698-0398

PD-AAK-066

(2)

PROJECT FOR

STRENGTHENING HEALTH DELIVERY SYSTEMS

IN WEST AND CENTRAL AFRICA

698-0398

SEMI-ANNUAL PROGRESS REPORT

JANUARY-JUNE 1980

TABLE OF CONTENTS

	Page No.
OBJECTIVE I.....	1
OBJECTIVE II.....	7
OBJECTIVE III.....	21
OBJECTIVE IV.....	28

Final Draft Report of Project Review Committee Meeting June 23-27, 1980

ANNEXES

OBJECTIVE I

1. List of Documents used in Multi-sectorial Management Workshop
2. List of Participants for Ministerial Workshop
3. List of Participants for Ministerial Workshop
4. Case Studies for Top Level Interministerial Management Workshop

OBJECTIVE II

1. Course Objectives for Each Training Course
2. Educational Objectives of The Training Course for Trainers of Village Health Workers
3. Work Schedule for Development of Supervisory Material
4. Government of The Gambia Request
5. RTC Lagos Follow-up
6. Lome Course Questionnaire

OBJECTIVE III

No Attachments

OBJECTIVE IV

1. Background Related to the Assignment
2. Trip Itinerary
3. AFRO Memorandum
4. Course Methodology
5. Course Objectives
6. Course Schedule
7. WHO/SHDS Guidelines for Applied Research on Health Service Delivery and Primary Health Care

OBJECTIVE I

To improve national and regional health planning and management.

Sub-objective 1: To strengthen health planning, programming and management training programs given by the Dakar and other collaborating Centers.

This subobjective concerns the 6 week planning and management course given annually at the Dakar Health Planning, Programming and Management Center. No direct action was taken regarding curriculum revision because of the crowded schedule of the center staff and the preparation needed for the top level multisectorial management workshop scheduled for April. However, as a result of the top level course, it is expected that the staff will increase the management content and employ training techniques used in the workshop (see subobjective 2). During the preparatory period for the workshop, SHDS consultants, Professor Bruce MacKenzie and Aliou Samba Diallo, revieweo management content and training techniques with the Dakar staff. This activity was undertaken during the week before the workshop and during the interval between the two sessions of the workshop. Thus, a total of 7 days was spent in staff training on management related activities.

In preparation for the workshop, SHDS provided the Dakar project with a small library of educational materials on management (see Annex 1 for list of materials). These will be used for the other training programs carried out by the Center.

Sub-objective 2: To improve intersectorial management capabilities of planners from the West and Central African countries in development of health programs.

The principal activity in this subobjective was the top level intersectorial management workshop and in-country follow-up. Originally, two (one Francophone and one Anglophone) workshops were planned, the former for March and the latter for November. However, final budgetary discussions resulted in funding for only one workshop for the Francophone countries during 1980.

The workshop was hosted by the Ministry of Health of Senegal, organized by SHDS and AFRO and held as a residential workshop in Aldiana, Senegal from 13-17 and 20-23 April. It was originally scheduled for the end of March; however, dates were changed because accommodations were not available in March. As a result, ministers from Togo and Niger were unable to attend.

Invitations were originally sent out in December 1979 to nine countries (Senegal, Guinea, Mali, Ivory Coast, Benin, Togo, Mauritania, Niger and Upper Volta). During the preparatory session for senior officials, eight countries (excepting Upper Volta) sent representatives for a total of 16 participants (see Annex 2 for list of participants and their positions). In the second session, six ministers from Senegal, Mali, Mauritania and Benin attended (See Annex 3 for list of ministerial participants).

The two workshop sessions were conducted by SHDS consultants, M. Aliou Samba Diallo of the Dakar Office of Organizational Management (Bureau d'Organization et Methodes), Prof. Bruce MacKenzie, and Dakar Project Management Specialist, M.M. Mena. Other staff members participated as resource persons. In addition, Prof. MacKenzie invited two information systems specialists to complete the roster of resource persons.

The objectives of the workshop were as follows:

a. To promote interministerial and intersectorial cooperation among those ministers principally concerned with social and economic development;

Sub-objective 2 of Objective I Continued.

b. Familiarize the senior officials with the broad spectrum of management themes related to multisectorial development and to identify the interests and priorities of the participating ministers;

c. Develop and edit a number of composite case studies which would represent priority problems relating to public health, social well being and productivity. These would ideally present problems of management, coordination and the coherent use of human and economic resources from several sectors;

d. Prepare a briefing for the participating ministers, either to be given to them before their arrival in Senegal or at the opening of the Top Level Workshop;

e. Sample and test certain of the materials, documents, questionnaires and cases from other workshops to ascertain their suitability and relevance.

Several broad categories of problems were first identified by the directors, following the introduction and discussion of all of the major themes: motivation, communication, delegation, styles of management and conflict resolution. Problem categories included:

1. Structural and Organizational Problems

   a. Lack of interministerial coordination
   b. Poor intraministerial coordination
   c. Overly personal nature of interministerial relations.

