapel Hill. Other training options had been discussed and rejected by the MOH: (1) A Master's degree program in health education was too long (two years); would necessarily continue beyond the end of project; and, since the Cameroonian government was no longer providing salary continuation to trainees on long-term programs abroad, it was unlikely that there would be many applicants. (2) A training program to be held in Yaounde could not utilize experiential methods and would be limited in scope unless UNC were allowed to send and could spare as many as 10 of its faculty.

Following discussions between the UNC-CH and Yaounde staffs, the UNC-CH Coordinator (Dr. John W. Hatch) submitted a proposal in July 1980 to the Project Director describing an intensive, bilingual month-long short course which could be held in Chapel Hill in July 1981 followed by an optional semester long Visiting Scholars' program. The Coordinator suggested that ten Cameroonians could attend the short course, and that two could remain in Chapel Hill for the Visiting Scholars' program. An important aspect of this proposal was that UNC-CH would invite participation by MOHs from other African countries. This would add diversity to the group and promote an exchange of experiences and ideas.

UNC-CH was encouraged by informal responses from Yaounde and began planning the program. In December, 1980, the Cameroon MOH began selecting applicants to attend. UNC designed and mailed invitations to Ministries of Health and health training institutions throughout Africa and the Caribbean to participate in the program.

In May 1981, UNC-CH learned that USAID/Yaounde was unwilling to approve Cameroonian participation in the short course. At this point it was impossible for UNC to cancel the short course because of the number of applications received from the health ministries of other African countries which had already been approved for funding by their respective USAID Missions. The short course was held from July 6 to August 1, 1981.

In mid-August we were informed that four Cameroonians were arriving to participate in the Visiting Scholars' program. Lucienne M'Bom, the project's training counter part, was the only name communicated. It was unclear as to who the other three were. M'Bom arrived on August 16 carrying with her the names and titles of the other visiting scholars. Abicho, Anye, and Ndjikeu arrived on August 23 with Anye having no more than a briefcase with him due to the rushed nature of their departure to be in Chapel Hill in time for the first week of classes.

II. MANAGEMENT AND LOGISTICS

Management of the Visiting Scholars program was provided by James J. Bozek of the U.S. Department of Health and Human Services International Education Division (HHS/IED) with Paul Seaton, the Project PTHE Administrator, serving in a liaison capacity between the University and HHS/IED.

Bozek and Seaton worked together closely and Bozek was at all times helpful and supportive. However, the lead time given was so short that IED could not generate special stipend checks until the participants had been in Chapel Hill for three weeks, and it was only through extraordinary effort by Bozek that the checks arrived when they did.

The delay of financial support for the participants when they arrived created an atmosphere of suspicion on the part of the participants, which often clouded the program. The participants found it difficult to believe that the PTHE administrator had no control over the issuing of stipends or the amount of the stipend. It was necessary for the administrator to spend approximately 50% of his time with the participants meeting their logistical needs. When the administrator eventually persuaded the University to lend the participants \$1000 two weeks after they had arrived, it served to reinforce the participants' notion that their money had been here in Chapel Hill all along. Additionally, the PTHE Coordinator and Assistant Coordinator made substantial personal loans to the participants during this period.

A. Housing. Although the participants' program was relatively short-term (four months), they received the stipend which was for long-term training. Thus, they could not afford to live in a hotel with this stipend. A family was found which was interested in boarding M'Bom. The three men moved into a small two-bedroom apartment. The administrator leased it and the furniture in his own name for a year. Students and staff of the department donated cooking utensils and other necessary items for housekeeping. Security deposits on the apartment, furniture, utilities and telephone were all absorbed by the university as well as the penalties for breaking the various leases after the four-month period. The participants could afford to pay the rent but were unable to pay for the other costs involved.

B. Transportation. The participants lived a few miles from the campus and purchased passes to ride the local busses. Additionally, volunteers with cars were available to provide them with supplementary transportation.

C. Books. The participants received a book allowance of \$50.00 which was inadequate to purchase the required texts for their courses. The University agreed to reimburse the participants for their books although the

money was not paid to them until their departure.

D. Field Trips. An important aspect of the program was demonstrations of community-based projects (See Section IV). State-owned automobiles were provided for transportation for all but the California trip. HHS/IED issued GTRs for transportation there. While in California and Arizona, local transportation was provided by automobiles rented by the University.

There were two trips requiring overnight stays -- the California trip (seven nights) and the South Carolina trip (four nights). HHS/IED provided \$21.67 per day for these 11 nights away from Chapel Hill, but that amount was inadequate for Los Angeles, Tucson and Charleston. The University expended a considerable sum of money from its own trust funds to provide the participants with adequate per diems for these cities.

E. Translation. The University hired Ms. Michelle Defour, an accomplished simultaneous interpreter, to accompany the francophone participants to lectures and related activities. She utilized headphones and microphones in providing this service. Ms. Defour, along with student volunteers, assisted the participants with their readings and written assignments.

III. LEARNING OBJECTIVES

The four visiting scholars initially met with the PTHE project assistant coordinator to discuss the degree of professional experience and technical training in their backgrounds and individual learning needs and interests they could each pursue during their four month program at UNC. It was quite clear that due to their varied interests and backgrounds, four individual programs of study were necessary to meet their different needs. In keeping with the PTHE approach and the UNC Department of Health Education's framework for training, each visiting scholar was given the main responsibility for outlining learning objectives and determining how best to achieve them in four months' time through course work offerings and field visits. To build in flexibility and a mechanism for feedback, they would meet as a group on a regular basis with the PTHE project director and assistant coordinator to discuss the strengths and weaknesses of their programs as well as suggestions for improvement.

