

HEALTH, NUTRITION, AND POPULATION OFFICERS  
CONTINUING EDUCATION PROGRAM ON  
PRIMARY HEALTH CARE IN AFRICA

NOVEMBER 15-20, 1981

LOMÉ, TOGO

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BUREAU FOR AFRICA, DIVISION OF HEALTH AND NUTRITION  
BUREAU OF SCIENCE AND TECHNOLOGY/HEALTH  
TRAINING DIVISION, OFFICE OF PERSONNEL MANAGEMENT,  
AGENCY FOR INTERNATIONAL DEVELOPMENT

THE AGENCY FOR INTERNATIONAL DEVELOPMENT

HEALTH, NUTRITION , AND POPULATION OFFICERS  
CONTINUING EDUCATION PROGRAM ON  
PRIMARY HEALTH CARE IN AFRICA

Held at:  
Lome, Togo  
November 15-20, 1981

HOSTED BY:

GOVERNMENT OF TOGO  
AND USAID MISSION TO TOGO

SPONSORED BY:

BUREAU FOR AFRICA, DIVISION OF HEALTH AND NUTRITION  
BUREAU OF SCIENCE AND TECHNOLOGY/HEALTH  
TRAINING DIVISION, OFFICE OF PERSONNEL MANAGEMENT,  
AGENCY FOR INTERNATIONAL DEVELOPMENT

Organized by:

American Public Health Association  
1015 15th Street, N.W.  
Washington, D.C. 20005

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## PREFACE

This continuing education program, entitled "Primary Health Care in Africa," was conducted in response to the need for accessible, accredited training for health professionals working overseas.

In an effort to ensure that health professionals stay abreast of new technologies, research, and skills, licensing bodies in most states in the U.S. have established continuing education criteria for renewal of licenses. For the past ten years ago, it has been standard practice to require such health professionals as physicians, nurses, dentists, and pharmacists to acquire continuing education credits through advanced academic training seminars, certain accredited professional meetings, or other means.

Such training forums, however, have not been readily available to staff stationed overseas. As a result, this requirement has constrained the ability of the Agency for International Development to recruit and retain health professionals. Those who have successfully maintained their licenses have done so without AID support and at considerable personal expense and effort. In some cases this barrier has caused separation from the Agency.

The Bureau for Africa, recognizing the need for Agency assistance in continuing education, obtained support from the Office of Health in the Bureau of Science and Technology (S&T/HEA) and the Office of Personnel Management, Training and Development Division (PM/TD), to plan and implement a continuing education program for its health, population and nutrition officers in Africa. The program was held in Lome, Togo, during November 15-29, 1982.

This report summarizes the week's program, which we sincerely hope resulted in an increased awareness and knowledge of primary health care in Africa for the health, population, and nutrition officers, and served as a stimulus to encourage AID to consider supporting future continuing education programs for its health personnel serving overseas.

James D. Shepperd, M.D., M.P.H.  
Chief, Health and Nutrition  
Bureau for Africa

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## ABBREVIATIONS USED IN THIS REPORT

AID	Agency for International Development
APHA	American Public Health Association
CCCD	Combating Childhood Communicable Diseases
CHW	Community Health Worker
CP	Community Participation
CDA	Concentrated Development in Africa
CE	Continuing Education
CME	Continuing Medical Education
EPI	Expanded Program on Immunization
MCH	Maternal and Child Health
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
S&T	Science and Technology
SMO	Senior Medical Officer
SHDS	Strengthening Health Delivery Systems
WASH	Water and Sanitation for Health
WS&S	Water Supply and Sanitation
WHO	World Health Organization

## I. OVERVIEW

The Bureau for Africa, Division of Health and Nutrition, in collaboration with the Office of Health in the Bureau of Science and Technology and the Training Division of the Office of Personnel Management, through a contract with the American Public Health Association (APHA), organized a continuing education program on primary health care (PHC) in Africa. This program took place on November 15-20, 1981, in Lome, Togo. Ninety-eight persons participated in the continuing education program, including 24 AID health, nutrition, and population officers and 29 African counterparts from 23 countries representing approximately 20 AID-supported projects. REDSO/West and East Africa, USAID/Togo, AID/Washington, the World Health Organization Training Centers in Togo and Nigeria, and the Peace Corps also sent representatives.

The faculty for the program included experts in the delivery of primary health care who have acquired experience by helping to implement and conduct projects and operate government systems in Africa; AID field staff; and national counterparts from ministries of health and AID-supported projects. The program, which offered a unique educational opportunity, was the first of its kind to be held in Africa under the auspices of the Agency for International Development (AID). The Africa Bureau canvassed USAID missions in Africa for suggestions about course contents and, wherever possible, incorporated their recommendations into the continuing education curricula.

The course was designed primarily to provide an opportunity for participants to learn about recently developed strategies of primary health care and technologies. It was designed to enhance the participants' technical skills and abilities in developing, implementing, managing, and evaluating primary health care programs. The program was accredited for continuing medical education through the American Public Health Association. Thirty-two participants received CME credits.

The participants were updated on technology in primary health care shared their experiences in developing projects and exchanged information on the problems that hinder successful implementation.

Nine subjects formed the contents of the continuing education program. They were:

- The Principles of Primary Health Care and Their Application in Africa
- The Rationale and Application of PHC Strategies in High-Risk Groups
- The Planning of Logistics, Including Pharmaceuticals, and Support for PHC
- The Role and Management of Community Participation

- Planning Water and Sanitation Programs in Africa
- Implementing Water and Sanitation Programs in Africa
- Evaluating Water and Sanitation Programs in Africa
- The Delivery Methods of Oral Rehydration
- Planning of Education Objectives and Training Methodology for Primary Health Care.

In addition to the continuing education course, evening sessions were scheduled to review and discuss current concepts of managing tropical diseases, AID development programs, and AID's current development efforts and their impact on the health sector. The faculty were available at additional workshops and informal sessions where information was exchanged and discussed. The emphasis was on the provision of technical information which would have immediate, practical implications for the health officers who plan and implement health projects and work to convince host-country health officials of the efficacy of particular strategies and interventions.

## II. OPENING SESSION

Dr. James D. Shepperd, Chief, Health and Nutrition, Africa Bureau, greeted the participants on behalf of the Agency for International Development; thanked the representatives of the Government of Togo for hosting the conference; and extended thanks and appreciation to Mr. John Lundgren, AID Representative in Togo, for his support and cooperation during the planning phase of the continuing education program.

Mr. N'DJalawe B. Assonam, Attache de Cabinet, Ministry of Health, Togo, welcomed the participants to Togo on behalf of his government. Dr. Hamed E. Neil extended greetings on behalf of the World Health Organization. Dr. Michael White, Health Officer, Senegal, spoke on behalf of USAID health officers and their colleagues in Africa. As the representative of the American Public Health Association, Dr. Susi Kessler warmly greeted the participants, offering them her congratulations and appreciation for the opportunity to collaborate with the Agency for International Development in planning and implementing this continuing education program for health, nutrition, and population officers in Africa.

The complete agenda for the continuing education program is attached as Appendix A. Chapter III contains summaries of each session.

### III. SUMMARY OF SESSIONS

#### Session I: The Principles of Primary Health Care (PHC) and Their Application in Africa.

Faculty: Dr. Cecile de Sweemer, Program Coordinator  
Mr. A. D'Almeida  
Mr. Hamed El Neil

The services provided in a primary health care program will vary, depending on the country and the community, but they will include at least the promotion of proper nutrition and an adequate supply of safe water; basic sanitation; maternal and child health (MCH) care, including family planning; immunization against the major infectious diseases; education about prevailing health problems and methods of prevention and control; and appropriate treatment for common diseases and injuries.

The concept of primary health care, though attractive, is not necessarily easily realized. It requires a change of habits, both of the beneficiaries and the health care profession. It sometimes calls into question well-established and familiar structures. For this and other reasons, a strategy to effect desired changes is essential.

A strategy should:

1. Respond to real collective needs.
2. Become an integral part of the national health system.
3. Integrate with other community development sectors (agriculture, education, public works, housing, communications, community organizations, and other services).
4. Develop a sustained dialogue on the implications of population growth and the provision of services.
5. Rely on local resources.
6. Integrate into a single program preventive care, health promotion, curative medicine, and rehabilitation.
7. Be dispensed at the most accessible level of health care by properly trained health personnel.
8. Follow up on the national decision to deliver primary health care.
9. Adopt an original approach in each country, taking into account each nation's specific conditions, needs, and resources.

10. Collaborate with traditional systems and attempt to encourage their participation and integration.

A strategy might entail the following five activities:

1. Obtain the participation of the community.
2. Organize the training of community health workers (CHWs).
3. Organize the supervision of community health workers.
4. Improve the delivery of services in the referral centers.
5. Organize and strengthen coordination with health services and with other sectors whose activities can influence community health.

At the end of the session, it was recommended that the focus be on intersectorial coordination, community participation, and appropriate training for CHWs.

Session II: The Rationale and Application of Primary Health Care Strategies in High-Risk Groups

Faculty: Dr. David M. Sanders  
Dr. Cecile de Sweemer, Program Coordinator

A high-risk strategy is one way to target and screen treatment for those populations that have a high probable rate of success. It is almost the opposite of 100 percent coverage and is most appropriate in efforts to optimize cost-effectiveness. The strategy must be intersectorial and include not only health, but also agriculture and education, in a program of selective outreach. The program should address specific health problems and attempt to target efforts to solve those problems by using non-physicians to motivate the population to assume responsibility for its own health and well-being.

Disease patterns show a strong link between nutritional status and the incidence and severity of communicable diseases. This interrelationship is highly sensitive. Nutritional deficiencies require certain interventions--a component to measure weight and relative growth, or a nutrition (health) education component that requires the use of locally produced foodstuffs. The latter component must be related to an agricultural intervention program, because undernutrition and its concomitant health problems are a result of underproduction.

Discussion groups were formed to further explore the kinds of high-risk strategies and interventions for malaria control, measles eradication, treatment of anemia, and tetanus prevention that can be integrated into primary health care programs. Malaria control, and not eradication, appears to be a realistic goal when the emphasis is on promotive (community development) and preventive care rather than curative care, which is expensive. Any antimalaria strategy must include lower-cost chloroquine, further research into required dosages for different epidemiological circumstances, and a workable logistics and distribution system to ensure that the drugs get to the community.

In determining the best way to maximize coverage and the efficacy of any PHC intervention, one must define the high-risk population that is to receive treatment, institute special surveillance measures, identify appropriate forms of care, and be able to refer cases to the next level of the health care system. This same approach is taken to devise strategies to treat other health problems.

### Session III: The Planning of Logistics, Including Pharmaceuticals, and Support for PHC

Faculty: Mme. Ana Coulibaly  
Dr. Reginald Gipson  
Dr. Rosalyn C. King

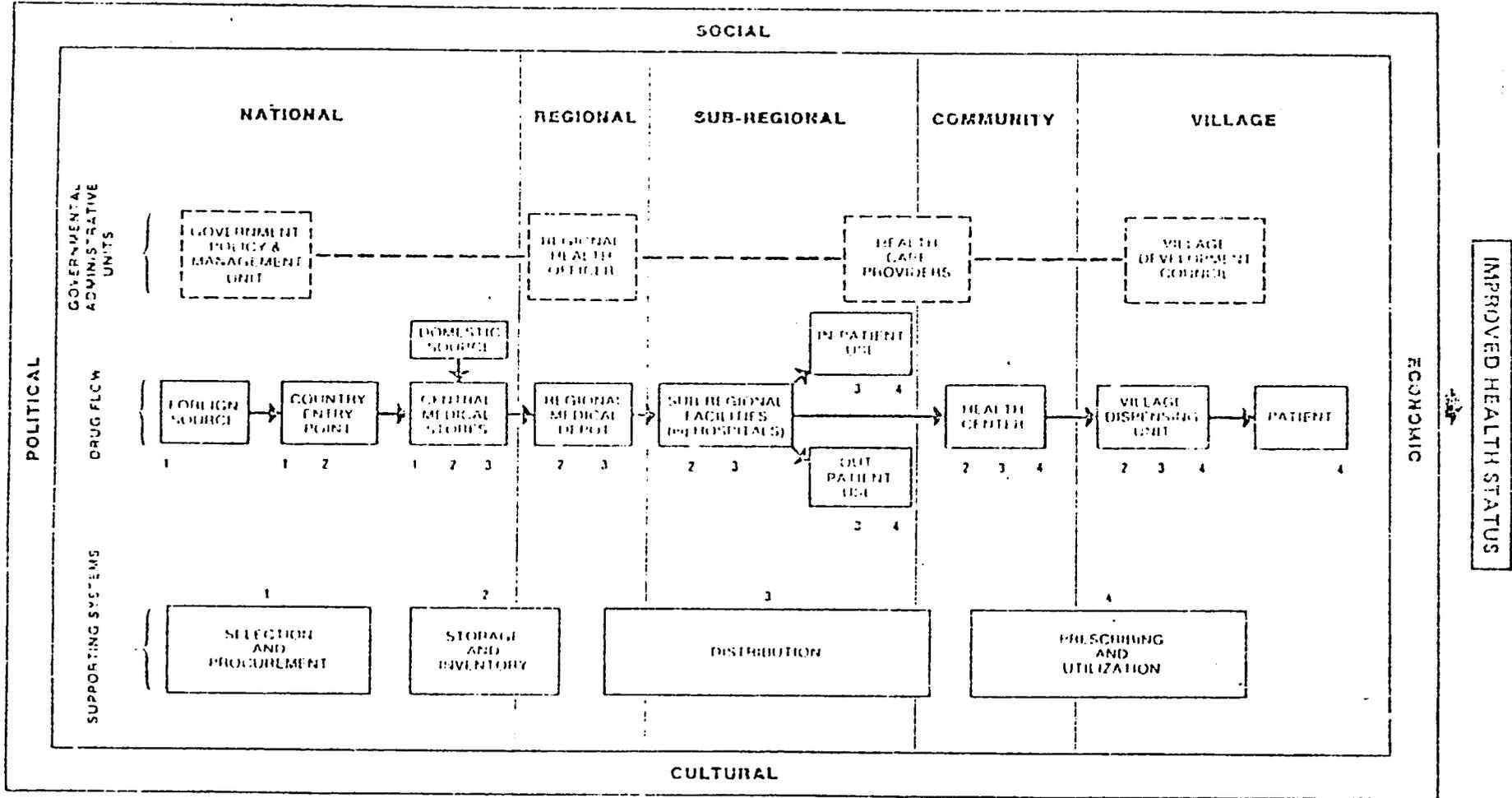
The planning process involves 10 essential steps. These are (1) establish PHC objectives; (2) establish PHC activities; (3) identify resources required; (4) assess the capacity of the current system to supply resources; (5) identify problems and constraints; (6) design solutions; (7) set priorities; (8) develop a plan; (9) implement the program; and (10) evaluate the activities.