2. Functional, Operating Problems

   a. Excessive concentration of decision-making power

   b. Insufficient, fuzzy job and position descriptions

   c. Confusion of roles and job duplication

   d. Inadequate definition of objectives

   e. Lack of importance given to evaluation and appraisals

   f. Poor utilization of resources

   g. Poor program planning and execution

   h. Decision-making based on erroneous information

   i. Decision-making without previous study or information

   j. Ignoring reporting or organizational lines

   k. Weakness in resisting outside pressures and influences

   l. Lack of follow-through

   m. Insufficient contacts throughout the organizational structure

Sub-objective 2 of Obj. I Continued.

n. Hostility and distrust among managers and between managers and their subordinates.

3. Personnel Problems

a. Lack of training programs and trained manpower.

b. Disparity of motivation and rewards between the public and private sectors, and among different sectors or the public sector.

c. Under-utilization and misuse of trained manpower, including over-concentration of skilled manpower in the urban areas.

After an introduction to the case method, analysis of several cases and a discussion period, small teams of directors worked together for the rest of the three and one half days in preparing five management case studies which formed the working materials of the ministers during their meeting the following week.

These five cases covered problems related to various aspects of the management cycle:

a. Functions of Management: Case No. 1 — Self-sufficiency in Food.

b. Organizational Diagnosis: Case No. 2 — "I Have to Stay in the Capital!"

c. Human Resources Management and Resolution of Conflicts: Case No. 3 — "Why Doesn't He Mind his own Business?"

d. Planning and Coordination: Case No. 4 -- Doing Everything Means Losing Everything (Qui trop embrasse, mal etreint!).

(See Annex 4 for case studies and other documents used during the workshops.)

Top Level Interministerial Management Workshop

The preparatory workshop was followed by a 3 1/2 day workshop for ministers. The six participating ministers represented health, social welfare, rural development, science and research, and communication development sectors. Their program consisted of analysis of the case studies and discussion of the major themes of modern management. A synopsis of the program follows.

Sunday p.m. - 20/4/80

First working meeting. Explanation of the methodology, materials and provisional agenda for the week. Discussion and suggestions by the participants and trainers with some revisions and changes in times of planned plenary sessions and individual, non-structured time. First projection of Turning Point.

Monday - 21/4/80

Overview of modern management processes, attitudes and latest trends as related to multisectoral development. Use of B. MacKenzie's Management in Three Dimensions reprint from the Harvard Business Review as basis of

Sub-objective 2 of Obj. I Continued

discussion of the management cycle: planning, organization, resource mobilization, execution and control.

Analysis and presentation of the various management functions through study and analysis of Case No. 1. Diagnostic techniques applied to organizational environments. Discussion of problem identification and tools available such as Likert's organizational profiling and his various systems 1-4.

Human aspects of management in larger organizations: delegation, motivation, communications, styles of management and stress minimization. Videodisc presentation of Turning Point with interactive participation by ministers with use of thematic booklets.

Study and analysis of Case No. 2. Problems of team building and conflict resolution. Use of schematic on negotiation and conflict resolution.

Tuesday - 22/4/80

Advanced technologies andmanagement tools available for multisectorial management in the African context. Presentations and discussions of management information systems, tele-analysis for rural development and interactive videodisc for training of health agents, rural development workers and management development.

Intersectorial collaboration and decision-making. Analysis and presentation of Case No. 3 and Case No. 4.

Styles of management and attitudinal change. Case study and analysis: The Day of Mr. Sarr. Use of Task-People Questionnaire and the Blake-Mouton Managerial Grid.

Presentations and discussions with reference to cases of motivation and delegation problems in management.

Individual analysis and demonstration of management styles with viewing and discussion of a recent management film: Adult, Where are You?. This includes a discussion of transactional analysis and its applications to modern management.

Wednesday - 23/4/80

Marketing and the public sector: its relevance to the various services needed or desired by different publics in a developing country. Presentation and analysis of marketing problems, the marketing mix and marketing attitudes in the creation and diffusion of goods and services.

Review and discussion of key themes for multisectorial management as seen through the composite cases. Distribution and brief discussion of additional documentation, diagnostic tools for use in back-home organization and individual plans for management action.

Open forum, discussion and evaluation of the Top Level Workshop with recommendations, for further training.

The Ministers proposed a series of recommendations for the continuation and expansion of management training in the region, which reflected an appreciation of management's role in development and the need for a variety of short

Sub-objective 2 of Obj. I Continued.

and long term approaches to training managers. Recommendations included the following:

I. Institutional Recommendations

- Creation of national and regional institutions specializing in modern management processes and techniques; and the strengthening of such institutions already in existence;

- Introduction of management courses in training institutions and faculities;

- Orientation of such courses and programs towards specific, real and timely administrative problems.

II. Organizational and In-Service Recommendations

- Regular, planned programs of management development and re-cycling for middle management and above through seminars, workshops and courses;

- Development and education in management for future managers in the various professional schools of each country;

- Development of an action plan aimed at overcoming the difficulities due to lack of qualified management trainers.