To provide a clearer understanding of the individualized nature of the visiting scholars' program, the learning objectives for each scholar are listed below:

Goni ABICHO

In his present position as the Chief of the Preventive Medicine and Rural Medicine Section for Maroua, he needs:

1. to understand health education principles, strategies, and techniques for motivating behavior changes among the population.
2. to be able to collect and analyze data for epidemiological studies with special reference to endemic disease control.
3. to improve his skills in supervising the 40 nurses responsible to him with special reference to team work in screening for endemic disease.

4. to up-date his laboratory techniques for detecting parasitic diseases;
5. to learn instructional methods for in-service training of nurses at all service delivery levels.

Samuel ANYE

As a member of the faculty of the Nursing School in Bamenda, he needs:

1. to improve his teaching skills with special reference to instructional methods and curriculum development for the clinical and theoretical aspects of nursing.
2. to acquire a general understanding of theory, approaches, and techniques particular to the administration of nurses' training institutions.
3. to learn the basic principles of primary health care.
4. to review and refresh basic laboratory skills for detecting common diseases.

Lucienne MBOM

In her roles as administrator and trainer for the PTHE project and the Division of Training and Continuing Education within MOH, she needs:

1. to learn how projects in the U.S. which are similar to PTHE conduct program planning, implement strategies, resolve problems, and conduct on-going evaluation.
2. to be able to plan, organize, implement, and evaluate public health training of trainers and in-service training programs.
3. to up-date her clinical knowledge of practice in the field of maternal and child health.

Edmond NDJIKEU

As a civil servant at the ministerial level of public health and as a professional with a terminal degree in health education, he needs:

1. to develop an outline for a manual of educational techniques specifically appropriate to the Cameroonian context in the prevention of endemic disease.
2. to develop the criteria and methodology for the evaluation of PTHE to propose to MOH.
3. to up-date and compare his knowledge of health administration techniques with the American orientation toward theory and practice in administration.

IV. PROGRAM DESCRIPTION

A. Course Work

In partial fulfillment of their learning objectives, the four scholars

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individually selected graduate courses being offered in the School of Public Health which appeared to be the most relevant to their specific needs and interests. The assistant coordinator then met with each of the instructors (1) to gain permission for auditing; (2) to orient them to the objectives of the visiting scholars' program and the backgrounds of the particular scholars interested in attending the course; and (3) to discuss the degree to which the course content and methodology could meet the scholars' individual learning objectives.

In addition to these course electives, all four scholars were strongly urged to attend HEED 230 and EPID 160 (described below) which are required courses for graduate students in health education. The health education faculty felt that because the four scholars had not participated in the intensive July 1981 short course, Community Health and Development: Program Plan and Design, exposure to the basic principles of applied health education and epidemiology through these two courses could provide the needed foundation for short-term graduate study in community health and development.

Each visiting scholar carried a course load of at least twelve hours per week. This is equivalent to a full-time semester of graduate work in public health. To reduce the language barrier for Abicho, Mbom, and Ndjikeu, they attended English language classes at the University for ten hours per week and were accompanied by a simultaneous translator to all their classes and other program activities.

A brief description of each of the courses taken is provided:

1. Course work pursued by all scholars:

<u>Course</u>	<u>Description</u>	
HEED 230	<u>Cross-Cultural Consultation</u> Concentration in the process and content of cross-cultural and international consultation; particular emphasis is placed on technical assistance to developing country health programs; special reference is made to planned social and behavioral change. Instructor: Dr. Steuart	3 hours/week
EPID 160	<u>Principles of Epidemiology</u> Introduction to meaning and scope of epidemiology and the use of morbidity, mortality and other vital statistics data in the scientific appraisal of community health. Instructor: Dr. Omran	3 hours/week
2. Goni ABICHO's individual course work		
PHNU 261	<u>Community Nursing Service Administration I:</u> Concepts and methods of administering community nursing services, examines functions of the nurse administrator in areas of organizing,	3 hours/week

staffing, program planning, priority setting and evaluation of services.

Instructor: Dr. Tigar

PHNU 271 Instructional Approaches in Public Health Nursing 3 hours/week

Educational issues involved in preparation for public health nursing practice and education; study and evaluation of public health - community nursing content in nursing curricula; strategies focus on instructional approaches involving innovation and change.

Instructor: Dr. Ossler

PALP Independent Study in Parasitology 3 hours/week

Focus on current activities in medical parasitology and tropical diseases of medical and economic importance in Africa with special emphasis on interrupting the life cycle of various disease vectors for prevention and control purposes.

Instructor: Dr. Gbakima

3. Samuel ANYE's individual course work

PHNU 261 Community Nursing Service Administration I: 3 hours/week

Concepts and methods of administering community nursing services; examines functions of the nurse administrator in areas of organizing, staffing, program planning, priority setting and evaluation of services.

Instructor: Dr. Tigar

PHNU 271 Instructional Approaches in Public Health Nursing 3 hours/week

Educational issues involved in preparation for public health nursing practice and education; study and evaluation of public health - community nursing content in nursing curricula; strategies focus on instructional approaches involving innovation and change.