The Niger National Bureau for Chemical and Pharmaceutical Products (NBCPP) is an example of a state corporation with financial autonomy (see Appendix J). It has a monopoly on the supply and distribution of drugs and medical and surgical supplies. Directly under the authority of the Ministry of Health, it is a well-established system that provides pharmaceuticals to the lowest operating level, the village.

An AID-supported, eight-nation survey (1981) of selected pharmaceutical supply systems in Africa has demonstrated that there are critical problems that need to be resolved to improve the acquisition, storage, and distribution of pharmaceuticals to health facilities, especially those at the village level. These problems include the integration of planning and management of the pharmaceutical supply system into the entire health care delivery system, knowledge of the composition of appropriate components of that system and how they function, and ability to manage those components. (The components of the pharmaceutical supply system are depicted in Figure 1.) Other important considerations are the selection of appropriate drugs for CHWs, the technical knowledge of the CHW, and support of the health system in relation to sales of drugs.

Figure 1

THE PUBLIC PHARMACEUTICAL SUPPLY SECTOR FOR RURAL  
PRIMARY HEALTH CARE IN A DEVELOPING COUNTRY:  
A SCHEMATIC OVERVIEW



At the end of the eight-nation survey (1981), the following recommendations were made:

1. Establish procedures for bulk procurement and light, in-system manufacturing.
2. Maintain close ties to WHO/AFRO and its program in essential drugs.
3. Increase interaction between the traditional sector and the modern sector. (One project developed a teaching program to identify and use traditional medicines to treat certain diseases.)
4. Increase access to technical information for health program administrators and health officers.
5. Review AID's procurement policy and assess its impact on PHC activity in the field.

Session IV: The Role and Management of Community Participation  
in Primary Health Care

Faculty: Dr. James D. Shepperd  
Professor Harbans Singh Takulia  
Mr. Ben Lamine

The term "community participation" has many meanings. It hinges on the definition of the community as a geographic or political entity with specific interests and activities. The strongest form of participation is absolute control of a health program, with community representatives taking full responsibility for and exercising authority over decisions, including the provision of funds. Frequently, participation involves shared control of programs in cooperation with a government or funding source. In this arrangement, the group of community representatives may be able to make decisions on its own, while also sharing other decisions with the source of funds or the regulatory agency. In a more limited form of participation, community groups make decisions only in concert with others.

Some participation may occur in efforts where general responsibility for a health program is shared.

An advisory group for a community clinic may be established to evaluate and provide feedback on activities, based on the "perceived needs" of the community. In some programs, the community advisory group may be responsible to an executive board of technical and administrative experts who have the "final" authority to act. Community participation may occur also in the organization around specific health issues or a single health problem. This is a highly effective method for directing attention and resources to a specific problem or disease which may become the focal point for a more comprehensive health program. Another form of community participation has

been defined as "free labor." The village volunteer and communicator give free medical care, medication, or health information.

Three other models are health cooperatives, which bring together the economic and technical resources of a community to enable it to "purchase" a necessary health service or goods (e.g., drugs); the payment of taxes and donations--a low level of community participation, because it may involve no emotional or time commitment to a program, concept, or movement; and negative participation. In this last approach, involvement is avoided or a program is boycotted.

The concept of community participation grew out of the community development movement, which was designed to promote better participation, initiated by the community, wherever possible.

The concept of community participation has become an integral part of primary health care which is both accessible and affordable, and which relies on the spirit of self-reliance and self determination.

Dr. Takulia exhorted health workers to learn, among other things, to develop skills to ensure that, rather than doing things themselves, they help people to help themselves. He encouraged the CHWs to work with and through formal and informal community leaders and satisfied users; to begin by identifying the health needs of the community, as the community perceives them, and make these the priorities of the primary health care effort. Perhaps most important, he exhorted them to learn to work with the political leadership without being condescending and resentful. Dr. Takulia also posed a number of unanswered questions: Why does community participation require the presence of external change agents? How, where, why, and by whom are the village workers to be trained to handle such enormous responsibilities? Can village health workers succeed where better trained functionaries could not deliver the goods?

Dr. Takulia issued a final word of caution by quoting Carl Taylor: "It is all too easy to be caught up in exaggerated community participation rhetoric and fail to recognize that if the communities were able to solve problems on their own they would have done so centuries ago." Dr. Takulia stated that there is a critical need to develop a developmental model in which the concepts of primary health care and community participation are realistically integrated, making it possible to provide health for all by the year 2000.

Mr. Ben Lamine defined community participation as "inclusion and active involvement of those affected by certain decisions in the decision-making process (planning, organization, implementation, control, and evaluation). The process of community participation...should be based on motivation and precede the implementation of any programs if one is to expect them to succeed." Mr. Lamine presented a variety of strategies and mechanisms that could be employed following study of the conditions in the community and an assessment of the community's readiness for action or resistance.

At one point, the participants divided into groups for role-playing, some taking the part of the Ministry of Health, others assuming the role of the USAID, the World Bank, and WHO.

At the end of the session, two important comments were made:

- "The professionals on the decision-making end are the ones who need learning." (Ms. Martha Belleh, Minister of Health, Liberia)
- "Projects are planned without input of the community. Input needs to come in the planning stages, not later, to convince community." (Paul Ehmer, USAID/Tanzania)

Session V: Planning Water Supply and Sanitation Programs  
In Africa

Faculty: Dr. Raymond Isely  
Mr. Craig Hafner  
Dr. Daniel Alexander Okun  
Dr. David Sanders

Science and Technology/Health's Water and Sanitation for Health Project (WASH) participated in the planning, design, and delivery of the water supply and sanitation portion of the workshop. The invitation to participate came as a result of multiple AID mission requests following the 1980 AID Health Officers Conference, where it had been concluded that water and sanitation issues had not been adequately addressed. This part of the program was organized after discussions with the Office of Health, Africa Bureau; APHA; and WASH. The objective of the session was to review the recommendations of a team of AID mission health officers and other interested parties. Specifically, participants were to analyze the planning, implementation, and evaluation of a water and sanitation project that was to be successfully completed in their country, and identify specific problem areas and possible solutions that reflect the cultural and political climate and resource constraints.

The program was divided into five parts: an opening, plenary session to provide baseline information; a workshop on planning water and sanitation (W&S) programs; a workshop on the implementation of these programs; a workshop on the evaluation of W&S programs; and a closing, plenary session to sum up the findings of the smaller groups.

A manual was prepared for each participant\* containing all the materials the individual would need to fully participate in the discussions. It included as many as possible of the other background papers prepared by the speakers for the plenary sessions.

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\* Available from:

Water and Sanitation for Health Project  
1611 North Kent Street, Room 1002  
Arlington, Virginia, 22209, U.S.A.

More than 80 persons attended the opening session. The speakers covered the organization of the workshop program (Isely), AID's commitment to water supply and sanitation (McJunkin), AID's water and sanitation policy (Bloom), current AID-financed water and sanitation projects and their accompanying problems in Africa (Hafner), and technical issues for projects in Africa (Okun). Of particular interest during the session was the showing of the film, "Piped Water Supply for Malawi," which generated considerable discussion about the role of community participation.

The small group sessions were workshops on planning, implementation, and evaluation. Approximately 25 people attended each session. The planning and implementation sessions were divided into five parts:

1. Presentation of a brief overview by the group leader.
2. Introduction to a discussion of a checklist and critique sheet for planning and implementing projects.
3. Study and discussion of a case study for planning (Burundi) and implementation (Malawi).
4. Use of the checklist to critique the case study and, simultaneously, the participants' own projects.
5. Work on potential solutions to identified problems.

A number of experiences particular to countries were highlighted during the discussions.

The objectives in planning were described as follows:

- In Upper Volta, the convenience of the source of water and the effects on agricultural productivity are taken as objectives.
- In Togo, the needs of animals and the washing of clothes are taken into account. Selection of a site has, however, been a political decision.
- In Sudan, irrigation needs seem to overshadow the need for water for domestic use (see Blue Nile Project).
- In several countries, health and sanitation objectives are not made clear and overly ambitious targets are set.

The collection of data was also discussed.

- In Cameroon, information on the costs, particularly local costs, of rural water supply and sanitation projects is important.

- In Liberia, information on possible resistance to source-siting has been considered essential.
- In Upper Volta, information on village organization is used in planning.

Some general problems related to planning were identified. They included:

- Establishment of the sequential stages of a project.
- Adequate and continuous testing of latrines. (This has been done successfully in Botswana.)
- Variations in taking the lead in planning (the role of the Ministry of Health).
- Failure to involve communities in the planning process.
- Failure to consider training for villagers.
- Other health problems associated with resettlement to provide a water supply.
- Low potential for national or local financing of projects.
- Coordination among donors.

Session VI: Implementing Water Supply and Sanitation Programs in Africa

Faculty: Dr. Raymond Isely  
 Mr. Craig Hafner  
 Dr. Daniel Alexander Okun  
 Dr. David Sanders

A variety of problems in implementing WS&S projects in various countries was identified. The problems included:

- Keeping a project on schedule, given the need to depend on voluntary labor, mobilize the population, and deliver materials.
- Providing training for sanitarians that is too theoretical (Senegal).
- Inadequate pump maintenance and lack of spare parts (Upper Volta).

- Inadequate supervision of sanitarians.
- Integration of health education.
- Deciding between dug wells and drilled wells (Senegal and Upper Volta).
- Integration of WS&S and primary health care.
- Relative cost-effectiveness of one worker as opposed to two workers (one for PHC and one for WS&S).

Country-specific problems were addressed also. In Mali, it was found that lack of maintenance, inadequate community involvement, and lack of concern for health efforts are all problems. In the Sudan, the lack of coordination among donors, the lack of health education, and the construction of wells for the sake of numbers are constraining efforts. In Liberia, wells are being constructed without provision for proper sanitation. And in Zaire, because few understand the work, the time factor is not appreciated. Moreover, the politics of spending and accounting for funds is a hindrance.

Because many preventable diseases are water-related and water supply is attractive to people, it was recommended that water supply and sanitation be integrated with primary health care. Much discussion of relevant concrete issues took place at the group sessions. Early in the the first session, however, complaints were voiced about the lack of sufficient technical detail in the presentations and discussion materials. Information on the selection of specific types of wells and pumps and details on techniques were desired. To meet the need for this information, a special technical session was organized, with Dr. Okun and Mr. McJunkin as resource persons. Approximately two-thirds of the participants attended this session.

#### Session VII: Evaluating Water Supply and Sanitation Programs in Africa

Faculty: Dr. Raymond Isely  
 Mr. Craig Hafner  
 Dr. Daniel Alexander Okun  
 Dr. David Sanders

The remaining participants attended a session on evaluation. The selection of indicators, evaluation planning targeted to the audience, and the need for evaluation criteria (e.g., operation and maintenance) were the major issues discussed at this session.

The technical session was an ad hoc meeting organized around questions and answers. Many worthwhile comments were made. Most of the session was held without simultaneous translation.

Of particular concern to the participants were simple water supplies; dry wells, springs, and driven wells. The issues of quantity and quality arose. Is it necessary to test the water in wells? How often? It was pointed out that protection of wells and springs from pollution by surface runoff is a critical objective. The area around the well can be graded to prevent surface water from entering the well. A parapet of stone can be erected to further protect the well and to keep children from falling into it. The well can be equipped with a hand pump, but provision also can be made for a rope and bucket in the event the pump breaks down. It was pointed out that the slight contamination from a bucket is unimportant compared to the large-scale contamination that results from surface runoff into the well.

The capping of springs (described in the Burundi case study which was distributed to the participants), water treatment, materials for piping, faucets, payment for water, supervision of water points, and the location of privies were among the subjects discussed.

Many American and African participants expressed appreciation for the special session and indicated that they would have liked to have had more time for such presentations. Some participants did not attend the session, showing more interest in other issues. Perhaps in the future, more simultaneous sessions, each devoted to a different subject, should be scheduled so that the special interests and needs of the participants can be accommodated.