In this last point, sectoral leaders should study:

- Possibilities of inter-African cooperation through pooling qualified resource people by way of the organization for technical cooperation among developing countries (TCDC);

- Increased training of trainers in management in specialized graduate schools and institutions both in Africa and in other geographic areas.

This suhobjective also included the development of an in-country follow-up program to the workshops. The Ministers indicated immediate interest in such a program, as reflected in their recommendations. The possibility of follow-up workshops was explored in Senegal and Mauritania. In Senegal, moreover, the USAID Mission also expressed interest in collaborating with the SHDS Project in a follow-up program. Meetings were held with USAID mission personnel and several information cables exchanged. Further meetings were planned for August following an official request by the GOS for a follow-up program. In this regard, the SHDS staff discussed follow-up activity with Senegalese participants. They indicated that the GOS was highly satisfied with the workshop and wished to hold a similar one for member ministries of the proposed National Health Council. A meeting in August in Senegal was planned to discuss this further. Participants from Mauritania expressed similar interest. Formal request to AFRO to follow-up are expected during the next reporting period.

In order to systematize the training methodology for further top level workshops as well as for follow-up programs, the facilitators proposed to develop a set of training modules based on the organization, content and teaching techniques of this workshop. The modules would be used to train other national facilitators to use the concepts and techniques of executive management training, and

Sub-objective 2 of Obj. I Continued

would serve as a guide or model for management workshops for government and private management training or development institutions. The proposal was submitted to AFRO, which responded favorably. It is planned to begin developing the modules during the next reporting period.

Sub-Objective 3: To strengthen the Dakar and other collaborating centers' capabilities to participate in and follow-up CHP exercises and facilitate the implementation of national health development programs.

No action was taken during this period for the following reasons.

a. Budgetary uncertainty precluded the development of specific plans, until well into April; and

b. The CHP exercises scheduled for 1980 will all be in countries outside of the SHDS Project region.

This activity will be carried over to 1981.

Sub-Objective 4: To develop health planning, programming and management capabilities of selected national education institutions.

The SHDS Project was invited to participate in the secretariat of the first AFRO consultation on health management training in Arusha, Tanzania. It was held 21-25 July, 1980. Further planning in this area is contingent upon the recommendations emanating from the Arusha Conference.

SHDS will provide 15 fellowships for non-degree study in health planning and management at the 6 week course in Dakar. This course is being run for English speaking countries this year. Funds were not provided for fellowships leading to degrees or to other collaborating centers.

OBJECTIVE II

Lome/Lagos

To increase the skills and improve the utilization of health personnel providing generalized health services at the supervisory and local levels.

Sub-objective 1: To develop, improve and harmonize methods of course design and implementation at the Lome and Lagos Centers.

The principal activities under this subobjective were 1) continuing education for center staff in systematic course design, 2) subject matter committee review of course content and 3) training of VHW trainers and middle level EPI personnel.

1) Further training in systematic course design was carried out informally during the on-going process of revision of existing and preparation of new courses. SHDS Project Educational Coordinator worked with staff of both centers on the design of courses during her April-May consultation.

2) Both centers continued to convene local subject matter committees for review of course content. In general, this is carried out on an ad hoc basis, and "committees" may consist of one to several persons. These persons not only review course content and prepare new materials, but also serve as course facilitators, further consolidating national involvement in the centers' teaching programs.

3) Lome held its second Training of Trainers course, and Lagos, its first.

Lome

There were 30 participants at the Lome course, 22 of whom came from SHDS countries (Cameroon - 2, Central African Republic - 2, Congo - 2, Gabon - 2 Guinea - 2 Equatorial Guinea - 1, Upper Volta - 2, Mali - 2, Niger - 2, Senegal - 2, and Togo - 3). The rest came from Burundi, Comores, Guinea-Bissau and Rwanda. To date, 47 persons have been trained from 15 French speaking countries. The SHDS Project was unable to provide consultant assistance to the course as needed because the public health nurse short term consultant had not yet been replaced. AID/W had refused to provide funding for such consultation. SHDS attempted to engage a former TOT course participant from Cameroon recommended by the Director of the Lome RTC. However, it was not possible to secure government permission in time. There were 7 instructors, the regular teaching staff of the center and three additional persons who have frequently been members of local subject matter committees or previous course participants.

The year's course was revised in consultation with the SHDS Educational Coordinator during her visit to Lome in October-December 1979 to complete the VHW training modules. The course itself was divided into 6 modules - two which dealt with study habits and group dynamics and 4 which dealt with course design and the use of the VHW training materials, teacher training, management and evaluation.

Lagos

There were 27 participants at the 13-week Lagos TOT course of whom 14 were from the SHDS Project region (Cameroon - 1, Gambia - 2, Ghana - 2, Nigeria 7, and Sierra Leone - 2). The remaining were from Ethiopia, Kenya, Lesotho, Malawi, Namibia, Swaziland and Tanzania. A SHDS consultant was engaged to assist the RTC staff which included short term (11 month) consultants provided by the Project - a management specialist and a public health nurse.