Instructor: Dr. Ossler

PALP Independent Study in Parasitology 3 hours/week

Focus on current activities in medical parasitology and tropical diseases of medical and economic importance in Africa with special emphasis on interrupting the life cycle of various disease vectors for prevention and control purposes.

Instructor: Dr. Gbakima

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- HADM 202 International Health 3 hours/week
 Weekly seminar dealing with current issues, problems and research in development, implementation and evaluation of primary health care endeavors in less developed countries; emphasis on independent research of particular interest area for presentation to class at end of semester.
 Instructor: Dr. Freymann
4. Lucienne MBOM's individual course work
- MHCH 210 Maternal and Infant Health and Family Planning 2 hours/week
 Health needs, problems, and programmatic issues in maternal-infant health and family planning. Includes biologic, sociocultural and psychological factors.
 Instructor: Drs. Siegel and Peoples
- HADM 202 International Health 3 hours/week
 Weekly seminar dealing with current issues, problems and research in development, implementation and evaluation of primary health care endeavors in less developed countries; emphasis on independent research of particular interest area for presentation to class at end of semester.
 Instructor: Dr. Freymann
5. Edmond NDJIKEU's individual course work
- HADM 209 Fundamentals of Health Administration 3 hours/week
 General introduction to health management concepts and methods in relation to managerial roles, program planning, implementation and evaluation.
 Instructor: Dr. Jain
- PALP Independent Study in Parasitology 3 hours/week
 Focus on current activities in medical parasitology and tropical diseases of medical and economic importance in Africa with special emphasis on interrupting the life cycle of various disease vectors for prevention and control purposes.
 Instructor: Dr. Gbakima

HEED Independent Study in Health Education 2 hours/week
 Overview of evaluation research methodology
 and design.
 Instructor: Dr. Schiller

HEED Independent Study in Health Education 2 hours/week
 Preparation of publications of the ethno-
 graphic study conducted in the Kadey Division
 of Cameroon.
 Instructor: Dr. Whitehead

B. Field Visits

To complement the academic aspects of course work, several field site visits of on-going projects and services were programmed for the visiting scholars to enable them to observe how theory can be put into practice. A brief overview of each site is provided:

1. Joint Orange-Chatham Community Action, Siler City, N.C.

Local anti-poverty agency serving the poor and near poor throughout numerous multi-purpose centers in rural Chatham and Orange counties. Activities include:

- Head Start Program for pre-kindergarten children;
- improved housing;
- community organization, transportation and adult education;
- the Senior Citizen Nutrition Program.

2. The Lincoln Community Health Care Center, Durham, N.C.

A family-centered primary health center, located in what was formerly the Lincoln Hospital -- an historically black hospital. Emphasis is placed on health education, mental health, prevention of disease and prenatal and family planning services.

3. General Baptist State Convention, Health and Human Services Project, Oxford, N.C.

With a membership of 480,000 blacks, the Convention's objective is to address the major health problems afflicting black Americans, such as diabetes mellitus, hypertension and infant mortality, specifically by:

- creating a formal mechanism for implementing health promotion activities at the association and local church levels.
- identifying and training 300 church members as health and human service coordinators within their respective churches in a Health and Human Services pilot program.

4. North Carolina Central University, Department of Nursing Bachelors' Program, Durham, N.C.

Historically black nursing education program in the U.S. which fits into the structure of the University of North Carolina. Activities included during the visit:

- Description of curriculum and four-year course of study
- Discussion of opportunities for African students to be admitted
- Comparison of nursing education in U.S. with that of Cameroon
- Tours of Media Center, Skills Laboratory, Reading Room, and a class in session.

5. Newton Grove Migrant Health Center, Newton Grove, N.C.

Rural primary health care program providing services to predominantly Haitian migrant workers.

6. Winston-Salem University, Nursing School, Winston-Salem, N.C.

LPN program in an historically black institution of higher education.

7. American Public Health Association Conference, Los Angeles, CA

The visiting scholars participated in the 109th annual meeting of the APHA in Los Angeles, California. The theme of "Energy, Health, and the Environment" provided the scholars with exposure to the issues and concerns of the more than 11,000 expected participants. Four hundred working sessions covering a wide variety of topics were available during the week-long conference. Some of the sessions included:

- Energy issues and health planning
- Environment: Food production in the 21st century
- Evaluating family planning service delivery and the impact of family planning programs
- Improvements in organizing and administering health services
- Paths to power for women in Health Administration

8. Martin Luther King Hospital and Drew Medical Center, Los Angeles, CA

Nationally recognized medical facilities and community outreach programs developed by and providing services to urban black communities. They are examples of community development and action approaches to health care delivery.

9. Indian Health Service, Tucson, Arizona

The Indian Health Service programs in Arizona were visited over a period of three days:

1. The Marana Community Clinic, serving the Yaqui Indian reservation
2. The Papago Indian reservation hospital and mobile health unit which integrates community participation through the work of community health representatives.

3. The Santa Rosa Clinic which is an outlying post on the reservation for treatment of minor health problems, staffed by nurse practitioners, and has a referral system to a near-by hospital.
4. The indigent Papago village in Gunsight, Arizona is the site of an experimental development project in solar energy exploitation which has established via solar cell arrays and distribution system a solar electric powered water pump and storage, lighting for homes, a small community refrigeration system, and power for washing and sewing machines.

10. Sea Island Comprehensive Health Care Corporation, John's Island, S.C.

This program is among the very few in the U.S. that has developed comprehensive health care and economic development initiatives. It is particularly well-known for the strong role that the black rural poor and near-poor residents play in determining policy.