#### Session VIII: Delivery Methods of Oral Rehydration

Faculty: Dr. R. Bradley Sack  
Mrs. Anne Tinker

Diarrheal diseases and dehydration usually are cited as the number one health problem in developing countries. During this session, it was reiterated that diarrhea and dehydration are the primary cause of morbidity and mortality and contribute to malnutrition in children. This presentation explored the epidemiology of diarrhea, etiological agents, pathophysiology, clinical symptoms, and various therapies. Audiovisual aids were used to illustrate the presentation. It was emphasized that treatment of diarrhea does not depend on a diagnosis. Treatment at the local level is the same everywhere, because oral rehydration therapy (ORT) is designed to treat diarrheal losses and is not to be mistaken as a source of calories or other necessary fluids. Antibiotics are useful in treating shigellosis, cholera, and giardia, but they should not be used indiscriminately to treat diarrhea.

Diarrhea is one of the most obvious targets of the water and sanitation decade. Discussion of acute diarrheal disease can be approached from epidemiological, clinical, and pathophysiological points of view, and should include consideration of the rationale for use of oral treatment and the practical problems associated with oral rehydration therapy. The presentation was condensed, but the speaker was available for more in-depth discussion of the issues throughout the week. (Note: For paper please see Appendix K.)

Session IX: Planning of Education Objectives and Training  
Methodology for PHC

Faculty: Dr. Hamed E. Neil  
Dr. A. D'Almeida  
Dr. David French

The objectives of this session were to explore with participants the process of formulating educational objectives based on task analysis; execute a task analysis based on the job description, and knowledge of the objectives of each function; and choose an educational methodology based on the objectives and a pre-existing level of education.

Representative from Strengthening Health Delivery Systems (SHDS) in Central and West Africa shared with the participants their experiences in training in Africa. SHDS staff work in collaboration with the World Health Organization and 20 African governments to develop training materials, in French and English, for the courses taught at the training centers in Lome and Lagos.

The systematic process of developing educational objectives was shared with the participants. Each step in the process was described. One should identify first the community's health needs, then establish priorities and assign tasks to community health workers; formulate educational objectives; select the content and methodology for training; develop an evaluation plan; and obtain or prepare instructional materials. Training should cover the specific tasks of the individual.

The MEDEX approach to developing five national PHC programs was also presented (Micronesia, Thailand, Guyana, Pakistan, and Lesotho). It was emphasized that PHC programs should be country-specific and designed as part of the national health system. The mid-level worker is one link in the tiered health manpower system.

Primary health care programs generally share the common problems of fragmentation, lack of a broad base, and obsolete infrastructures for effective delivery.

Participants were informed that additional information on programs is available from the following sources:

SHDS Project

Dr. David French  
04 B.P. 799  
Abidjan 04, Ivory Coast

MEDEX

Health Manpower Development Staff  
John A. Burns School of Medicine  
1833 Kalakaua Avenue, Suite 700  
Honolulu, Hawaii 96815, U.S.A.

Session X: Evaluation and Feedback

Faculty: Dr. James D. Shepperd  
Dr. Cecil de Sweemer, Program Coordinator

Ninety-eight persons participated in the session on evaluation and feedback. The breakdown was as follows:

	<u>Number</u>
AID Missions/Africa	24
African Counterparts	25
AID Contractors	16
CME Faculty	10
AID/Washington	6
Peace Corps/Togo	6
WHO	6
Foreign Service	3
APHA Staff	<u>2</u>
TOTAL	<u><u>98</u></u>

The following CME topics were evaluated:

- The Principles of Primary Health Care and Their Application in Africa
- The Rational and Application of PHC Strategies in High-Risk groups
- The Planning of Logistics, Including Pharmaceuticals, and Support for PHC
- The Role and Management of Community Participation in PHC
- Planning Water Supply and Sanitation (WS&S) Programs in Africa
- Implementing WS&S Programs in Africa
- Evaluation WS&S Programs in Africa
- The Delivery Methods of Oral Rehydration

- Planning of Educational Objectives and Training Methodology for PHC.

Several complementary sessions were arranged. The topics of these sessions were:

- PHC Operations Research
- Combating Childhood Communicable Diseases (CCCD)
- Concentrated Development in Africa
- AID Nutrition and Population Programs
- Review of Tropical Diseases
- Current U.S. Emphasis on Development: Impact on Health Programming.

The results of the participants' evaluation are attached as Appendix I. A summary of responses to the request for information and continuing education questionnaire is attached as Appendix J.

CONTINUING EDUCATION PROGRAM  
PRIMARY HEALTH CARE/AFRICA  
Lome, Togo  
November 15-20, 1982

AGENDA

Sunday, November 15, 1981

7:00 PM Pre-Program Activities

- Registration
- Orientation

8:00 PM Informal Reception

Monday, November 16, 1981

9:00 AM Opening Session - Hotel du 2 Fevrier  
Keran Room

Presiding: Dr. James D. Shepperd  
Chief of Health and Nutrition  
Africa Bureau  
Agency for International Development  
Washington, D.C., U.S.A.

Welcome and Introductory Remarks from Government  
and Agency Representatives:

- Mr. John Lundgren  
Representative  
USAID/Togo
- Dr. Hamed El Neil  
Director  
World Health Organization Training  
Center/Yaba  
Lagos, Nigeria
- Dr. Michael White  
Health Officer  
USAID/Senegal
- Dr. Susi Kessler  
Director  
International Health Programs  
American Public Health Association  
U.S.A.
- Mr. N'DJalawe B. Assonam  
Attaché de Cabinet  
Ministry of Health  
Togo

10:30 AM

Session I: The Principles of Primary Health  
Care and Their Application in Africa

Faculty: Dr. A. D'Almeida  
World Health Organization Training  
Center  
Lome, Togo

Dr. Hamed El Neil  
World Health Organization Training  
Center/Yaba  
Lagos, Nigeria

Assisted: Dr. David French  
Director  
Strengthening Health Delivery  
Systems Project (SHDS)  
Abidjan, Ivory Coast

Dr. Sif Ericsson  
Strengthening Health Delivery  
Systems Project (SHDS)  
Abidjan, Ivory Coast

1:00 PM

LUNCH

2:30 PM

Session II: The Rationale and Application of  
Primary Health Care (PHC) Strategies  
in High-Risk Groups

Faculty: Dr. David Sanders  
Lecturer in Pediatrics and Child Health  
University of Zimbabwe  
Salisbury, Zimbabwe

Dr. Cecile de Sweemer  
Associate Professor  
Department of International Health  
Johns Hopkins University  
Baltimore, MD, U.S.A.

6:00-8:00 PM

Complementary Session I

Agency for International Development Programs

1. Primary Health Care - Operations Research

- Mrs. Anne Tinker  
Acting Chief  
Health Services Division  
S&T/Health  
AID/Washington  
U.S.A.

- Dr. Stanley Scheyer  
Senior Scientist  
Center for Human Services  
Washington, D.C.  
U.S.A.
2. Combating Childhood Communicable Diseases (CCCD)  
Concentrated Development in Africa (CDA)
    - Dr. James D. Shepperd  
AID/Washington  
U.S.A.
    - Mr. Andrew Agle  
Centers for Disease Control  
Atlanta, GA, U.S.A.
  3. Nutrition Programs
 

Dr. John McKigney  
Nutrition Advisor  
Office of Nutrition  
AID/Washington  
U.S.A.
  4. Population Programs
 

Mr. William Bair  
REDSO/WA  
USAID/Ivory Coast

Tuesday, November 17, 1981

9:00 AM

Session III: The Planning of Logistics, Including  
Pharmaceuticals, and Support for PHC

Faculty: Mlle. Ana Coulibaly  
Office National des Produits  
Pharmaceutiques et Chimiques  
Niamey, Niger

Dr. Reginald Gipson  
Project Director  
Charles R. Drew Postgraduate  
Medical School  
Nairobi, Kenya

Dr. Rosalyn King  
Public Health Pharmacist  
Charles R. Drew Postgraduate  
Medical School  
U.S.A.

4:30 PM

Session IV: The Role and Management of Community Participation (CP) in PHC

- Definitions
- Training
- Management, Planning, Implementation, and Maintenance of Participation

Faculty: Dr. James D. Shepperd  
AID/Washington  
U.S.A.

Mr. Ben Lamine  
Health Educator  
World Health Organization Training  
Center for Health  
Services Personnel  
Lome, Togo

Harban S. Takulia  
Professor  
Muhimbili Medical Center  
Dar es Salaam, Tanzania

5:30 PM

Groups (4) - Problem-Solving

6:15 PM

Coffee Break

6:30 PM

Discussion of Solutions to Problems

Panelist: Professor Harban S. Takulia  
Professor  
Tanzania

Dr. Joseph D. Otoo  
SMO in Charge  
Health Manpower Development  
Ministry of Health  
Accra, Ghana

Dr. Raymond Isely  
Associate Director  
Water and Sanitation for Health  
Project (WASH)  
Arlington, VA  
U.S.A.

Mr. Ben Lamine  
WHO Training Center/Togo  
Lome, Togo

Dr. James D. Shepperd  
AID/Washington  
U.S.A.

Mrs. Martha K. Belleh  
Minister of Health  
Monrovia, Liberia

Wednesday, November 18, 1981

9:00 AM

Session V: Planning Water Supply and Sanitation  
(WS&S) Programs in Africa

- Types of Water Supply and Sanitation Projects and Their Contribution to PHC Programs
- The Role of the Health Officer in WS&S Projects
- Steps in Designing WS&S Projects
- Methods for Ensuring Efficiency and Effectiveness of Projects
- Adaptation of Conceptual Approach to Local Resource Constraints
- Discussion
- Evaluation

Faculty: Dr. Raymond Isely  
Associate Director  
Water and Sanitation for Health  
Project (WASH)  
Arlington, VA  
U.S.A.

Dr. Craig R. Hafner  
Senior Project Officer  
Water and Sanitation for Health  
Project (WASH)  
Arlington, VA  
U.S.A.

Dr. Daniel A. Okun  
Kenan Professor of Environmental  
Engineering  
University of North Carolina for  
WASH Project  
U.S.A.

Dr. David M. Sanders  
University of Zimbabwe  
Salisbury, Zimbabwe

Mr. F. Eugene McJunkin  
Chief  
Water Supply and Sanitation  
Division  
S&T/Health  
AID/Washington  
U.S.A.

1:00 PM

LUNCH

2:30 PM

Session VI: Implementing Water Supply and  
Sanitation Programs in Africa

- Types of Water Supply and Sanitation  
Projects and Their Contribution to PHC  
Programs
- The Role of the Health Officer in WS&S  
Projects
- Steps in Designing and Implementing WS&S  
Projects
- Methods for Ensuring Efficiency and  
Effectiveness of Projects
- Adaptation of Conceptual Approach to  
Local Resource Constraints
- Discussion
- Evaluation

Faculty: Dr. Raymond Isely  
Associate Director  
WASH Project  
U.S.A.

Dr. Craig R. Hafner  
Senior Project Officer  
WASH Project  
U.S.A.

Dr. Daniel A. Okun  
University of North Carolina  
U.S.A.

Mr. F. Eugene McJunkin  
AID/Washington  
U.S.A.

6:00-8:00 PM

Complementary Session II

1. Review of Tropical Diseases

Dr. Peter Knebel  
Public Health Advisor  
USAID/Mali

2. Current U.S. Emphasis on Development -  
Impact on Health Programming

Mrs. Abby L. Bloom  
Health Policy Analyst  
PPC/PDPR/HR  
AID/Washington  
U.S.A.

Dr. James D. Shepperd  
AID/Washington  
U.S.A.

Thursday, November 19, 1981

9:00 AM

Session VII: Evaluating Water Supply and  
Sanitation Programs in Africa

- Types of Water Supply and Sanitation Projects and Their Contribution to PHC Programs
- The Role of the Health Officer in WS&S Projects
- Steps in Designing and Evaluating WS&S Projects
- Methods for Ensuring Efficiency and Effectiveness of Projects
- Adaptation of Conceptual Approach to Local Resource Constraints
- Discussion
- Evaluation

Faculty: Dr. Raymond Isely  
Associate Director  
WASH Project  
U.S.A.

Dr. Craig R. Hafner  
Senior Project Officer  
WASH Project  
U.S.A.

Dr. Daniel A. Okun  
University of North Carolina  
U.S.A.

Mr. F. Eugene McJunkin  
AID/Washington  
U.S.A.

1:00 PM

LUNCH

2:30 PM

Session VIII: The Delivery Methods of Oral Rehydration

- Pathophysiology of Dehydration from Diarrhea: Appropriate Prevention and Treatment

Dr. R. Bradley Sack  
Chief  
Division of Geographic Medicine  
Johns Hopkins University School of  
Medicine  
Baltimore, MD  
U.S.A.

3:30 PM

Coffee Break

3:45 PM

- Planning and Delivery of Oral Rehydration Therapy in Primary Health Care

Dr. R. Bradley Sack  
Johns Hopkins University  
U.S.A.

Mrs. Anne Tinker  
AID/Washington  
U.S.A.