Sub-objective 1 of Obj. II Continued

There were a total of six facilitators for the course including the Director of the center. The course was divided into five modules including systematic course design, working with the community (community mobilization and program management), teacher training practice and evaluation. The participants were divided into 5 groups, each having the responsibility of developing part of the VHW training program for environmental health, control of communicable diseases, maternal child health, nutrition, first aid and evaluation (see Annex 1 for course objectives of each course).

A total of 61 persons from SHDS countries have been trained in the three TOT courses. Both courses stress the participant's role in training, supervision and evaluation of the VHW during training and village work, teach the participants to define educational objectives and teaching activities, and give 15 days of practice teaching to show participants how to teach session plans which they have developed. Although the objectives of the courses are similar, differences in teaching approaches, previous background and training of participants, and field work resources result in special characteristics for each of the training programs.

Lome

1. Tightly organized, specifies each day the objectives, content, activities to be covered.

2. Follows teaching pattern established through experience in other courses.

3. Teach participants how to adapt VHW training materials, plan primary health care projects and administer and supervise a training program for VHWs.

Lagos

1. Gives more responsibility to teaching staff and plans courses on a weekly basis, specifying how many days are taken up by certain course units.

2. Emphasizes development of individual session plans rather than methods of adapting existing VHW training materials.

3. Permits participants to work in villages doing community development work with villagers and relating this work to VHW training.

The main difference in the two programs is access to PHC field sites. Lome RTC field practice is carried out in a mission run program for health "catechistes", who are generally more educated and knowledgeable than VHWs would likely be. This field practice does not afford opportunity to work with the community. The Lagos RTC, on the other hand, is in the process of developing a primary health care program and thus leads the participants through an active process of developing real VHW programs. Participants provided the training for 18 village health workers from 13 villages in the Badagary area.

The report of the SHDS Educational Coordinator made the following observation in this regard.

> The graduate of the Lagos course will be a better trainer of VHWs. He will be able to go into the village, work with the villagers on community projects, help select the VHW and train him probably with more assurance than the Lome graduate. Since he has more practical experience of these tasks they will be

Sub-objective 1 of Obj. II Continued.

easier for him. He will also have a good understanding for the problems facing the VHW and probably also be able to provide a good supervision of this VHW.

The graduate of the Lome course, although capable of doing these tasks will probably not do them with the same ease that the Lagos graduate has. He has had considerably less practical experience in working with the villagers, selecting the VHW, and with the conditions in the villages during the training. On the other hand, he may be more capable of planning, implementing and evaluating a program in primary health care, including the training of VHWs than the Lagos graduate, since that has been one focus of his training.

No further training materials were produced during this period. However, work still continued on the development of an Instructors' Manual to guide trainers in adapting the VHW training materials. The French version of three modules completed in 1979 were reproduced at the Lome Center, used in the course and distributed to past course and workshop participants as well.

The center reproduced the materials on a mimeograph machine which left much to be desired as far as quality was concerned. This was unavoidable as the SHDS Project still has not yet obtained the long promised waivers to purchase the planned offset printing equipment. Several verbal promises were given during this period by AFR/RA officials, but no action was taken. The same is true for the remaining equipment originally requested for Lome 18 months ago.

Offset printing equipment ordered for Lagos had not yet arrived owing to problems with the distributor and as the center's own mimeographing equipment was no longer functioning, the English version of the remaining modules was not reproduced. It is hoped that equipment will arrive early on during the next reporting period and the modules will be duplicated by September.

See Objective III for a discussion of the introduction of a TOT for middle level EPI personnel.

Sub-objective 2: To develop training materials at the Lome and Lagos RTCs for community health workers and supporting personnel.

This subobjective concerned 1) the field testing of the VHW training materials and 2) the production of materials to train VHW supervisors.

1) Field Testing

During discussions in December 1979 with RTC Directors regarding the field testing and the response to in-country requests, the following decisions had been made:

- The main objective of the field testing should be to test the adaptibility of the VHW materials and specify the instructions necessary for easy use of the materials. Specific issues such as the accuracy of the materials should be of secondary importance during the field testing and generally resolved through consultation with subject matter experts.

- The field testing should take place before the end of 1980.

- Since the field testing would consist of; 1) assisting the trainers of village health workers with the adaptation of the training materials, 2) helping the graduates of the TOT course to train others to use the materials and train village health workers, it seemed optimal to combine the field testing with responses to in-country requests.

- The field testing should be done in the first two countries which requested help with adapting the materials to in-country conditions. If after adapting the materials in these two-countries there is still insufficient information available for the production of a final copy, field testing would continue in the next country that requested assistance. The Gambia and Mauritania had indicated that they are interested in receiving assistance in developing village health worker programs with the use of the VHW materials. These two countries have tentatively been designated as field test sites. This would allow for field testing in both an anglophone and a francophone country under different environmental conditions. Liberia and Gambia also indicated their interest in adaptation of the VHW training materials. These countries will be included in the 1981 program.