The slave trade history of John's Island is of particular interest to Africans visiting the U.S. Due to its physical and social isolation from mainstream America, strong cultural links with West African ethnic groups still exist in terms of language, tradition, and customs.

C. Work with PTHE

M'Bom was involved for 2 hours/week with the UNC-CH PTHE staff in developing the final year strategy for the PTHE project in Cameroon. Emphasis was placed on the development of the specific methods and procedures involved in implementing the final year strategy. This included a work plan that outlines the timing, roles and outputs of the PTHE team in Yaounde, the UNC support team in Chapel Hill, the Cameroonian Ministry of Health, and other relevant Cameroonian ministries and officials.

An important aspect of the final year strategy is the design of an evaluative instrument by the UNC-CH staff this fall. This instrument will focus on the following strategic points:

1. Comparative analysis of the relative successes and failures in village organization and committee developments that have occurred to date;
2. Intensive and detailed analysis of the processes and outcomes involved in efforts to strengthen the village and school programs in the Mefou and the Kadey; essentially an evaluation of the role model to be left by the PTHE. Special attention is given to the major problems confronting the program in the Kadey. In particular, the issues of multi-ethnic village organization, migrating labor problems, and possible examination of a single ethnicity as a foundation for future work.
3. Analysis of the determinants for (a) effective diffusion from stronger health center programs to those in their defined cluster and (b) effective inter-village diffusion. Systematic attention and reinforcement will likely be needed during the final year.

V. FACULTY ASSESSMENT OF PROGRAM

The original concept of the Visiting Scholars Program was designed to provide Cameroonian health personnel working with PTHE an academic experience

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which would enhance their skills and expand their working knowledge of community health. It was not meant to be a substitute for a degree program nor for basic training in public health. Therefore, it would be important for the visiting scholars to begin their short-term study with basic notions of public health practice and exposure to the strategies of PTHE at the very least. As a result of discussions held with MOH, the direct advantage of sending middle and upper middle level Cameroonian health personnel as visiting scholars would be their increased ability to work within the health system to diffuse, continue, and assess PTHE activities when they return.

As mentioned earlier in this report, the initial proposal for the Visiting Scholars Program included participation in the Department of Health Education's intensive four week short-course held in July. Along with senior health officials from Africa and the Caribbean the short-course would have provided them with an in-depth orientation to community health and development program planning. It was also expected that the short-course experience would have given the Cameroonian scholars a clearer idea of the resources and expertise available to them for developing and pursuing a more specialized program of study during the fall semester from August to December.

Given that most of the above expectations were not fully met, the program was modified accordingly. The most immediate change resulted from the fact that no one, including the scholars themselves, knew in advance who was coming and when. Thus, the PTHE faculty and staff at UNC were required to spend the first three weeks following the arrival of the scholars almost exclusively on their logistical needs as described in Section II. Substantive training preparations such as course selection, orientation to the School of Public Health, and assessment of learning needs not only took second priority during this time but also were done quite hurriedly since the scholars needed to begin course work immediately.

Abicho and Anye experienced the most difficulty during this period. They had previously experienced little travel outside of Cameroon. Therefore, problems of acculturation were more pronounced for them. Also, having had no prior experience with nor exposure to the activities of PTHE, Abicho and Anye had difficulty understanding the relationship between the project and their professional roles. In retrospect, it would have been more productive had UNC faculty affiliated with PTHE taken more time personally to orient them to the project's approach, activities, and objectives rather than providing them with documents to read and assuming that M'Bom and Ndjikeu could adequately answer most of their questions. As it was, Abicho did not actually understand the project until the middle of the semester. This came as a result of the Cameroon team assignment in Dr. Steuart's course. Anye ended the program with a superficial description of PTHE activities but not much more. Most of his energies were focused on continuing his nursing studies in the U.S. and not on expanding his role in Cameroon to include PTHE activities. Abicho and Anye also had less formal training in public health than either M'Bom or Ndjikeu. Consequently, the range of options open to them was quite overwhelming in that they did not have a strong enough foundation in public health to select a specific direction to follow. On the other hand, whatever they were exposed to was new and of interest. They were both very open to absorb and learn as much as they could while at UNC.

Although Ndjikeu's arrival was just as hurried as Abicho and Anye's he experienced fewer acculturation problems due to his having spent a significant amount of time in Europe and the U.S. before coming as a visiting scholar to UNC. However, his expectations concerning logistical support and his role

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as a visiting scholar were unrealistic. Holding a doctorate in health education and the status of an assistant chief of service, Ndjikeu requested special consideration, such as a chauffeur driven car, which PTHE faculty and staff were not able to fulfill, either because resources were simply not available or because his demands were not felt to be justified. To further illustrate, Ndjikeu did not intend to do any course work at all, but rather, planned to invest his time in writing and in securing funds for publishing a manual on specific educational techniques for disease prevention on Cameroon, with each disease having its own technique. An independent study with an instructor who has expertise in tropical medicine was arranged, however, neither the content area nor the funds for publication was related to the purpose of the Visiting Scholars Program. Additionally, his expectation to design the PTHE evaluation while he was in Chapel Hill and then to receive funding from USAID to implement it when he returned to Cameroon was also not feasible. When it was made clear that a collaborative effort between USAID, MOH and PTHE was already underway, but could certainly benefit from his input, Ndjikeu no longer pursued this interest in evaluation methodology.