4:15 PM

Group Sessions (3)

5:00 PM

Group Reports

Group I: Dr. Bernard Diop  
Ministry of Health  
Dakar, Senegal

Group II: Dr. Joseph D. Otoo  
Ministry of Health  
Accra, Ghana

Group III: Mr. Sofo Bawa Mamane  
Administrator  
Ministry of Health  
Niamey, Niger

5:30-6:00 PM

Discussion - Plenary

6:30-8:00 PM

In Meeting Room I

Dr. Sack and Dr. Peter Knebel were available for in-depth discussions

Friday, November 20, 1981

8:00 AM

Session IX: Planning of Education Objectives  
and Training Methodology for PHC

Faculty: Dr. Hamed El Neil  
WHO/Yaba  
Nigeria

Dr. A. D'Almeida  
WHO/Togo  
Togo

Dr. David French  
SHDS Project  
Ivory Coast

Mr. Saul Helfenbein  
SHDS Project  
Ivory Coast

Dr. Sif Ericsson  
SHDS Project  
Ivory Coast

11:00 AM

Closing Session

Session X: Program Evaluation and Feedback

Faculty: Dr. James D. Shepperd  
AID/Washington  
U.S.A.

Dr. Cecile de Sweemer  
Johns Hopkins University  
U.S.A.

Appendix B

COMMUNICATIONS ON CONFERENCE  
AND CABLES FROM USAID MISSIONS

# Department of State

Appendix B

## TELEGRAM

PAGE #1 LOME #5716 01 OF 02 211025Z 4610 045690 A102104

LOME #5716 01 OF 02 211025Z 4610 045690 A

ACTION A10-35

ACTION OFFICE AA/AF-01

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FVA-02 PPCE-01 AAST-01 STHE-01 STN-03 POP-04 IV-06  
NHS-03 PVC-02 AFDA-01 ATPC-04 RELO-01 HAST-01 DO-01  
/063 12 021

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TO SECSTATE WASHDC PRIORITY 3284

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AMEMBASSY BRAZZAVILLE  
AMEMBASSY BUJUMBURA  
AMEMBASSY CONAKRY  
AMEMBASSY COTONOU  
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AMEMBASSY DJIBOUTI  
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AMEMBASSY MASERU  
AMEMBASSY MBABANE  
AMEMBASSY MOGADISHU  
AMEMBASSY MONROVIA  
AMEMBASSY NAIROBI  
AMEMBASSY NIAMEY  
AMEMBASSY NOUAKCHOTT  
AMEMBASSY OUAGADOUGOU  
AMEMBASSY PRAIA  
AMEMBASSY SALISBURY  
AMEMBASSY YAOUNDE

UNCLAS SECTION 01 OF 02 LOME #5716

AIDAC

AID/W FOR AA/AF, AA/PPC, AA/S&T, AFR/DR

E.O. 12958/N/A

SUBJECT: CONTINUING EDUCATION PROGRAM ON PRIMARY HEALTH  
CARE/AFRICA - LOME, TOGO 15-20 NOVEMBER 1981

1. THE CONTINUING EDUCATION PROGRAM FOR HEALTH OFFICERS  
TOOK PLACE IN LOME, TOGO NOV. 15-20. IT WAS ORGANIZED BY  
THE AFRICA BUREAU, THE OFFICE OF HEALTH S&T, TRAINING  
OFFICE, AND AMERICAN PUBLIC HEALTH ASSOCIATION. THE PROGRAM  
WAS ATTENDED BY 97 PARTICIPANTS INCLUDING 25 AID FIELD  
OFFICERS AND 38 AFRICAN COUNTERPARTS FROM 21 COUNTRIES.  
OTHER PARTICIPANTS INCLUDED CONTRACTORS, M.H.O. STAFF AND  
PEACE CORPS STAFF IN FIELD.

2. THE CONFERENCE ON PHC APPLICATION IN AFRICA:  
- A) UPDATED TECHNICAL SKILLS OF PARTICIPANTS;  
- B) FOSTERED CONTACT BETWEEN AID STAFF, COUNTERPARTS,  
- CONTRACTORS AND M.H.O. STAFF;

- C) PROMOTED EXCHANGE OF SPECIFIC COUNTRY EXPERIENCES;
- D) INCREASED AWARENESS OF NEW AID POLICIES AND PROGRAMS  
BY FIELD STAFF.

3. THE CURRICULUM COVERED:

- PRINCIPLES OF PHC AND THEIR APPLICATION IN HIGH RISK  
GROUPS;
- PLANNING OF LOGISTICS INCLUDING PHARMACEUTICALS;
- THE ROLE OF COMMUNITY PARTICIPATION AND ITS MANAGEMENT;
- PLANNING, IMPLEMENTATION AND EVALUATION OF WATER  
SUPPLY AND SANITATION;
- ORAL REHYDRATION;
- TRAINING METHODOLOGIES FOR PHC.

4. COMPLIMENTARY SESSIONS WERE PRESENTED ON THE PHC/OR  
PROJECT, CCCD PROJECT, SHOS PROJECT, MEDEX PROJECT,  
NUTRITION, POPULATION, TROPICAL DISEASES.

5. THE FACULTY INCLUDED BOTH U.S. AND AFRICAN SPECIALISTS.  
THE PROGRAM INCLUDED LECTURES, GROUP DISCUSSIONS AND  
LEARNING EXERCISES. TRANSLATION WAS PROVIDED INTO FRENCH.  
FOCUS WAS ON TECHNICAL UPDATES AND PLANNING/MANAGERIAL  
ASPECTS IN ABOUT EQUAL PROPORTIONS. CONTINUING MEDICAL  
EDUCATION CREDITS WERE PROVIDED TO 32 PHYSICIANS THROUGH  
THE AMERICAN PUBLIC HEALTH ASSOCIATION.

6. WHILE THE SINGLE LARGEST GROUP OF PARTICIPANTS WERE  
PHYSICIANS, THE PRESENCE OF NURSES, ADMINISTRATORS AND  
SOCIAL SCIENTISTS PROVIDED AN INTERDISCIPLINARY MIX  
7. BRINGING TOGETHER AID STAFF WITH AFRICAN COUNTERPARTS  
GENERATED A COMMON LEARNING ENVIRONMENT. PARTICIPANTS  
COMMENTED ON THE FREENESS OF DISCUSSIONS AND THE FACT THAT  
THE PRESENCE OF AFRICAN COUNTERPARTS BROUGHT A LEVEL OF  
PRACTICALITY AND REALISM TO THE DISCUSSIONS AS WELL AS  
UPDATING ALL PARTICIPANTS' TECHNICAL SKILLS.

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LOME 05716 02 OF 02 211030Z 4612 045692 AID2105

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A PARTICULARLY APPROPRIATE POINT OF INTERVENTION FOR  
DEVELOPING COMMUNITY PARTICIPATION AND SELF RELIANCE.

ACTION-OFFICE AAAP-01  
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AMEMBASSY NAIROBI  
AMEMBASSY NIAHEY  
AMEMBASSY NOUAKCHOTT  
AMEMBASSY OUAGADOUGOU  
AMEMBASSY PRAIA  
AMEMBASSY SALISBURY  
AMEMBASSY YAOUNDE

UNCLAS SECTION 02 OF 02 LOME 05716

AIDAC  
AID/W FOR AA/AFR, AA/PPC, AA/S&T, AFR/OR

8. INTEREST AND COMMITMENT APPEARED TO BE EXTREMELY HIGH  
AS EVIDENCED BY THE CONSISTANT ATTENDANCE AT ALL SESSIONS  
AND THE EXTENSION OF THE PROGRAM LATE INTO EACH EVENING.

9. HIGH LEVEL OF INTEREST WAS EXPRESSED PARTICULARLY IN  
ORAL REHYDRATION WITH RECOGNITION OF THE POTENTIAL IMPACT  
OF THIS INTERVENTION ON MORBIDITY AND MORTALITY AND EXTENSIVE  
DISCUSSIONS OF TECHNIQUES AND ASSOCIATED HEALTH INTERVENTIONS

10. INTEREST ALSO EXPRESSED IN TECHNICAL INFORMATION ON  
WATER AND SANITATION AND LOGISTIC SYSTEMS PARTICULARLY  
ASSESSMENT OF CURRENT STAT. OF THE ART KNOWLEDGE ON  
TECHNOLOGIES BASED ON COUNTRY EXPERIENCES.

11. PARTICIPANTS, ESPECIALLY AFRICAN PHYSICIANS NOTED  
THAT DISCUSSION OF ISSUES INVOLVED IN GENERATING COMMUNITY  
PARTICIPATION ENCOURAGED A NEW LEVEL OF AWARENESS ON THEIR  
PART AND RECOGNITION THAT VILLAGE LEVEL HEALTH REPRESENTED

12. REVIEW OF AFRICAN HEALTH SITUATION MAKES IT CLEAR  
THAT OVERALL DEVELOPMENT OBJECTIVES WILL NOT BE MET UNLESS  
SUFFICIENT ATTENTION IS PAID TO HEALTH IMPROVEMENT.  
13. WE WANT TO ACKNOWLEDGE THE COOPERATION OF THE GOVERN-  
MENT OF TOGO IN HOSTING THE TRAINING PROGRAM AND THE  
VALUABLE AND GRACIOUS ASSISTANCE PROVIDED BY USAID/TOGO  
WITH LOGISTICS AND SUPPORT. HICKS

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## Department of State

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TELEGRAMPAGE 01 GABORO 05335 011406Z ,503 052287 AID8823  
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R 011225Z DEC 81  
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 TO SECSTATE WASHDC 3296  
 INFO AMEMBASSY MBABANE  
 AMEMBASSY MASERU

UNCLAS GABORONE 5335

AIDAC

E. O. 12065: N/A  
 SUBJECT: CONTINUING EDUCATION PROGRAM ON PRIMARY HEALTH CARE/AFRICA  
 LOME, TOGO 15-20 NOVEMBER 1981.

REF: LOME 05718

1. DEBOSE, REGIONAL HEALTH DEVELOPMENT OFFICER (RHDO) PRESENTLY ON TDY GABORONE PARTICIPATED IN SUBJECT PROGRAM. HE BELIEVES THAT PROGRAM WAS VERY SUCCESSFUL IN UPDATING SKILLS OF PARTICIPANTS IN THE AREAS OF RURAL WATER AND ENVIRONMENTAL SANITATION AND ORAL REHYDRATION.
2. THE LARGE NUMBER OF PARTICIPANTS IN ATTENDANCE PROVIDED AN UNUSUAL OPPORTUNITY FOR AID STAFF, AFRICAN COUNTERPARTS AND CONTRACTORS TO EXCHANGE SPECIFIC FIELD EXPERIENCES IN PLANNING AND IMPLEMENTING PRIMARY HEALTH CARE PROGRAMS IN AFRICA. THE CONCLUSIONS REACHED FROM REVIEW OF THE HEALTH SITUATION IN AFRICA CAN BE SUMMARIZED AS: (A) HEALTH DEVELOPMENT MUST BE INCLUDED AS A PART OF OVERALL ECONOMIC AND SOCIAL DEVELOPMENT, (B) PRIMARY HEALTH CARE (PHC) IS THE APPROPRIATE STRATEGY FOR IMPLEMENTING HEALTH DEVELOPMENT, AND (C) PLANNING, DESIGNING AND IMPLEMENTING PHC PROGRAMS AER TASKS MORE DIFFICULT TO SUCCESSFULLY ACCOMPLISH THAN MOST HEALTH EXPERTS REALIZED A FEW YEARS AGO.
3. DEBOSE WOULD LIKE TO CONGRATULATE THE AFRICA BUREAU, THE OFFICE OF HEALTH S AND T, TRAINING OFFICE, AND AMERICAN PUBLIC HEALTH ASSOCIATION FOR EXECUTING A WELL BALANCED AND STIMULATING CONTINUING EDUCATION PROGRAM.  
DAWSON

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Department of State

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PAGE 01 LOME 06159 211053Z  
ACTION AID-35

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SPACING AS RELATED TO MATERNAL/CHILD HEALTH. NICKS

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ACTION OFFICE AMAF-01  
INFO AFCM-03 AFDR-06 PPCE-01 PDPR-01 PPPB-03 AAST-01 STHE-01  
ED-02 HNS-09 AFDA-01 RELO-01 MAST-01 /05: A4 322  
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INFO OCT-00 AMAD-01 /03E W

-----147733 211054Z /38

R 211028Z DEC 81  
FM AMEMBASSY LOME  
TO SECSTATE WASHDC 3473  
INFO AMEMBASSY ABIDJAN

UNCLAS LOME 06159

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E.D. 12065:H/A  
SUBJECT: CONTINUING EDUCATION PROGRAM ON PRIMARY HEALTH  
- CARE/AFRICA - LOME, TOGO 15-20 NOV. 1981