During this period, it was recommended that the field testing and in-country assistance cover the following areas:

-- assistance with the planning of village health worker programs;

-- assistance with the adaptation of the VHW materials; and

-- assistance with giving courses for trainers of village health workers.

Together with Dr. Adjou-Moumouni, a plan to give in-country courses for trainers of village health workers was drawn up (See Annex 2). This course program assumes that the RTC would be able to send two people to assist the graduates of the course in Lome/Lagos to give a three week course in the country for trainers of village health workers. The course would include adaptation of the materials to conditions in the country. It was assumed that the SHDS Project would be responsible for providing the two people and also copies of the VHW materials, while the country would assume responsibility for all other personnel and materials.

Sub-objective 2 of Obj. II Continued.

The assistance from the two centers may be given differently.. The structure of the assistance from the Lome center would be focused on giving a course tailored to the use of the materials and with a strict adherence to the methods used to give courses at the center. Since the Lome center has given in-country courses arranged by WHO already, it appears that such experience will be useful for the project.

The Lagos center on the other hand has not developed such expertise and has not really considered which methods to use for the in-country assistance. Since the Lagos staff members have not used the VHW training materials in their course they might have difficulty making these central to an in-country course. This fact may make field testing of the materials in anglophone countries a bit more difficult.

A pool of consultants should be set up which can be used by the different countries on request for assistance with their primary health care programs. The consultants should mainly be African with experience in primary health care, primarily graduates of the courses at the Lagos/Lome centers and/or the CESSIs.

When assistance is requested from the SHDS Project via WHO, consultants from this pool would be used together with RTC staff to assist with the planning and implementation of primary health care programs. Time limits should be established for the maximum use of a given consultant to avoid conflicts with his own country's need for his services. However, the use of consultants from other countries in the region would increase the cooperation between such countries and also lead to a sharing of experiences in this regard which can only have beneficial effects on the primary health care program.

See subobjective 3 for further discussion on adaptation and field testing of VHW training materials.

1). <u>Training Materials for VHW Supervisors:</u>

The next step in the development of training materials on primary health care concerns the need for training supervisors of VHWs. Discussions were held in June 1979 regarding the development of such materials with the directors of the two training centers. Since the VHW materials were developed in Lome, it was felt that it would be better to develop the supervisory materials under the guidance of the Lagos center since the revision of the VHW materials would create demands on the Lome center staff. Dr. El Neil also pointed out that the Nigeria Basic Health Services Scheme (BHSS) for the last two years, worked on the development of instructional materials for the training of community health aides and assistants. Part of this material includes management materials for the supervisory functions at the health centers in Nigeria. Thus, in the earlier discussions it had been decided that the SHDS project should assist with the development of such materials and provide technical assistance with the adaptation of this materials for use in other countries.

The BHSS staff has been trained in systematic course design in October 1979. The staff participates regularly as subject matter committee members and as facilitators in the RTC courses. In this project activity staff members would continue in the same capacity.

Since the budget negotiations had taken such a long time, it had been impossible to start the SHDS involvement in the development of the materials before this

Sub-objective 2 of Obj. II Continued.

time. The SHDS Educational Coordinator reviewed the materials which had been developed to this point, reviewed the need for technical assistance, and set up a work schedule for the project (see Annex 3 for the work plan).

In summary, the following decisions were made:

- BHSS would develop the educational objectives for the supervisory materials for three different types of health centers, and with three levels of personnel.
- Dr. Kolawole, who was planning a trip to the U.S. in June, would bring these objectives with him and the objectives would be reviewed by me at that time.
- Further discussions would be held at that time and decisions regarding technical assistance would be made.

Thus, major activity in the development of these materials will begin during the next reporting period.

Sub-objective 3: To develop RTC consulting capabilities to collaborate with countries of West and Central Africa in the development of effective training programs for village health workers and other personnel and test them in the field.

This subobjective concerns 1) the adaptation of the VHW training materials and 2) the evaluation of the RTC TOT participants on return to their home countries.

Adaptation of VHW Materials

1) As indicated in the discussion of subobjective 2, Mauritania and the Gambia requested follow-up from the Lome and Lagos RTCs in the development of their respective VHW training programs. In May, the SHDS Assistant Project Director and the SHDS Educational Coordinator visited Nouakchott to identify the modalities for such collaborative assistance. Owing to illness, the RTC Director could not join this visit.

RTC collaborative assistance was requested jointly by the MOH and USAID Mission which are sponsoring a PHC program in the Trarza region of Mauritania. (This is the USAID/Mauritania Rural Medical Assistance Project.) The Director of Preventive Medicine had been a participant in the June 1979 VHW training workshop conducted in Lome and had decided to adapt the SHDS Project training materials for the PHC program. Two Mauritanians were subsequently sent to the RTC TOT course in 1979.