As evidenced from these two examples among others, there was a conflict of expectations concerning the relationship of PTHE to the Visiting Scholars program. The priority of UNC was to ensure direct benefits to PTHE continuation efforts through the visiting scholars' learning experience at UNC. Ndjikeu was more committed to pursuing opportunities for personal gain and development. These two objectives do not necessarily have to be mutually exclusive, but in this case there was very little overlap. One aspect, however, on which Ndjikeu and UNC do agree is that he did not meet any of his learning objectives during his four month program. Moreover, there was no relationship between his learning objectives and the needs of PTHE.

M'Bom's experience was quite different from any of the other three scholars. She arrived with a very positive and clearly defined relationship to PTHE both personally and professionally. As the project training technician counterpart for the past year and a half with CESSI level training, M'Bom needed very little orientation to community health and development. Her professional interest as a nurse-midwife led her naturally to focus on maternal and child health aspects more than on training methods. In fact, two field visits were specifically arranged for her to see the obstetrics and pediatrics facilities at Duke Medical Center and to meet with the Dean of the Nursing School at UNC to discuss childbirth preparation methods. PTHE faculty benefitted from her presence in that she actively contributed to the development of evaluation instruments and provided additional insight to possible strategies for continuation of PTHE.

However, difficulties were experienced in her seeming lack of interest in doing assignments outside of class and meetings. The time that was not committed to class or meetings was spent getting acquainted with mainstream America. This in itself was a very positive learning experience for her. However, it did reduce the degree to which she achieved her learning objectives. In retrospect, a formal independent study allowing her to meet and discuss with each faculty member in the Department of Health Education on a rotation basis would have been more beneficial than the sporadic meetings she had with them on an as-needed basis. She appears to work better in a structured setting.

Overall, the high degree of diversity among the visiting scholars' needs and backgrounds as well as ill-planned timing and the reduced period of stay from six to four months were major factors which contributed to the sense of unfinished business. The UNC faculty and staff were not able to be as flexible

as the program required. The necessary level of individualized attention was not anticipated by the UNC faculty and staff, nor realistically feasible in light of very limited advance preparation, when coupled with the UNC faculty and staff's on-going responsibilities. Prior commitments such as academic teaching, consultation, community service, and technical assistance had already been made for the fall semester. The project assistant coordinator who played a major role in the Visiting Scholars Program had a prearranged obligation to spend the month of October in Cameroon, for example. Her absence reduced the degree of direct communications between the scholars and UNC faculty, and no one else had the time available to fill the temporary gap.

Nonetheless, the four month long program was productive and time well spent for the scholars and UNC in two ways. First, the content area of community health and development was consistently reinforced and expanded through each of the courses taken and each of the field sites visited. This was possible due to this School of Public Health's basic philosophy and commitment to training professionals for work in community health, and due to the innovative rural health and community development efforts found predominantly in the southeastern region of the U.S. The degree to which each of the scholars will be able to apply the principles they learned and the approaches they observed will depend on their ability to synthesize and modify these concepts to fit the Cameroonian community health context. It is the faculty's assessment that those scholars who have had more practical experience in the field will be more effective in applying their UNC experience than those who have predominantly worked as administrators.

Secondly, despite their frustrations with the training or teaching methods, it was a positive learning experience. The exposure to alternative methodology forced them to reassess their own past encounters with training as trainers and trainees. They have become more critical as well as more open to the notion that method or technique can be as important as content.

The visiting scholars made many friends while they were in the U.S. It is without a doubt that they have a greater appreciation for the diversity and complexity of American society. And, it is also without question that the Americans who met them have a greater appreciation for the diversity and complexity of Cameroonian society. The experience was a mutually rewarding one. All the faculty, staff, students, and practitioners involved in the program would look forward to a similar collaborative effort based on the lessons learned from this initial experience.

VI. VISITING SCHOLARS ASSESSMENT OF THE PROGRAM

Exit interviews were held between the assistant coordinator and the visiting scholars on an individual basis in the third month of their four month stay. The purpose of the interviews was two fold:

1. To elicit their general assessment of the value of the course work and field visits when compared with their needs and interests.
2. To identify how they could best contribute to the continuation of community health and development activities once they returned to Cameroon.

In reference to the first purpose cited above, all four scholars expressed frustration with the teaching methods, but not with the content, they encountered in the classrooms. With the exception of EPID 160, all other courses were

conducted as seminars with a discussion group format based on assigned readings and personal experience or observations. This methodology was quite different from what they had experienced and come to expect in formal training settings in which the instructor lectures rather than facilitates, and in which the student absorbs and does not question. The impression left with the four scholars was that instructors did not master the material well enough to present it in an orderly fashion, i.e., in a straight lecture ending with a written summary to be presented to the students.

The degree of frustration, of course, varied among the four, with those having worked with PTHE training sessions being less anxious but still agitated. M'Bom's comment, for example, was "This is the same method we use in PTHE, and at times it is frustrating for the Cameroonians we train, like the OCEAC students." She is not convinced that either the "French" or the "American" method is the best and is trying to find a common ground. Anye felt that, despite his fluency in English, he could easily miss an instructor's point during a seminar and had difficulty with the "lack of direction" in doing tasks in small group work. He, too, was not sure about the merits of the American teaching methodology. Ndjikeu simply did not like the method and stated: "I am not here to do the work without having the theory first." It was important for him to know what the instructor's point of view was before he could react accordingly.