REF: LOME 5716

1. REFTEL PROVIDED AN OVERVIEW OF PARTICIPANTS, PURPOSE, CONTENT AND OUTCOME OF SUBJECT SEMINAR. REFTEL, HOWEVER, FAILED TO REVIEW IMPORTANT PRIMARY HEALTH CARE POLICY STATEMENTS CONTAINED IN OPENING SPEECH PRESENTED BY TOGOLESE SPOKESMAN FOR THE MINISTER OF PUBLIC HEALTH. THE TOGOLESE SPOKESMAN STRONGLY ENDORSED PRIMARY HEALTH CARE AS AN APPROACH TO HEALTH DELIVERY IN TOGO AND COMPLIMENTED AID'S INITIATIVES IN PH AREA.
2. THE TOGOLESE SPOKESMAN STATED TOGO'S NATIONAL HEALTH POLICY IS TO PROVIDE MAXIMUM HEALTH CARE THROUGHOUT TOGO AND THAT THE GOVERNMENT OF TOGO HAS ADOPTED THE OBJECTIVE OF PROVIDING HEALTH CARE FOR ALL TOGOLESE BY THE YEAR 2000. HE STRESSED THAT IN THE TOGO CONTEXT, WHERE ONLY A SMALL PORTION OF THE POPULATION RECEIVES HEALTH CARE (AND RESOURCES ARE LIMITED), THE ONLY CONCEIVABLE MEANS OF ACHIEVING THIS OBJECTIVE IS THROUGH A NATIONAL PROGRAM OF PRIMARY HEALTH CARE. HE SAID THAT TOGO'S PRIMARY HEALTH CARE PROGRAM SHOULD FOCUS ON PREVENTATIVE MEDICINE, RURAL POPULATIONS, AND PROMOTE OUTREACH PROGRAMS WHICH ENCOURAGE VILLAGE PARTICIPATION.
3. THE SPOKESMAN ALSO PRAISED AID FOR ITS ASSISTANCE TO TOGO'S EXPANDED PROGRAM OF IMMUNIZATION (EPI) AND NOTED THAT THIS PROGRAM IS A PART OF TOGO'S PRIMARY HEALTH CARE PROGRAM WHICH NEEDS MUCH MORE EXTERNAL ASSISTANCE. HE ALSO ENCOURAGED OAR'S EFFORTS TO DESIGN A CCCD PROGRAM FOR TOGO, WHICH AS HE NOTED, WILL NOT ONLY SUPPORT TOGO'S EIP EFFORTS BUT WILL ALSO PROMOTE A PROGRAM OF ORAL REHYDRATION AND COMBAT YAWS. THE SPOKESMAN ACKNOWLEDGED AID'S CONTRIBUTION TO THE CONSTRUCTION OF THE FAMILY HEALTH CENTER AND ENDORSED THE CENTER'S PURPOSE TO PROVIDE INTERDISCIPLINARY TRAINING TO PHYSICIANS AND PARAMEDICAL PERSONNEL IN THE FIELDS OF FAMILY PLANNING, NUTRITION, MANAGEMENT AND PROJECT DESIGN AND EVALUATION.
4. COMMENT: OAR PLEADED THAT ITS INTENSIVE EFFORTS TO WORK WITH TOGOLESE HEALTH OFFICIALS TO MOVE INTO THE MAINSTREAM OF CURRENT THOUGHT ON RURAL HEALTH DELIVERY AND PRIMARY HEALTH CARE HAD GROWN SO RAPIDLY. THE FOREGOING STATEMENT IS A STRONG PUBLIC CONFIRMATION OF JOINTLY DEVELOPED STRATEGIES IN THE HEALTH SECTOR. HOWEVER, WE WOULD HAVE LIKED TO HAVE HEARD A STRONGER STATEMENT FROM THE MINISTRY ON THE SUBJECT OF CHILD SPACING, BUT ATTRIBUTE THIS OMISSION TO LINGERING NEGATIVE PUBLIC SENTIMENT AND SENSITIVITIES RATHER THAN A LACK OF FIRM COMMITMENT BY HEALTH PROFESSIONALS TO THE POSITIVE PRINCIPALS OF CHILD

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UNCLASSIFIED  
Department of State

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PAGE 01

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ACTION AID-35

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INFO AFDR-06 PDPR-01 PPPB-03 AAST-01 SIHE-01 ED-02 AFDA-01  
RELO-01 MAST-01 AGEE-01 /021 A4 731  
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INFO OCT-00 AMAD-01 /036 W

----- 045742 311248Z /38

R 311248Z DEC 81  
FM AMEMBASSY NAIROBI  
TO SECSTATE WASHDC 7288

UNCLAS NAIROBI 28807

AIDAC

E. O. 12065: N/A

SUBJECT: CONTINUING EDUCATION PROGRAM ON PRIMARY HEALTH  
CARE (LOME 15-20 NOVEMBER, 1981)

1. USAID HEALTH OFFICERS NEEDS AND INTERESTS FOR  
CONTINUING EDUCATION APPEAR TO VARY WIDELY BETWEEN POSTS.  
WOULD SUGGEST CIRCULATION OF SHORT LIST OF POSSIBLE  
WORKSHOP TOPICS DEALING WITH UPDATES OF TECHNICAL  
ASPECTS OF JOB FOR RANKING BY POSSIBLE PARTICIPANTS. NOT  
ALL OFFICERS MAY BE INTERESTED IN SPECIFIED AREAS, AND  
PERHAPS SMALLER GROUPS MEETING AT A GEOGRAPHICAL LOCATION  
CONVENIENT TO THE GROUP MAY BE MORE FRUITFUL.

2. ON RECENT TDY IN CONJUNCTION WITH HOME LEAVE MACKIE  
FOUND TWO DAYS SPENT AT CDC AND NIH VERY USEFUL, IF TOO  
SHORT TO COVER TOPICS SELECTED IN ADVANCE. MAY BE  
USEFUL TO CONSIDER MAKING SUCH ARRANGEMENTS FOR OTHERS.  
HARROP

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PAGE 01 HOUAKC 05799 071713Z 9904 056259 A10J361  
 ACTION AID-35

HOUAKC 05799 071713Z 9904 056

LEVEL COURSES IN PUBLIC HEALTH/TROPICAL MEDICINE/ETC RE  
SET UP IN AFRICA, LEADING EVENTUALLY TO A MASTER'S  
 DEGREE. THE CCDC, CHDS AND INTRAM PROJECTS COULD DEVELOP  
 VERY USEFUL COURSES IN THEIR PARTICULAR DOMAINS. THE  
 REGIONAL TRAINING CENTER IN LOME, RECENTLY ENLARGED COULD  
 SERVE AS AN INSTITUTE FOR SUCH COURSES. SCHRAGER

ACTION OFFICE AFDR-06  
 INFO AFER-03 AFFM-04 AFCW-03 AFCE-01 PDPR-01 PPPD-03 AACT-01  
 STAG-02 STHE-01 STH-03 AFDA-01 AGRI-01 RELO-01 MAST-01  
 AGEE-01 /033 AG AOT

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 AMEMBASSY BANAKO  
 AMEMBASSY BANJUL  
 AMEMBASSY LOME  
 AMEMBASSY NAIROBI  
 AMEMBASSY NIAMEY  
 AMEMBASSY OUAGADOUGOU

UNCLAS HOUAKCHOTT 05799

AIDAC

SECSTATE FOR AFR/DR/HH, ST/HEALTH AND PPC

E.O. 12865: N/A  
 SUBJECT: CONTINUING EDUCATION PROGRAM ON PRIMARY HEALTH  
 CARE (PHC) LOME, TOGO 15-20 NOVEMBER 1981

REF: DAKAR 09929

1. USAID AND MAURITANIAN DIRECTOR OF HEALTH THANK AFR/DR/HH, ST/HEALTH, AFHA AND USAID LOME FOR HAVING ARRANGED THIS VERY USEFUL CONFERENCE.
2. THE ADDITION OF AFRICAN COUNTERPARTS, THOUGH HOTLY DEBATED AT LAST YEAR'S HEALTH OFFICER'S MEETING, PROVED VERY VALUABLE. IT OPENED UP FRANK DISCUSSIONS ABOUT ISSUES IN PHC PROJECTS WHICH, ALL TOO OFTEN, REMAIN QUOTE AID PROJECTS UNQUOTE. THE MAURITANIAN COUNTERPART SAID IT GAVE HIM AN OPPORTUNITY TO UNDERSTAND AID POLICIES AND PROCEDURES BETTER AS WELL AS TO DISCUSS PHC PROGRAMS WITH USAID PERSONNEL AND AFRICAN COLLEAGUES.
3. THE SESSIONS ON ORAL REHYDRATION AND WATER AND SANITATION WERE PARTICULARLY VALUABLE. DR. SACKS' EXCELLENT PRESENTATION AND THE ACCOMPANYING MATERIALS HAVE ENABLED US TO REFINE OUR ORAL REHYDRATION PROGRAM IN PHC PROGRAMS AND PLAN ITS STANDARDIZED INTRODUCTION INTO HEALTH FACILITIES. THE MAURITANIAN PARTICIPANT FOUND THE WATER AND SANITATION SESSIONS ESPECIALLY HELPFUL AS THE HEALTH MINISTRY BECOMES MORE INVOLVED WITH RURAL DEVELOPMENT PROJECTS.
4. USAID AGREES WITH THE CRITICISMS AND RECOMMENDATIONS REFTEL AND UNDERLINES THE SUGGESTIONS PARA 7 REFTEL AS PRIORITY TOPICS FOR NEXT CONFERENCE.
5. AN ADDITIONAL SUGGESTION BY MAURITANIAN COUNTERPART IS THAT TECHNICAL BOOKS AND MANUALS SENT TO HEALTH OFFICERS INCLUDE AN EXTRA COPY FOR HEALTH MINISTRY.
6. USAID SUGGESTS THAT AID/W DEVELOP OTHER WAYS TO IMPROVE CONTINUING EDUCATION. CONSIDERING THE VIRTUAL LACK OF PUBLIC HEALTH TRAINING FOR AFRICAN HEALTH PERSONNEL (ESPECIALLY FRANCOPHONE), AND CONSIDERING THAT THIS IS ONE OF THE MAJOR OBSTACLES TO THE DEVELOPMENT OF PHC AND OTHER PUBLIC HEALTH PROGRAMS, USAID SUPPORTS THE SUGGESTION MADE INFORMALLY BY DR. SHEPARD THAT GRADUATE

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Appendix C

PRESS RELEASE/TOGO

FOR IMMEDIATE RELEASE

16 November 1981

PRESS RELEASE

**AID Africa Health Officers Continuing Education Program**

The remarks of the Minister of Health, Bodjona Hodabalo, were presented by Mr. N'Djalawe B. Assonam as USAID opened the Primary Health Care Continuing Education Program for Health Officers serving many African Countries. The program is sponsored by the United States Agency for International Development and was organized by the American Public Health Association. The Government of Togo kindly agreed to serve as host for the conference, which is being held at 2 Fevrier Hotel, November 15-20, 1981. Among the participants were Ministry officials from 30 African countries, including Togo. The objective of the conference was to enhance the knowledge and skills of health workers in order to strengthen the efforts to provide basic preventive and curative health services to rural underserved communities. The primary health care strategy is the method adopted to reach the social goal of health for all by the year 2000. The Agency for International Development works in cooperation with many African nations, the World Health Organization, United Nations Infants and Children Fund, and many other agencies to achieve this goal.

Togo is assisted by AID in supporting the Lomé Primary Health Care Training Center, which is operated in cooperation with the Ministry of Health and the World Health Organization. A rural water project has also recently been started.

Welcoming remarks were made by Dr. James D. Shepperd, Chief of Health and Nutrition, AID Bureau for Africa, Washington, D.C.; Dr. Michael White, USAID Health Officer, Senegal; Dr. Hamad El Neil, Representative, World Health Organization; Mr. John Lundgren, Director, AID Mission to Togo; and Dr. Susi Kessler, Director, International Health Programs, American Public Health Association.

Appendix D  
PROGRAM PARTICIPANTS

## PROGRAM PARTICIPANTS

Abouki, Mamadou  
 Ingenieur de l'Equipement Rural  
 Directeur de l'Hydraulique  
 B.P. 385  
 Cotonou, Benin  
 Tel. 31-34-87, 31-32-98

Affanou, Roger-Jean  
 Infirmier diplome d'Etat  
 Ministere de Sante Publique  
 Hopital Parakon  
 Cotonou, Benin

Agle, Andrew N.  
 Deputy Director, IID, IHPO  
 CDC  
 1600 Clifton Road  
 Atlanta, GA 30333  
 Tel. (404) 329-2536

Aguillaume, Claude J., M.D.,  
 M.P.H., D.T.M.  
 USAID  
 170 W. 76 Street  
 New York, NY 10023  
 (212) 873-5250

Akono, Laurent, M.D.  
 USAID/Cameroon  
 Medecin-chef SDMPR de l'Ocean  
 B.P. 130  
 Kribi, Cameroon  
 Tel. 46-12-80

Aldis, John W., M.D.  
 Regional Medical Officer/Bamako  
 U.S. Foreign Service  
 Department of State - Bamako  
 Washington, D.C. 20520

Ali, Magda, M.A., M.D.  
 Assistant Director, Primary Health  
 Care Programme  
 Ministry of Health  
 Khartoum, Sudan

Amesefe, Kodzo  
 Associate Peace Corps Director  
 Peace Corps, B.P. 2985  
 Lome, Togo  
 Tel. 21-06-14

Assonam, N'Djalawe B.  
 Attache de Cabinet  
 Ministere de la Sante Publique  
 Lome, Togo  
 Tel. 21-42-62

Ateka, Tom Nyangena  
 Public Health Officer  
 African Medical and Research  
 Foundation  
 P. O. Box 30125  
 Nairobi, Kenya

Bair, William  
 REDSO/WA  
 c/o American Embassy  
 Abidjan, Ivory Coast

Bakele, Barandao  
 Directeur de la Division des  
 Services de Sante de Base  
 Directeur General-Adjoint  
 Ministere de la Sante Publique  
 B.P. 336  
 Lome, Togo  
 Tel. 21-01-42, 21-35-24

Bandian, Sidime, M.D.  
 Co-Directeur  
 Project A.M.I.S.  
 USAID/Guinea  
 Mamou, Guinea

Barh, S. Benson, M.D.  
 County Public Health Physician  
 Ministry of Health  
 Box 1926  
 Monrovia, Liberia