The SHDS mission identified 5 stages for the development of VHW training for the Mauritania PHC project: 1) preparation of nurses/midwives as VHW trainers 2) assessment of village health conditions in relation to VHW tasks, 3) adaptation of VHW training materials, 4) the development of a village health worker training program, and 5) the development of a retraining program for VHWs and indicated where collaboration with the RTC would be most effective (see Annex 4 for the proposed follow-up strategy.) This plan was reviewed by the MOH and the USAID Mission and with appropriate modifications approved. During the PRC meeting, the Assistant SHDS Project Director and the Mauritanian representative to the PRC discussed the plan with AFRO officials. General agreements were reached. The MOH plans to make an official request to AFRO for collaborative assistance from the RTC scheduled to start in September-October 1980.

A similar planning visit was carried out in the Gambia by the Director of the RTC Lagos and the Assitant SHDS Project Director in June. The Gambian program was developed in cooperation with an AFRO-WHO general task force. It is a multi-donor project. Two Gambians participated in the RTC Lagos TOT course and on return to the Gambia were assigned the responsibility of developing a VHW training program. Four areas for follow-up were identified: 1) development of an operational plan for the VHW training program, 2) review of the task analysis and session plans, 3) assistance in conducting and administering the training program, and 4) development of an evaluation, supervision and retraining program. These recommendations were approved by the MOH and an official request was made to AFRO for follow-up the first stage of which is scheduled to begin in July (see Annex-for follow-up plan/memo regarding the GO[illegible]ial request for collaboration from RTC Lagos).

Subobjective 3 of Objective II Continued

As mentioned in subobjective 2, the centers have different strengths and have placed different emphasis in their TOT courses. This will affect what they can offer in follow-up programs as well as the kinds of assistance which is likely to be expected and requested. In addition, it is clear that both centers will have to maintain a flexible approach to follow-up as the needs of the countries will vary owing to special characteristics of their PHC programs, the varying stages of development of these programs, the competencies of the TOT graduates, and the other training programs and expertise which is locally available. In general, both RTCs believe they can offer assistance within the three areas specified above in subobjective 2. While it is too early to develop a model for such collaboration, the basic approach as proposed in the implementation plan appears to be desirable on site visits to review PHC program and develop a plan of action in consultation with the MOH and TOT graduates to match needs and resources within the context of the SHDS program possibilities. At present, informing countries of the availability of collaborative assistance is carried out on a personal basis through meeting with government officials and bilateral missions. As the number of countries with PHC program grows as the RTCs gain experience, it is hoped that a more formal system can be instituted. In pursuing this objective, a balance will have to be maintained between the two goals of adapting the training materials and developing consultative capabilities of the two RTCs.

2) Evaluation of RTC TOT course Participants

The following plan for evaluation has been developed:

-- The graduates will be sent a questionnaire which will provide some information about their own evaluation of the use they have made of what they learned in the course and how relevant they felt the course to be to course-related work on the job.

-- When in-country assistance is provided with the help of graduates from a course at the center, an evaluation will be made at the same time of how well they are able to use the knowledge and skills they had acquired at the center.

-- Visits to different countries for in-country evaluation of the graduates' work was also discussed, but no decision was made regarding the feasibility of such an evaluation. It was assumed that due to budget constraints such visits, if incorporated in the evaluation program, could not be made. before 1981.

A questionnaire has been developed for the Lome course and sent out to past participants (see Annex 6). Lagos RTC has maintained informal communication with course participants but plans to formalize an evaluation system for the course in 1981. The competencies of the TOT graduates will be best evaluated as they begin to work on VHW training courses.

OBJECTIVE II

CESSI Dakar and Yaounde

Sub-objective 1: Reformulate the CESSI curriculum in order to strengthen the programs' ability to train nurses and midwives for assuming effective roles in primary health care programs in light of new emphasis on PHC.

CESSI Dakar

The first phase of reformulating the curriculum for CESSI Dakar was carried out in 1979 with the evaluation of the CESSI program (see progress report for July - December 1979). The second phase was undertaken from March to May by SHDS consultant Dr. G. Vansintejan in collaboration with the CESSI/Dakar staff. Each step of the curriculum development process was carried out by a small task force and then discussed by the faculty as a whole to arrive at a consensus. The steps in the curriculum development process used were as follows:

1. Definition of the philosophy of CESSI with respect to primary health care, and the selection of institutional objectives;

2. Development of a conceptual model to articulate the philosophy and institutional objectives and to structure intermediate objectives and course intent;

3. Definition of intermediate objectives, to describe the knowledge, attitudes and skills to be attained by CESSI graduates. Faculty members then developed course descriptions corresponding to each intermediate objective. Primary health care approach as defined by the Alma Ata Declaration was integrated throughout. The curriculum is presently in the final stages of development and will be submitted to the CESSI technical Review Board (Composed of representatives of the University of Dakar and the Minister of Health) and WHO/AFRO. Implementation of the new curriculum is planned for October 1980. The teaching program for the new curriculum is currently being prepared. This will be done on a trimester basis including:

    1. translation of content to a trimester syllabus.