In relation to this question of methods was the issue of student-teacher roles. Since they had been trained in the teacher-centered approach, which is unidirectional with communication going from teacher to learner and centralized in power with assessment of learning being made only by the teacher, they were extremely ambivalent about their roles as auditors who were not required to do assignments nor to take exams. They did not feel justified in taking up class time to ask questions when there were other students who were enrolled for credit. The Cameroonians also did not feel comfortable going to instructors outside of class due to their non-student status. Similarly, they did not want to ask other students for help outside of class because they expected the students to be preoccupied with studying, and because the scholars apparently viewed their classmates as only "students" and not as "professionals". As a result, the process of satisfying learning objectives through course work occurred predominantly within the walls of the classroom. Outside readings and assignments were, therefore, not completed for the most part.

Nonetheless, the four scholars expressed general satisfaction with the content of their course work. Anye and Abicho felt particularly favorable toward the two public health nursing classes, which were 50-100% relevant to their work in Cameroon. These two scholars also greatly benefitted from the epidemiology course due to the fact that they had very little exposure to these skills in their training backgrounds. Abicho stated that EPID 160 was the best course for enhancing the effectiveness of his position in Maroua since he can now collect and analyze data to determine the impact of his activities, such as vaccinations. They differed on their assessment of the parasitology independent study, mainly due to the varying degree of experience each one had had with laboratory work. Anye feels more confident about his ability to teach laboratory techniques to nursing students as a result of this course and believes he now has a strong enough base for developing these skills further on his own. On the other hand, Abicho learned nothing new in terms of laboratory techniques since he already does this on a regular basis as part of his responsibilities in Maroua. Nonetheless, both scholars expressed equal appreciation for the bibliography and other resource materials generated from this course.

M'Bom expressed satisfaction with the caliber of the instructors. She felt they were knowledgeable and had considerable experience in their respective fields of expertise. The MCH course provided a good survey of what projects and research exist in the U.S. and allowed her to realize that no new developments or innovations, of which she was not aware, had occurred in maternal-infant health. The epidemiology course was an excellent opportunity for M'Bom to review and refresh the skills she had acquired in her training with CESSI at Dakar several years ago. However, the expectations she had for the international health course (HADM 202) were not met. She attributed this largely to the self-directed nature of the course learning process which was not beneficial for a short-term auditor. What she had hoped for were more concrete examples of projects and strategies in international health, including specific training techniques which had been used.

Ndjikeu's assessment of the parasitology independent study falls between those of Abicho and Anye. He found it to be a good refresher course since he has not used his laboratory skills in recent years, but again he learned no new skills. The bibliography and materials on parasitic disease were quite useful in partially meeting his objective of elaborating an educational manual on prevention of endemic disease in Cameroon. Ndjikeu felt that the health administration course was satisfactory for meeting his interests. The two independent studies in health education on evaluation and ethnographic methods, however, were found by him to be entirely unsatisfactory. He, in fact, stated that they were useless and a mutual waste of time for him as well as for the instructors. The task of doing an assignment on evaluation to provide the instructor with a clearer idea of what the student already knows was not appreciated nor accepted by Ndjikeu. The explanation he offered was that as a visiting scholar he did not expect to do assignments like a student, and that what an instructor should do is present the material as if the scholar knew nothing and he in turn would indicate if it was old material as they progressed. The independent study for writing publications on the Kadey ethnographic study was not useful for Ndjikeu since he felt that the instructor needed no further input from him. As a result, both independent studies were dropped after two months. The epidemiology course was also dropped during the first month but for other reasons. He felt that the material would only be a review for him.

In respect to the cross-cultural consultation course in health education, all four scholars valued the exposure to Dr. Steuart and felt that the content was relevant to all their learning objectives but in and of itself was not sufficient. An important aspect of this course was small group work in which all students were placed in teams to respond to hypothetical grant proposal requests from USAID. The three French speaking scholars were to work with two masters students, who also speak French, in developing a proposal for continuation and diffusion of PTHE activities in Cameroon. The proposal was to be presented both in writing and orally to the class. Anye was placed with another team to reduce the need for simultaneous translation on the Cameroon team. Nonetheless, all four scholars and the three on the Cameroon team in particular did not feel comfortable with the unstructured nature of the task nor with the lack of direct feedback/direction from Dr. Steuart until the end. They each stated that the task was unclear. As a result, nothing substantive was achieved by the Cameroon team. M'Bom's assessment of her experience in this course very well sums up the others' perspective: "The cart was placed before the horse. Dr. Steuart didn't give us the basic principles before asking us to do the proposal." They each felt that they could have learned more with continual input in lecture form from Dr. Steuart.

The field visit component of the program was considered to be highly informative and interesting. In addition to the value of meeting with practitioners, they had the opportunity to see rural areas and talk to community people. All four visitors would have liked to have spent more time at each site to receive more than just a taste of how community action and citizen participation can be implemented in health care programming. However, they did come away with the opinion that there was simply not enough financial resources in Cameroon to construct and equip facilities such as the ones they visited. Ndjikeu did not feel that the field visits helped him to meet any of his learning objectives since nothing he saw could be replicated in Cameroon. The other three saw value in making the comparisons between the two countries, however. Moreover, they learned a lot about the heterogeneity and disparity of resources in America from their visits to migrant, American Indian, and rural black communities.