Belleh, Martha K.  
 Minister of Health  
 Ministry of Health  
 Monrovia, Liberia  
 Tel. 261998

Bloom, Abby L., Mrs.  
Health Policy Analyst  
PPC/PDPR/HR  
Agency for International Development  
Washington, D.C. 20523  
(202) 632-8952

Brasfield, Alberta, R.N., M.S.  
Conference Manager  
American Public Health Association  
1015 15th Street, N.W.  
Washington, D.C. 20005  
(202) 789-5684

Camarnor, Ivan F., M.D.  
Deputy Chief Medical Officer  
Ministry of Health and Social Welfare  
Box 9009  
Monrovia, Liberia  
Tel. 224221, 261394, 261812

Chemfor, Johnny  
Sanitary Engineer  
Ministry of Health  
B.P. 10534  
Niamey, Niger  
Tel. 73-36-25

Chen, Joan, R.N.  
Embassy Nurse  
Medical Unit (Peace Corps)  
American Embassy  
Lome, Togo  
Tel. 21-0614

Coulibaly, Ana, Mrs.  
Office National des Produits,  
Pharmaceutiques et Chimiques  
MSP/AS  
Niamey, Niger

D'Almeida, Ayité  
Coordonnateur National des Etudes  
Centre Formation OMS  
P.O. Box 917  
Lome, Togo  
Tel. 21-08-23

Debose, Charles  
Regional Health Development Officer  
USAID  
c/o American Embassy  
Mbabane, Swaziland

Delas, A. E., M.D.  
World Health Organization  
Niamey, Niger

De Sweemer, Cecile  
Associate Professor  
Johns Hopkins University  
615 N. Wolfe Street  
Baltimore, MD 21205  
(301) 955-6719

Diop, Bernard, M.D.  
Ministere de la Sante  
Dakar, Senegal

Edmondson, Marilyn, Ph.D.  
Assistant Professor  
Howard University  
1131 University Blvd., W., #1811  
Silver Spring, MD 20902  
(301) 649-5354

Egan, William  
General Development Officer  
USAID Burundi  
Department of State  
Washington, D.C. 20520

Ehmer, Paul G.  
Public Health Advisor  
USAID/Dar Es Salaam (ID)  
Department of State  
Washington, D.C. 20520

Eicher, Lawrence R.  
Program Manager  
USAID/Ghana  
P. O. Box 1630  
Accra, Ghana  
Tel. 75346 Ext. 40

El Neil, Hamed, M.D., Ph.D.  
Director  
World Health Organization/Yaba  
P.M.B. 1036  
Yaba, Lagos, Nigeria  
Tel. 681504

Ericsson, Sif, Ph.D.  
SHDS Project, BUMC  
53 Bay State Road  
Boston, MA 02215  
(617) 353-4582

French, David M., M.D.  
Director, SHDS Project  
04 B.P. 799  
Abidjan 04, Ivory Coast  
Tel. 41-32-42

Fry, Sarah  
Public Health Advisor  
USAID  
B.P. 2012  
Cotonou, Benin

Gblokpor, Kwaku  
Agent d'Animation Sociale  
Service des Affaires Sociales  
Centre Social Kpalime  
B.P. 357  
Lome, Togo

Gerski, Dianna  
Health Project Manager  
AID/Guinea  
c/o American Embassy  
Conakry, Guinea  
Tel. 44-15-20

Gipson, Reginald, M.D.  
Project Director  
Charles Drew Postgraduate Medical  
School, Box 61237  
Nairobi, Kenya  
Tel. 62253

Grieser, Mona Y.  
Chief of Party and Public Health Advisor  
USAID/Dimpex Associates, Inc.  
B.P. 222  
Nouakchott, Mauritania

Hacen, Mohamed Mahmoud, M.D.  
Directeur Sante Mauritanie  
B.P. 177  
Nouakchott, Mauritania  
Tel. 514.52

Hafner, Craig, Mr.  
Senior Project Officer  
WASH Project  
1611 N. Kent Street, Rm. 1002  
Arlington, VA 22209  
(703) 243-8200

Harper, Oliver, M.R., Dr.  
Public Health Advisor  
USAID  
B.P. 35  
Ouagadougou, Upper Volta  
Tel. 341.40

Helfenbein, Saul  
Assistant Director  
SHDS Project  
04 B.P. 799  
Abidjan, Ivory Coast  
Tel. 41-32-42

Henry, Sarita, Mrs.  
S&T/Health  
Agency for International Development  
Washington, D.C. 20523

Hottle, A. Kess  
Management Advisor  
Rural Health Development Project  
(Lesotho)  
P/B A-60  
Maseru 100, Lesotho  
Tel. Maseru 24196

Houenassou-Houangbe, T., Dr.  
Directeur General de la Sante  
Publique  
Ministere de la Sante Publique  
B.P. 336  
Lome, Togo  
Tel. 21 35 24

Isely, Raymond B., M.D.  
Associate Director  
Water and Sanitation for Health  
Project  
1611 N. Kent St., #1002  
Arlington, VA 22209  
(703) 243-8200

Jones, George, Ph.D.  
Regional Health Officer  
REDSO/WA  
c/o American Embassy  
Abidjan, Ivory Coast

Jones-Patron, Katherine  
Health IDI  
USAID/Liberia  
APO New York 09155  
Tel. 261807

Joseph, Fitzroy G., M.D.  
Team Leader Intercountry Family  
Health Project  
African Region  
World Health Organization  
Box 918  
Cotonou, Benin

Kagone, Meba, Dr.  
Directeur, Departemental de la Sante  
USAID  
B.P. 1052 Bobo-Dioulasso  
Upper Volta  
Tel. 99362

Kane, Ismaila, M.D.  
USAID/Senegal  
Medicine Chef Region Sine-Saloum  
Senegal  
Tel. 41 11 78

Karsa, Tchasseu, Dr.  
Directeur de la Division de l'Epidemiologie  
et de l'Hygiene Publique  
Ministere de la Sante Publique  
B.P. 336  
Lome, Togo  
Tel. 21-47-94, 21-37-31

Kessler, Susi, M.D.  
Director, IHP  
American Public Health Association  
1015 15th Street, N.W.  
Washington, D.C. 20005  
(202) 789-5691

Khelghati, Amrullah, M.D., M.P.H.  
Physician  
Peace Corps  
B.P. 2985  
Lome, Togo

King, Rosalyn C., Dr.  
Public Health Pharmacist  
Charles R. Drew Postgraduate Med. School  
915 S. Belgrade Road  
Silver Spring, MD  
(301) 649-6626

Knebel, Peter, M.D.  
Public Health Advisor  
USAID/SDPT  
c/o American Embassy  
Bamako, Mali

Laison, Agbodji, M.D.  
Medecin-Chef des Services de PMI  
Ministere de la Sante Publique  
Direction Generale de la Sante  
Publique  
Lome, Togo  
Tel. 21-35-24

Lamine, Ben H.  
Health Educator  
World Health Organization  
B. P. 917  
Lome, Togo  
Tel. 21-41-58

Lauya, Michael J.  
Public Health Officer  
Regional Ministry of Health  
Department of Primary Health  
Care, Box 88  
Juba, Sudan

Lucas, Steve  
Educatteur Sanitaire  
AID Contractor  
B. P. 1052  
Bobo - Dioulasso, Upper Volta

Mamane, Sofo Bawa, Mr.  
Administrateur  
Ministere de la Sante  
B.P. 623  
Niamey, Niger  
Tel 72 35 05

Markarian, C.A., Mr.  
Projet Manager  
MSCI, P.O. Box 119  
American Embassy/Khartoum  
APO New York 09668

Martin, Raymond, Mr.  
Health Development Officer  
USAID/Yaounde  
Department of State  
Washington, D.C. 20523

McEnaney, John, Mr.  
Health Development Officer  
USAID/Niger  
Department of State  
Washington, D.C. 20523  
Tel. Niger 72 35 05

McJunkin, F. Eugene  
Chief, Water Supply and  
Sanitation Division  
S&T/Health  
Agency for International Development  
Washington, D.C. 20523  
(703) 235-9823

McKigney, John, Ph.D.  
Nutrition Advisor  
Office of Nutrition  
Agency for International Development  
Washington, D.C. 20523  
(703) 235-1960

Mensah, Amavi, Mlle  
Direction Generale de la Promotion  
Feminine  
B.P. 1247  
Lome, Togo  
Tel. 21-56-20

Micka, Mary Ann, M.D.  
Health Officer  
USAID/Sudan  
P. O. Box 119  
American Embassy/Khartoum  
APO New York 09668  
Tel. Khartoum 43095

Nalder, Susan  
Assistant Clinical Professor  
Columbia University Center for  
Population and Family Health  
60 Haven Avenue  
New York, NY 10032  
(212) 694-6966

N'Diaye, Cheikh Samba, M.D.  
Directeur Technique Project  
USAID/Bakel  
Bakel, Senegal  
Tel. 65-01-02

Neili, Maryanne  
c/o USAID/Togo  
Lome, Togo

Neuhauser, Linda  
Health Officer  
USAID/Mauritania  
c/o American Embassy  
B. P. 222  
Nouakchott, Mauritania

Ntabindi, J.  
Directeur Adjoint  
Departement Europe, Americain  
du Nord  
Ministere des Affaires Etrangere  
et de la Cooperation  
B. P. 1840  
Bujumbura, Burundi  
Tel. 2653 - 1840

Okun, Daniel A., Sc.D.  
Kenan Professor of Environmental  
Engineering  
University of North Carolina  
for WASH Project  
Chapel Hill, NC 27514  
(919) 966-1023

Otoo, Joseph D., Dr.  
SMO in Charge, Health Manpower  
Development  
Ministry of Health  
P. O. Box M-44  
Accra, Ghana  
Tel. 65421 x 8216

Park, Thomas  
Health Officer  
USAID/Bamako ID  
Department of State  
Washington, D.C. 20520

Phillips, Ronald  
APCD  
Peace Corps  
B. P. 3194  
Lome, Togo  
Tel. 21-06-14

Plopper, Suzanne  
Health Education Specialist  
USAID Rural Water Project  
B.P. 1052  
Bobo Dioulasso, Upper Volta

Prins, Agma  
Advisor  
USAID/Togo  
American Embassy  
Lome, Togo

Rankhethoa, J. N.  
Principal Nursing Officer  
Lesotho Government  
P. O. Box 514  
Maseru-100, Lesotho

Rednell, Mary  
Peace Corps, B.P. 2985  
Lome, Togo

Robinson, Cynde  
Health Advisor  
USAID/The Gambia  
B.P. 596  
Banjul, The Gambia (Tel. 601)

Sack, R. Bradley, M.D.  
Chief, Division of Geographic  
Medicine  
Johns Hopkins University School  
of Medicine  
Baltimore City Hospitals  
4940 Eastern Avenue  
G-Building, Room 128  
Baltimore, MD 21224  
(301) 396-8923

Sanders, David, M.D.  
Lecturer in Paediatrics and Child Health  
University of Zimbabwe  
Box A178  
Salisbury, Zimbabwe

Scheyer, Stanley, M.D.  
Senior Scientist  
Center Human Services  
5530 Wisconsin Ave., N.W.  
Washington, D.C.  
(301) 654-8338

Shepperd, James D., M.D.  
Chief, Health and Nutrition  
Room 2492, N.S.  
Bureau for Africa  
Agency for International Development  
Washington, D.C. 20523

Silberstein, Spencer M.  
Population Officer  
USAID/Kenya  
Box 202  
APO New York 09675  
Tel. Nairobi 331160

Simmons, Keith  
Project Manager  
USAID/Banjul (ID)  
Department of State  
Washington, D.C. 20520  
Tel. 8533

Smith, Richard A., M.D.  
Director, Health Manpower Development  
Staff  
University of Hawaii School of  
Medicine  
1833 Kalakaua Ave, Suite 700  
Honolulu, Hawaii 96815  
(808) 948-8643

Takulia, Harbans S.  
Professor  
Muhimbili Medical Centre  
Box 65015  
Dar es Salaam, Tanzania  
Tel. 27081, 28920

Tcha-Tokey, Jato  
Directeur Developpement Communautaire  
Affaires Sociale  
B.P. 12383  
Lome, Togo  
Tel. 21-48-71

Thompson, Graham  
Chief, Project Development Office  
USAID  
c/o American Embassy  
Abidjan, Ivory Coast  
Tel. 324616 Abidjan

Thornton, Richard  
Health Officer  
USAID/Zaire  
Kinshasa, Zaire

Tinker, Anne, Mrs.  
Acting Chief  
Health Services Division  
S&T/Health  
Agency for International  
Development  
Washington, D.C. 20523  
Tel. 235-9650

Tranb, Leslie  
Peace Corps/Togo  
B.P. 2985  
Lome, Togo

White, Michael K., M.D.  
Health Officer  
USAID/Senegal  
B.P. 49  
American Embassy  
Dakar, Senegal  
Tel. 22-58-80

Wilson, Arnold  
World Health Organization  
Bamako, Mali

Winshall, Robert, M.D.  
Health Consultant  
c/o Dr. M. White  
USAID/Dakar  
B.P. 49  
American Embassy  
Dakar, Senegal  
Tel. 22-58-80, 21-66-80

Whitten, Charles  
Health Officer  
USAID/Liberia  
c/o American Embassy  
Monrovia, Liberia  
Tel. USAID/Monrovia 261807