    2. meetings with outside lecturers, facilitators, and specialists in primary health care to fill in details of course content.

    3. development of a program of PHC-related practical field work.

    4. development of evaluation tools.

Planning for these steps begins during the next reporting period.

CESSI Yaounde

The first phase of the reformulation of the curriculum, i.e. evaluation of the CESSI program, continued during this period. The implementation of the evaluation questionnaires for CESSI graduates and their employers was completed in Cameroon in January. The SHDS consultant, Jeanne Carriere, began the analysis in collaboration with faculty members. As in the case of Dakar, each step requires involvement and commitment of the institution's faculty. In Yaounde, tabulation and analysis of results proceed slowly because of the complexity of the evaluation (two different groups are involved) and the acute staff shortage which limits the amount of time staff can devote to non-teaching activities. By June the tabulation and analysis were completed and the report was being prepared for typing. This will be the basis

Subobjective 1 of Obj. II - CESSI/Yaounde

for phase two reformulation of the curriculum.

The pace of activity in the CESSIs is determined by the staffing situation. While the staff is committed to program development, it's principal mandate is teaching. The staff situation in CESSI Dakar had improved this year with the continuation of an SHDS sponsored short term consultant, the addition of two Senegalese faculty, and a WHO faculty position. The situation in Yaounde was aggravated by the loss of two faculty positions. Hence, the SHDS consultant had to assume some teaching responsibilities.

Subobjectives 2 & 3 of Objective II

Sub-objective 2: To develop programs of continuing education, follow-up and evaluation for CESSI faculty and graduates in order to better respond to nursing services needs of the participating countries.

The first continuing education program will be held in December for 25 CESSI staff members and graduates who are currently teaching in basic schools of nursing. Two workshops were planned, but due to budgetary limitations only one was held. This workshop will be coordinated by AFRO and held at the RTC in Lome. A workshop program has been developed and approved by AFRO. The program will introduce the concepts of teaching primary health care, using EPI as an example. Further evaluation of CESSI graduates will be carried out during the next reporting period.

Sub-objective 3: To strengthen instructions in basic research methods which CESSI graduates can systemmatically apply in their work in identifying health service problems and finding solutions in the context of multi-disciplinary health teams especially those related to primary health care.

This subobjective is depended on the reformulation of the curriculum. However, during this period, a research program was developed by CESSI/Yaounde faculty members. This is being reviewed by CUSS, AFRO and SHDS, and may provide the context in which to train students to carry out PHC related research, as well as to carry out operational research related to health service and training. Further development of this approach is planned for the next report period.

Sub-objective 4: To continue to prepare nationals to assume responsibility of the total CESSI Program.

Following are criteria established for the award of a fellowship:

1. The candidate must be a national graduate of the CESSI.

2. The candidate must return to CESSI faculty position upon graduation.

3. The government accepts commitment to assigning the candidate to a faculty position.

Three fellows meeting these criteria for the 4 available fellowships, were identified, two from CESSI Dakar and one from CESSI Yaounde. This award of the fellowships was to be administered by SHDS, AFRO, AID/W and the respective USAID missions. The Boston University nursing coordinator worked out procedures with the AFR/RA office in this regard. SHDS and AFRO notified the CESSIs. In December, 1979 on the basis of a request by AFRO, USAID agreed to allow two of the four fellows to go to French speaking Nursing education programs at the University of Montreal. CESSI Yaounde nominated a current intern, M. Andre Noumssi as a candidate for the fellowship. Noumssi had previously been accepted to the nursing program at the University of Montreal. CESSI Dakar informed SHDS and AFRO that nominations would be determined through a national exam. The exam took place in mid-April. However, as results of the exam were not available by mid-May (deadline for most admissions to 1980-1981 programs), the GOS proposed two candidates who had been admitted to the nursing program in Montreal for 1979-80, but who had not been able to go because of the unavilability of fellowships. The candidates were M. Jean Baptiste Thiam and M. Moctar Baidy Niang, both former CESSI graduates and teachers in the Basic School of Nursing. Owing to: 1) previous admission to the University of Montreal; 2) the lack of time to apply to U.S. Schools of Nursing and 3) the lack of English language proficiency of the two CESSI Dakar candidates, AFRO and SHDS agreed to request a third waiver for study at Montreal. In a preliminary discussion with the AID/Washington representative on this matter during the SHDS PRC meeting in Brazzaville, AFRO officer was told this was possible and that an official request should be made.

In the next reporting period the remaining procedures will be implemented. SHDS has informed the Regional Affairs Office which will administer the fellowship award from AID. According to the procedures established, Washington will notify the USAID Missions, prepare the necessary PIO/P and request missions to provide medical exams as necessary. SHDS will furnish tickets and stipend advances. It is hoped that these procedures, worked out in advance, will function smoothly.