In respect to the scholars' potential contribution to the development of community health and development activities in Cameroon, three of the four expressed concrete ideas. Abicho was enthusiastic about initiating in-service training for his chief nurses of health centers and his hospital personnel in community organization and disease prevention. He would very much like to begin a program of village health committees and would, therefore, welcome a ministerial decision to diffuse PTHE activities to his sector in Maroua. He strongly feels that the role he, and others in the same position, plays is key to a successful plan for the continuation of PTHE.

Anye foresees a definite possibility with his work at the Bamenda nursing school in terms of the students' field training component, placing more emphasis on community health aspects than it presently does. Supervising the field practicum is one of his responsibilities. Moreover, he envisions a very good opportunity for the CUSS and CESSI students who come to Bamenda for their field practicum the year following their practicum in the Mefou with PTHE. He feels the Bamenda nursing school faculty would be very open to the idea of integrating more community health education principles into the practicums.

M'Bom would like to be able to conduct training of trainers sessions for PTHE when she returns as part of the continuation plan. She feels that more emphasis needs to be placed on defining the roles of divisional and provincial level health personnel in community health and development. From her experience with PTHE and from her stay in Chapel Hill, she has come to realize the need for supervisory and support skills among this level of personnel, if front line workers are to be effective at the village level.

Ndjikeu feels that his contribution would be that of an administrator while he is in the Health Education Service. He also stated that since he has learned more about Americans, he will better understand American experts who come to Cameroon in the future.

VII. RECOMMENDATIONS

Given that the Visiting Scholars Program experience is still fresh on the minds of the PTHE faculty and staff at UNC, it would prove beneficial for us and all readers of this final report to propose concrete suggestions for improving any future effort of a similar nature, i.e., short-term, academic, non-degree training at UNC for middle and upper level health personnel from developing nations with limited facility in English.

1. Selection criteria for candidates should include at least three years of practical work experience in the field of community health care delivery to ensure the transfer of theory and research to service.
2. An open-ended questionnaire requiring short answers should be developed by UNC to gain a clearer idea of the backgrounds, learning needs, and professional interests of the candidates before they arrive in Chapel Hill. The information should prove extremely useful for program planning and logistical preparations to be made in advance.
3. Scholars should arrive at least three weeks prior to the beginning of an academic semester to minimize the interference of acculturation and personal needs with the substantive aspects of the program.
4. A structured course in health education designed specifically for the visiting scholars as a group should be required as part of the program in addition to HEED 240 and EPID 160.
5. Additional funds should be allocated for hiring tutors with facilities in French to assist the scholars in preparing assignments and understanding readings. An option would be for the scholars to take the exams as well for informal feedback from the instructors.
6. The number of field sites should be reduced to allow the scholars to visit each site more than once to further pursue any specific aspects of the site's activities.
7. A certificate from the Department of Health Education awarded to each visiting scholar at the end of the program would provide a needed incentive for participation during the program.
8. The MOH and Project Technicians of the candidates' country should hold a formal orientation session with the scholars before they leave for UNC to clearly define expectations for their technical input once they return.

APPENDIX M

SUMMARY OF RECOMMENDATIONS FROM
THE PTHE MID-PROJECT EVALUATION REPORT

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APPENDIX M

SUMMARY OF RECOMMENDATIONS FROM
THE PTHE MID-PROJECT EVALUATION REPORT

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Recommendations

1. That the PTHE Project place top priority on three inter-related outputs: the Village Health Committee Program; the Program of Recyclage for Health and Other Workers; and the Program for the Health Sector Institutions, in order to create a viable field training experience in the Kadey and Mefou for future classes of students from CUSS, ENISFAY and OCEAC.
2. That the Ministry of Health commit, on a progressive basis over a two-year period of time, the fiscal resources necessary for maintaining the following aspects of the PTHE program:
 - the existing Village Health Committee Program in the Kadey and Mefou districts (including vehicle and supervisory support)
 - the program of Practical Field Training with CUSS, OCEAC and ENISFAY, et. al.
3. Regarding the PTHE Field Level Program:
 - a) that the PTHE Project implement the concept of the "Rayon d'Action" (Action Zone) in which itinerant agents and volunteers serve as catalysts for health promotion. This concept creates an emphasis on quality and intensity of contact and interaction within a more concentrated area than outlined by the quantitative focus of the original project paper.
 - b) that a core of specific health education functions - as defined by the PTHE Team (UNC/MOH) - required of itinerant agents and Peace Corps Volunteers. In addition to these activities, individuals can negotiate with their supervisors to initiate other projects responding to village and health center needs.
4. Regarding AID-donated, MOH-administered training funds:
 - a) that the MOH keep account of all expenditures for training activities provided under the PTHE project and submit the necessary vouchers/documentation to USAID/Y.
 - b) that USAID continue to approve use of these training funds for payment of per diem and honoraria at the present GURC rate for the duration of AID's participation. (Exceptions noted in Special Remarks Section on Per Diem)
 - c) that the USAID/Y Project Manager monitor/verify MOH accounting of project expenditures, and that this responsibility be removed from the UNC technical staff.

5. That the PTHE Project Team (UNC/Y; UNC/CH; MOH) prepare an up-dated evaluation plan for USAID review (preferably using the "logical framework") taking into consideration:

- The revised and new outputs/indicators proposed in this report;
- PTHE field experiences to date;
- Preparation of learning objectives for each level of student health personnel in the proposed field training programs.