Appendix E  
CONTINUING EDUCATION PROGRAM FACULTY  
AND  
RESOURCE PERSONS

CONTINUING EDUCATION PROGRAM FACULTY  
AND  
RESOURCE PERSONS

<p>Mrs. Abby L. Bloom Health Policy Analyst PPC/PDPR/HR Agency for International Development Washington, D.C. 20523</p> <p>Mme. Ana Coulibaly Office National des Produits Pharmaceutiques et Chimiques Niamey, Niger</p> <p>Ayite D'Almeida, M.D. Coordonnateur National des Etudes Centre Formation OMS Lome, Togo</p> <p>Cecile de Sweemer, M.D., DrPH. Associate Professor Johns Hopkins University Baltimore, MD 21224 and Continuing Education Program Coordinator</p> <p>Sif Ericsson, Ph.D. Strengthening Health Delivery Systems Project WHO Training Center Lome, Togo</p> <p>David M. French, M.D., MPH. Director, Strengthening Health Delivery Systems Project Abidjan, Ivory Coast</p> <p>Reginald Gipson, M.D., MPH. Project Director Charles Drew Postgraduate Medical School, Box 61237 Nairobi, Kenya</p> <p>Mr. Craig Hafner, M.A. Senior Project Officer Water and Sanitation for Health Project Arlington, VA 22209</p> <p>Raymond Isely, M.D., MPH. Associate Director Water and Sanitation for Health Project Arlington, VA 22209</p>	<p>Dr. Rosalyn C. King Public Health Pharmacist Charles R. Drew Postgraduate Medical School 915 S. Belgrade Road Silver Springs, MD 20902</p> <p>Peter Knebel, M.D. Public Health Advisor USAID/SDPT C/O American Embassy Bamako, Mali</p> <p>Mr. F. Eugene McJunkin Chief, Water Supply and Sanitation Division, Science and Technology/ Health Agency for International Development Washington, D. C. 20523</p> <p>John McKigney, Ph.D. Nutrition Advisor Office of Nutrition Agency for International Development Washington, D.C. 20523</p> <p>Hamed El Neil, M.D. Director World Health Organization/Yabe Lagos, Nigeria</p> <p>Daniel Alexander Okun, Sc.D. Kenan Professor of Environmental Engineering Department of Environmental Sciences and Engineering School of Public Health University of North Carolina Chapel Hill, North Carolina 27514</p> <p>R. Bradley Sack, M.D. Chief, Division of Geographic Medicine Johns Hopkins University School of Medicine Baltimore, Maryland 21224</p> <p>David Mark Sanders, M.D., Ch.B. Department of Pediatrics Godfrey Huggins Medical School Salisbury, Zimbabwe</p>
--	---

CONTINUING EDUCATION PROGRAM FACULTY  
AND  
RESOURCE PERSONS

James D. Shepperd, M.D., MPH.  
Chief, Health and Nutrition  
Bureau for Africa  
Agency for International Development  
Washington, D. C. 20523

Harbans S. Takulia  
Professor  
Muhimbili Medical Center  
Dar es Salaam, Tanzania

Mrs. Ann Tinker, MPH  
Acting Chief  
Health Services Division  
Science and Technology/Health  
Agency for International Development  
Washington, D.C. 20523

Appendix F

CONTINUING EDUCATION PROGRAM PAPERS

## CONTINUING EDUCATION PROGRAM PAPERS

Adjou-Moumouni, B.S.F., Dr., and Dicko, G. Mme. Principles of Primary Health Care. French and English.

Case Study of a Rural Water Supply Program in Malawi. English only.

Case Study of UNICEF Water Supply Project in Burundi. English only.

Coulibaly, Ana, Mme. Establishment of the National Bureau for Chemical and Pharmaceutical Products (Niger). French and English.

Gipson, Reginald, M.D. Case Study of C X's Logistics and Supply System. English only.

Lamine, Ben H. Community Participation. English only.

Participants Manual for Sessions on Water Supply and Sanitation. English only. Available from Water and Sanitation for Health Project, 1611 N. Kent Street, Room 1002, Arlington, Virginia 22209, USA.

Sack, R. Bradley, M.D. The Delivery Methods of Oral Rehydration. English only.

Sanders, David Mark, M.B.Ch.B., Epidemiology of Water and Sanitation-Related Diseases, and Interventions Related to Primary Health Care. English only.

Sanders, David Mark, M.B.Ch.B., Rationale and Application of High Risk Strategies in Primary Health Care. English only.

Takulia, Harbans S. Community Participation in Primary Health Care-Some Unanswered Questions. English only.

Tcha-Tokey, Jato. Water and Health Project in Rural Togo - Strategy for Intervention. French only.

Why is Community Participation Important in Health Services for Developing Countries? English only.

## RESOURCES

Manpower and Systems Development for Primary Health Care. Health Manpower Development Staff, John A. Burns School of Medicine, University of Hawaii at Manoa, Honolulu, Hawaii 96815, U.S.A. English only.

Training Course for Community Health Workers. Contact: David M. French, M.D., Director, Strengthening Health Delivery Systems Project, 04 B.P. 799, Abidjan 04, Ivory Coast. English and French.

Appendix G

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Appendix H

SUMMARY OF EVALUATION BY PARTICIPANTS

## SUMMARY OF EVALUATION BY PARTICIPANTS

<u>Respondents</u>	<u>Number</u>
AID	15
National Governments	15
Contractors	7
Other	<u>7</u>
Total	<u>44</u>

Questions and Responses

1. Are you required to obtain Continuing Education (CE) credits for licensure?

Yes 22                      No 22

2. The need for CE on the subjects covered by this program was:

	Minimal 1	2	Average 3	4	Considerable 5	No Response
Responses	1	1	10	14	12	6

3. This CE program fulfilled its learning objectives:

	Minimal 1	2	Average 3	4	Considerable 5	No Response
Responses	0	7	26	9	1	1

4. Did you acquire new information, viewpoints, or attitudes?

	No new information, viewpoints, or attitudes acquired			Much new information, viewpoints, or attitudes acquired			No Response
	1	2	3	4	5		
Responses	0	7	22	14	1	0	

	Excel- lent	Very Good	Good	Fair	Poor	No Response
5. Overall Effectiveness of the Faculty - Responses	5	11	15	3	1	9
6. Overall Course Quality - Responses	1	9	20	5	3	6
7. Overall Relevance to Practice - Responses	<u>4</u>	<u>9</u>	<u>15</u>	<u>9</u>	<u>1</u>	<u>6</u>
Total	<u>10</u>	<u>29</u>	<u>50</u>	<u>17</u>	<u>5</u>	<u>21</u>

8. Would you recommend this course to a colleague?

Yes 32 No 5 No Response 5 Other 2

9. What specific things did you like most about this CE program?

	<u>Number of Responses</u>
a. Presentation on Oral Rehydration	14
b. Presentations on Water Supply and Sanitation	13
c. Exchange of Experiences and Ideas with Colleagues	8
d. Information on Experiences in Other Countries	5
e. Participation of African Counterparts	4
f. Interchange between AID/W, AID/Africa, Counterparts and Faculty	3
10. What one thing about this CE program would you change?	
a. Provide Opportunity for Problem-Solving Sessions	8
b. More Time for Informal Exchange	7
c. Provide all Materials in French	6
d. Less Crowded Program	5
11. Which information and/or technology will be of most value to you on the job when you return home?	
a. The Information on Oral Rehydration	13
b. Planning, Implementing, and Evaluating Water Supply and Sanitation Programs in Africa	9
c. Documents Provided	5
d. Resources Available to AID/W Managers for Health, Nutrition, and Population Programs	3
e. Information on Primary Health Care Workers	2
f. Importance of Community Participation	2

Appendix I

SUMMARY OF RESPONSES TO THE REQUEST FOR  
INFORMATION AND CONTINUING EDUCATION QUESTIONNAIRE

SUMMARY OF RESPONSES TO THE REQUEST FOR INFORMATION  
AND CONTINUING EDUCATION QUESTIONNAIRE

Twenty-two participants responded to the enclosed questionnaire which was given out on the last day of the CME program. The number of participants who checked each question is indicated in the box opposite the question on the enclosed questionnaire provided for that purpose. The following information ranks the responses in descending order:

<u>Questions</u>	<u>Number of Responses</u>
1. Drug Purchasing at the Village-Level Schemes	16
2. Selection of Technologies for PHC programs in MCH	16
3. Planning Manpower Requirements for PHC	15
4. Management for Problem-Solving	15
5. Pathophysiology of Various Health Problems: Malaria	15
6. Management of the Cold Chain in Immunization Programs	14
7. Planning Manpower Requirements for Health Centers, Dispensaries, and Mobile Teams	13
8. Selection of Technologies for PHC Programs: Water	12
9. Pathophysiology of Various Health Problems: Diarrhea	12
10. Clinical Signs and Symptoms of Schistosomiasis	12
11. Selection of Technologies for PHC Programs: EPI	11
12. Planning Manpower Requirements for Ministries of Health	11

<u>Questions</u>	<u>Number of Responses</u>
13. Clinical Signs and Symptoms of Onchocerciasis	11
14. Pathophysiology of Respiratory Diseases	10
15. Health Delivery Systems: Primary Health Care	10
16. Communication with People from Other Countries and Cultures	10
17. Health Delivery Systems: Economic Incentives and Initiatives (e.g., Family Planning)	9
18. Pathophysiology of Other Tropical Diseases	8
19. Clinical Signs and Symptoms of Malaria	7
20. Health Delivery Systems: Health Cooperatives	6
21. Clinical Signs and Symptoms of:	
Xerophthalmia	5
Kidney Disease	5
Hypertension	4
Asthma	1

Enclosure

## REQUEST FOR INFORMATION AND CONTINUING EDUCATION

There is a clear need for continuing education of Health Workers in Africa. There are many ways to organize these programs for interested groups. Please identify topics about which you would like to have training activities.

### 1. Pathophysiology of Various Health Problems:

Diarrhea	<u>12</u>
Respiratory Diseases	<u>10</u>
Malaria	<u>15</u>
Other Tropical Diseases	<u>8</u>

### 2. Treatment of Clinical Problems in Tropical Diseases

#### Please List:

Infant diarrhea - rehydration using locally available materials

### 3. Clinical Signs and Symptoms of:

Malaria	<u>7</u>
Xerophthalmia	<u>5</u>
Schistosomiasis	<u>12</u>
Onchocerciasis	<u>11</u>
Asthma	<u>1</u>
Hypertension	<u>3</u>
Kidney Disease	<u>5</u>

#### Others:

1. Malnutrition and Improvement of Malnourished Children
2. Variety of Skin Diseases
3. Guinea Worm, Immunizable Disease (i.e., measles)
4. Skin Diseases, Tetanus, and Tuberculosis

4. Health Delivery Systems:

10 Primary Health Care

6 Health Cooperatives

16 Drug Purchasing at the Village Level Schemes

9 Economic Incentives and Initiatives (e.g., Family Planning)

5. Health Manpower Requirements

Planning Manpower Requirements for:

11 Ministries of Health

15 Primary Health Care

13 Health Centers, Dispensaries, Mobile Teams

6. Management of the Cold Chain in Immunization Programs 14

7. Selection of Technologies for Primary Health Care Programs:

12 Water

11 EPI

16 MCH and Family Planning

8. Management for Problem-Solving 15

9. Communication with People from Other Countries and Cultures 10

\*\*\*\*\*

Additional topics suggested by the participants:

1. Traditional versus modern treatments
2. Integration of traditional health systems with modern techniques
3. Demography: population patterns and their significance related to poor or improved health
4. Nutrition interventions: identification of high risk populations (Avoid non-specific health education sessions)
5. Describe a few case studies--both poorly managed and well-managed programs
6. Short course on basic epidemiological techniques, statistics, and field research.
7. Copies of bibliographic materials, especially state-of-the-art in primary health care and tropical medicine.

Appendix J

NATIONAL BUREAU FOR CHEMICAL AND PHARMACEUTICAL PRODUCTS

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NATIONAL BUREAU FOR CHEMICAL AND  
PHARMACEUTICAL PRODUCTS

Establishment of the National Bureau for Chemical  
and Pharmaceutical Products (NBCPP)

The NBCPP is a state cooperation. Set up immediately after independence, it replaced the old colonial pharmaceutical department.

It is a government cooperation with financial autonomy under the Ministry of Public Health and Social Affairs. The Board of Directors is chaired by the Minister of Health.

The NBCPP has the monopoly on the importation and supply of pharmaceutical products (e.g., bandages, medical and surgical materials, and laboratory chemicals) to the government, the community, and public institutions.

Social Services

Satisfying the population's needs for prophylactic and curative products under the most favorable conditions is of key importance. These needs are met:

- through importation;
- through the production of pharmaceutical products that are substituted for imported products, thereby reducing dependence on the foreign market;
- through the opening of retail drugstores throughout the country; and
- through the creation of a national laboratory for drug control.

The structure of NBCPP has two advantages. One, it provides regular supply under favorable conditions, as a result of the volume of transactions and easy terms of payment to the suppliers. Two, it brings together under the same umbrella all sectors dealing with drugs. This allows not only the monitoring of all drugs that come into the country, but also the financing of all activities of the cooperation.

Activities of NBCPP

The NBCPP conducts two major activities. It supplies drugs, and it distributes drugs. The supply consists of purchase and replenishment of stock through importation and production. The NBCPP has two production units. Imports represent 90 percent of consumption.

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### Various kinds of Orders

Regular orders or current products (approximately 3,000 references) are made in accordance with demand. Supplies are delivered every other month or every quarter. Annual orders, by tender, are issued for the following products:

- antibiotics;
- bandages;
- surgical materials; and
- films, sutures, and chemical products.

Bi-Annual orders are placed for some highly consumed dietetic and other products.

For all these orders, the NBCPP deals with 400 suppliers. The number of suppliers is increasing constantly.

### Means of transport

Thirty percent of the imports is by air-freight. Air-freight is used for expensive, non-bulky products, and for fragile products such as vaccines and chemical solutions. Seventy percent of the imports is by sea. Among these imports are bulky and heavy products, such as syrups, bandages, and some antibiotics. The volume of imports was 380 tons in 1978, 480 tons in 1979. It was nearly 900 tons in 1981.

### Main handicap

The NBCPP's main handicap is that the country is land-locked. This means that for unforeseeable situations (e.g., late deliveries, port strikes, the rainy season, etc.), expensive air-freight must be used.

Air-freight delivery takes three months; sea freight takes six months.

### Production

The NBCPP has two production units. The unit for the production of bulk solution was set up in 1972 by the European Department Fund and National Investment Fund. The production capacity averages 2,000 bottles per day.

This meets the country's requirement, which is approximately 200,000 to 300,000 bottles. The breakdown is as follows:

5% Glucose	100.000
15% Glucose	6.000
30% Glucose	1.000
0.9% Saline	60.000
Ringer's Solution	34.000

The compression unit was set up two years ago to produce aspirin and chloroquine to meet national demand. A national control and test laboratory was recently equipped to monitor the quality of local and imported products.

### Distribution

The distribution schedule is prepared by the Ministry of Public Health, quarterly for hospitals and bi-annually for dispensaries.

In each department, the orders placed by each medical establishment are centralized under the health department which controls the orders. A list is prepared for each establishment and sent to the Ministry of Health. There, it is amended in accordance with the funds allocated to each medical establishment.

The NBCPP receives the order, prepares it, and sends it to the health department for distribution. The NBCPP services 343 medical establishments with a budget of 1.5 billion.

### Local Drug Stores

One of the objectives of the NBCPP is to cover the national territories with local drug stores. There are 17 such stores (soon there will be 19) scattered all over the national territory. This represents a business volume of one billion (CFA). The stores are managed by state nurses, except for two pharmacies in Niamey, which are managed by pharmacists.

The village chemists or the village health team covers between 3,000 and 9,000 villages.

After the first state supplies, channeled through the medical department or the hospital department center, are depleted, resupplies are obtained from the local drug store, where a 20 percent discount is granted to achieve the NBCPP's objective: to make drugs accessible to the population, wherever it may be, and at the same price.

## Comments

The NBCPP supplies local companies (SOMAIR, COMINACK, and SONICHAR), thus adding one billion to the business volume of the cooperation.

## Perspectives

The following action should be taken to improve operations:

Put in place a computerized system to improve management.

Increase the range of production of injectable ampules, syrups and eyedrops.

Create a research unit on traditional pharmacology, pending the inception of an institute of medicine and traditional pharmacology.

## Staff

There are 254 salaried workers; 124 are at the headquarters. These are 10 chemists and 30 state nurses.

## Village Drug Stores

The village drug stores can be found in some districts only. The problems encountered in the medical centers with village drug stores inhibit generalizing operations, which would be practical because emergency units can be supplied not far from the point of treatment. In particular, funds have been managed poorly (embezzlement, poor bookkeeping) and supplies to the village drug stores have been irregular. To help the emergency units to reduce the cost of transportation to the medical center or the nearest local drug store, the officers in the medical center should bring some quantity of the drugs and materials that are in demand.

In general, the emergency units receive their supplies from a chemist, using income collected from sales of products.

The following table indicates the number of personnel trained for emergency units and as midwives.

Year	Emergency Units	Midwives	TOTAL
1979	405	211	616
1980	830	715	1,545
1981	900	784	1,684
<b>TOTAL</b>	<b>2,135</b>	<b>1,710</b>	<b>3,845</b>

National Coverage: 8 Emergency Units for 10,000 Inhabitants

General Situation: 4,404 Emergency Units

4,341 Midwives

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8,745 ESN Officers

Mme. Ana Coulibaly

Appendix K

The Delivery Methods of Oral Rehydration

Continuing Education Program  
on Primary Health Care in Africa  
for USAID Health, Nutrition and Population Officers  
November 15-20, 1981  
Lome, Togo

The Delivery Methods of Oral Rehydration

By R. Bradley Sack, M.D., Professor of  
Medicine, and Associate Professor of  
Microbiology, The Johns Hopkins  
University School of Medicine and  
Joint Appointment, Department of  
Pathobiology, School of Hygiene and  
Public Health. Chief, Division of  
Geographic Medicine. Director,  
Infectious Enteric Disease Study Center

Introduction

1. Diarrhea is one of the most obvious targets of the water and sanitation decade.
2. I would like to discuss our present understanding of acute diarrheal disease, from an epidemiological, clinical, and pathophysiological point of view.
3. Based on this information, I will discuss the rationale for use of oral treatment and the practical problems associated with it.
4. This presentation will obviously be condensed, however, I will be available through Friday if you would like to discuss issues further.

A. Epidemiology

1. Diarrhea is primarily children's disease. (Slide 1 - child with dehydration)
2. Diarrhea is the first cause of morbidity and mortality and the major contributor to malnutrition in small children in the developing countries.
  - a. This is true for diarrhea due to all pathogens
  - b. 6-24 months, highest attack rate in children
  - c. Diarrhea is a traveler's disease also, and for visitors to the developing world.
3. Seasonality is characteristic
  - a. Warm season - Bacteria infections predominate
  - b. Cool season - Viral infections predominate
4. Epidemics of diarrhea may occur. Example: Cholera in Africa in 1970.

5. Spread of diarrheal disease: Fecal-oral route
  - a. Transmission primarily through food and water
  - b. Most pathogens are primarily human; some are also animal pathogens.
6. Risk factors for diarrheal disease:
  - a. Low stomach acid
  - b. Age (immunologic status)
  - c. Malnutrition (immunologic)
  - d. Exposure possibilities to pathogen

B. Etiologic Agents

1. Can identify them in 75% of cases if laboratory is available.
2. Review the many different agents: viral, bacterial, protozoal. (Slides 2, 3).
3. Most worldwide important are: E. Coli, Shigella, Rota virus.
4. Diagnosis is not usually possible, microbiologically, because of lack of laboratory facilities.
5. Fortunately laboratory diagnosis is not necessary for effective treatment.

C. Possibilities for vaccine control - Rota virus/E. Coli (in laboratory development)

D. Pathophysiology of diarrhea

1. Useful to make clinical distinction, for bacterial diarrhea, of secretory versus invasive pathogens.
2. Secretory - enterotoxigenic E. Coli, V. Cholera - (Slide 4, histology of Cholera small intestine).

Small bowel, inoc. size, colonization, toxin production.

Mucosa not damaged.

Clinical → dehydration due to large stool losses → Electrolyte composition.

Dehydration is usually isotonic. (Electrolyte composition of stool on board).

3. Invasive - Shigella, Campylobacteria, primarily large bowel → damaged mucosa; protein loss. Clinical: fever, blood/pus in stools. (Slide 5, histology of large bowel in Shigellosis).

4. Viral diarrheas resemble secretory type clinically.
5. Malabsorption frequently accompanies these diarrheal syndromes.

E. Clinical Picture

1. Onset usually only a few days. In severe cholera, it may only be a few hours.
2. Vomiting is common with all diarrheas.
3. Liquid stools - watery, bloody, mucous.
4. May have fever - children especially.
5. Clinical Examination: in addition to above, important to be able to identify signs of dehydration (pulse, fontanelles, skin turgor, mucous membranes).
6. Laboratory is rarely of any use. Examining for pus cells in stool may be useful.

F. Therapy: Most important is restoring and maintaining fluid balance.

1. Therapy other than electrolyte replacement

- a. Antibiotics: useful only in Shigella, Cholera, E. Hist. or Giardia.

From standpoint of practice:

- (1) Shigella - Treat with Ampicillin, tetracycline or TMP-SMX (trimethoprim-sulfamethoxazole)
- (2) Cholera - Treat with Tetracycline.

- b. Not useful to use antiemetics or Kaolin/Pectin.
- c. Dietary most important - begin food/breast milk early.
- d. Antisecretory drugs are being studied in laboratory; none yet useful clinically.

2. Oral Glucose - Electrolyte Treatment

- a. Present ORT dates to mid-1960's - Cholera in Dacca & Calcutta. Prior to that oral treatment of sorts was used for mild diarrhea in the U.S. - for empirical reasons. Prior to that - traditional medicine in many countries calls for using barley water, or rice water, or some sort of gruel during treatment, and stopping regular feedings. You will be able to judge the efficacy of these practices for yourself.

b. Rationale

- (1) Sodium must be absorbed; if given alone, it will not be.
- (2) Glucose stimulates absorption of Na<sup>+</sup> (first identified in guinea pig's ileum) - glucose absorption is intact in essentially all diarrheas).

c. Historical - Cholera: Calcutta/Dacca - developed primarily because intravenous fluids were not widely available.

- (1) Found it highly effective in adults; could replace up to one liter per hour.
- (2) Studies in adults → children → other etiologies - etiology not important for success of ORT.
- (3) Now it is considered a universal solution for all acute diarrheas.
- (4) Composition of fluid - (1978 WHO Global CDD Program) (Slide 6 and Table - Composition of ORS).

d. Why not widely used in developed countries? (ORS study being done in U.S.) - Pediatricians have reservations of safety.

e. How is it used? - 2 aspects of treatment (ideal versus practical).

- (1) Replacement of deficit.
- (2) Replacement of continuing losses.
- (3) Preventive of early dehydration.

f. Deficit replacement

- (1) Estimate how dehydrated a child is:

Clinical Evaluation:

< 5	~5%	7-8%	10%
None	Mild	Moderate	Severe (IV fluids necessary)

- (2) Replace that amount with ORT in first few hours

~ 4 hrs. (10 kg x 5% = 500 ml. - Example)

ISOTONIC deficit is usually seen.

G. Continuing loss replacement

Equal volume/volume basis for every stool - replace approximate volume with ORT.

- H. No evidence that ORT will shorten diarrhea; it may appear to aggravate it. Practically speaking, ORT would be of little use if careful measurements were necessary for its use.
1. Built in "Volume - stat" - so that fluids can be given in "supervised ad-lib" way. Child will stop drinking when deficit replaced.
  2. Important to begin other fluids and foods after initial rehydration is complete; such as breast milk, in few hours.
  3. ORS is only for diarrheal losses - not for other needs -
    - a. IS NOT calorie source
    - b. DOES NOT replace other fluid requirement.
  4. So in actual practice - someone has to estimate about how much the child needs to replace deficit, and some instructions about how much to use.
  5. If given too much ORT, child will put out excess in urine/(puffy eyes may develop). If given too little ORT, child will not be rehydrated and will continue to do poorly.

I. Potential problems and limitations of ORT

1. Shock - requires IV therapy initially.
2. Problem of large stool output ( $> 10$  ml/kg/hr) - usually only in Cholera.
3. Problem of severe vomiting - rare.
4. Problem of malabsorption of glucose  $\rightarrow$  osmotic diarrhea.
5. Problem of hypernatremia - theoretical one.
6. Use in hospitals/clinics/homes - will discuss practical uses.
7. Effect on appetite.

J. Possible alterations in fluid composition of ORS

1. Alternative CHO source:
  - a. Sucrose (table sugar) is nearly as good as glucose, but must be broken down to glucose/fructose. Must use twice as much Sucrose per liter.
  - b. Rice powder/other CHO sources, are under investigation.
  - c. Amino Acids also stimulate  $\text{Na}^+$  absorption, and may be useful in future.
2. Different  $\text{Na}^+$  composition. (Safe effective limits - 40-100 mEq/L) 90 vs lower amount (50-60).

3. Omit  $K^+$  ? (Can be supplied in food)

Problem of  $\downarrow K^+$  in malnourished children.

4. Omit  $HCO_3^-$  or use another base.

Acetate or citrate (Renal mechanism can compensate)

} One absorbed  
without  
glucose

5. Taste? Color?

6. Ultimate simplification

Salt	Sugar only,
5g (1 Tsp)	40g (8 Tsp)/Liter or 3 Tbs)

spoons - pinch/scoop - etc.

7. (Packets - ideal - may be too expensive (10¢) versus simpler methods - may be mixed incorrectly).

a. Volume of water is important for mixing.

b. If packets not available - pharmacy can prepare. Some means of delivery of simpler form of formula - Realize the limitations of this therapy.

Ingredients are simple and available.

\* \* \* \* \*

Table of Measures

	<u>MW</u>			
Na	- 23	NaCl	1g	= 17 mEq.
Cl	- 35	NaHCO <sub>3</sub>	1g	= 13 mEq.
O	- 16	KCl	1g	= 13 mEq.
K	- 39?	Glucose	1g	= 5.5 mM

ORS Composition

	<u>Grams</u>
NaCl	3.5
NaHCO <sub>3</sub>	2.5
KCl	1.5
Glucose	20.1 (or Sucrose 40.0)
Water to make	1 litre

ORS Composition in mEq/L

Sodium	90
Chloride	80
Bicarbonate	30
Potassium	20
Glucose	111