6. That the PTHE Team (UNC/MOH) develop a viable long-term vehicle support system for the Village Health Committee Program, integrated into the Ministry of Health and based on suggestions made in this report regarding:

- UNICEF donations of vehicles; parts; training of a mechanic; and/or
- a system for financing purchases of motorcycles/ mibilettes by itinerant agents;
- use of MOH-allocated funds for construction of a garage for repair of motorcycles in the Mefou.

7. That the Ministry of Health designate one additional technical counterpart, preferably from the MOH Training Division or Rural Medicine Division, who can devote 50-60% of time to the PTHE project activities.

8. That the MOH, Peace Corps, USAID/Y and UNC attempt to maintain continuity of personnel specifically trained/designated to work within the framework of the PTHE project for its duration.

9. Regarding lines of communications and designated roles of major donor agencies:

- a) That USAID/Y consult with the PTHE team (UNC/MOH collective) prior to mailing correspondence affecting the PTHE Project to the Ministry of Health.
- b) That MOH, USAID/Y and UNC reach agreement regarding lines of communication and roles and responsibilities outlined in this document on pp. and in Appendix D.

10. Regarding improved coordination of PTHE project:

- a) Formation of a coordinating sub-committee of critical donor agencies (UNICEF, Peace Corps, USAID/Y-Project Manager, Chief of Project, and one MOH representative from the PTHE team)

to meet every month regarding PTHE project plans, execution and evaluation. Findings and problems raised are to be presented to the formal coordinating committee.

b) Presentation of PTHE Project issues and reports, as appropriate, before the existing MOH intra-ministerial coordination committee in order to promote horizontal flow of information.

c) To promote vertical flow of information within the MOH and other related ministries:

- Tours be made of the project areas approximately every 2 months by PTHE technicians, other participating donor agencies, and related services/ministries.

- Information discussions be held approximately every 30 days with administrative officials by PTHE team members, including field level personnel. (Especially since the role of préfets and sous-préfets is one of overall coordination of sectoral involvement.)

11. That the Ministry of Health provide an accounting to USAID/Y of MOH funds allocated and disbursed for the PTHE project for the GURC fiscal year 1979/80, as well as for each fiscal year through the remainder of the project period.

12. That an in-house evaluation of the status of the Program for the Health Sector Institutions be scheduled for December, 1980 by USAID, UNC and MOH. Based on evaluation results, consideration be given to extension of the UNC contract in order to ensure that one or two graduating classes from CUSS, ENISFAY and OCEAC, etc. al. have experience with the PTHE Project in the Mefou or the Kadey.

13. That monies originally allocated (approximately \$95,000) for upper level health education training and/or conferences be used to implement the Program of Practical Training Workshops for Middle and Upper Level Health Personnel involved in the PTHE Project. (Refer to output No. 8)

14. Regarding development work in the Kadey:

- a) that the PTHE Project maintain community organization efforts in the Kadey, drawing especially on the expertise of the new and experienced UNC Community Organization technician, as part of a process for gathering needed information about the peoples of the region. We refer the PTHE technicians to the theoretical discussion of the problems in the Special Remarks Section.

b) that prior to initiating further development activities in the Kadey (e.g. such as MEDCAM), USAID implement a socio-anthropological study of the area in order to:

- understand the socio-anthropological factors contributing to the current status of underdevelopment, and
- help develop strategies for achieving success of projects.

15. That MEDCAM project planners review this evaluation report and plan future integration of the PTHE-trained "itinerant agents" into the MEDCAM program, particularly in the Kadey districts where the programs will eventually overlap. Experienced itinerant agents could help develop community organizations and could train and/or supervise the residential village health worker envisioned by MEDCAM.

16. That the organizations designated take the following actions essential to the operation of the Audio-Visual Workshop:

- a) MOH: immediate hiring, assignment or transfer of an audio-visual technician and an artist; continue construction on the building site designated.
- b) Peace Corps: placement of a new PCV with appropriate qualifications, as determined by Peace Corps.
- c) Ministry of Finance: investigation of more efficient procurement of audio-visual materials and supplies through customs duty waivers.

17. That use of donated construction materials be limited, and that they be used only for public facilities (i.e. schools, health centers, etc) for which work will be provided by local initiative. That U.S. Embassy Self-Help funds be utilized only if they can be channeled more directly through local Cameroonian community organizations.

PROGRAM EVALUATION SUMMARY (PES): PART II

13. SUMMARY

The Practical Training in Health Education Project is behind schedule in relation to the original project purpose. The mid-term evaluation team assesses the causes for this as follows:

- The original project design was overly ambitious, particularly in attempting to integrate health education curricula into village schools on a national basis. This objective alone could constitute a four (4) year project;

- Unforeseen personnel problems, particularly change of UNC Chief of Project in the first year and delay in replacing the UNC Community Development Technician;

- Problems of communication and differences in project conceptualization among USAID, the contract agency (UNC) and the Ministry of Health (MOH);

- Inadequate administrative support within the project for training activities and for logistical support of the Village Health Committee Program.

Despite early set-backs, the existing UNC/MOH field team has made significant progress toward achieving specific end of project objectives, as follows:

- Formation of an operational coordinating committee composed of the donor organizations, related agencies and ministries, and integrated into the MOH administrative structure for the project.

- Inclusion of MOH health personnel at all levels (national, provincial, departmental and district) in planning PTHE activities and in training of personnel in both the Mefou and Kadey districts.

- Training activities benefitting significant numbers of health personnel at all levels, including the development of a new cadre: the itinerant agent.

- Development of viable health education field training sites in the Mefou for future classes of students from CUSS, ENISFAY and OCEAC.