Post Basic Nursing Education in Liberia, Sierra Leone and The Gambia

Sub-objective 1: Develop and implement a continuation program in primary health care for graduates of the Basic Schools of Nursing in Liberia, Sierra Leone and The Gambia.

This subobjective, as originally planned included three activities:

1. the development of a non-degree post basic course at TNIMA (Tubman National Institute of Medical Arts) in Liberia.

2. one workshop in The Gambia, on curriculum development and,

3. a 2 week workshop, also in The Gambia, on the role of nursing in primary health care.

The first two activities could not be undertaken because a budget was not provided. The third will be carried out during the next reporting period. A workshop planning session has been scheduled for mid-July. The SHDS nursing program coordinator and AFRO temporary advisor, Professor E.O. Adebo, who served as a facilitator in the 1979 curriculum development workshop will collaborate with nursing education and service personnel in The Gambia to develop the workshop objectives, program and materials.

Sub-objective 2: To strengthen nursing service and education programs in Liberia, Sierra Leone and The Gambia through education of nurse trainers and primary health care program supervisors and managers.

The principal activities envisioned under this objective concerned the development of the nursing program at Cuttington University College. This was to be undertaken by a SHDS Field Consultant working in collaboration with the nursing faculty of Cuttington and two short term consultants recruited by AFRO to supplement the teaching staff for this program.

As originally conceived, the curriculum for the new program at Cuttington was to have been developed in the period between the first curriculum workshop and the start of classes at Cuttington in March 1980. Although consultation for this purpose had been budgeted, SHDS was not authorized by AID/W to proceed with recruitment until the proposal for this project had been approved. Following the approval of the project by the PCC meeting in Monrovia in 1979, SHDS proceeded to recruit for a field consultant position. However, the completion of this process was delayed because: 1) no action was taken on the 1980 budget until after the first quarter of the year, 2) Boston University could not make commitments to engage a field consultant for 2 years witnout contractual and budgetary assurances, 3) AID/W insisted that the candidate have past or present affiliation with B.U. School of Nursing. The first candidate recruited for this position was rejected by AID/W. The second candidate, Dr. Charlotte Ferguson, head of the Department of Community Health at the B.U. School of Nursing, has been approved, but no action can be taken until this position is explicitly provided for the Boston University contract with AID/W for the project during the 1981-82 period.

Subobjective 2 of Obj. II - Post Basic Nursing

Assurances are expected to be forthcoming and it is hoped the consultant will be in place early on in the next reporting period.

Four fellowships to Cuttington were provided to participants from The Gambia and Liberia. Although the AFRO/SHDS budget had not yet been approved, AFR/RA authorized AFRO to provide the fellowships. It is hoped that these 4 participants will be able to take advantage of the new curriculum during the second year of study. At present they are following the existing post-basic curriculum. Because of the political events in Liberia, no candidates could be nominated for masters degree fellowships for the 1980-1981 school year.

OBJECTIVE III

To improve regional and national disease surveillance and health information systems and to integrate these systems in the national planning delivery systems.

Although the statement of the four subobjectives of Objective III was somewhat different, the goal and purpose of SHDS Project objective III, as presented to the 1979 PCC Committee Members meeting in Liberia, remained the same. What was strengthened in the re-statement of the subobjective for 1980 was the emphasis on development of the training and information gather aspects of Obj. III. The accomplishments during the January-July 1980 period with respect to the subobjective and recommendations made by the 1979 PCC members are as follows:

Sub-objective 1: To expand immunization activities (multiple antigen) in the region.

Continued progress is being made in the expansion of immunization activities in the 3 demonstration and training countries. (Cameroon, Ivory Coast, Gambia)

Cameroon (Based on Heyman and Murphy monthly reports and studies)

Cameroon with a population of 7,663,246 selected 3 DTA's. They are Yaounde Eseka and Bamenda - Bafoussaum. (total popultation 716,480). Although multiple antigen immunization activities began in 1977, a full time SHDS/CDC operations officer was not assigned to the Ministry of Health until March 1979 and a revised 5 year EPI plan was adopted in September of 1979. Therefore, in evaluating this program the date of September 1979 will be used. Excepting Eseka, the other 2 DTA's are now fully operational and plans to expand, beginning in July of 80 to 1981, to the towns and surrounding areas of Douala, Maroua, Garoua, Ebolowa, Sangnelina M'Balmayo, Bafia and Bentoua have been made. This would mean 1,875,145 of the total population would be covered. An immunization survey was conducted in Yaounde in November, December 1979. 209 infants between the ages of 12-23 months were selected at random according to the EPI cluster sampling method. Of the 209 infants surveyed, 31% had received all of the indicated vaccines.

Vaccination coverage surveys conducted in the other 3 areas were:

Area	Vaccines BCG	Measles	DPT(2)	Polio (3)
Eseka	56.810	11.4%	9%	3%
Bamenda	65.2%	47.8%	48%	10%
Bafoussam	66.5%	29.4%	40%	28.9%

Vaccination coverage is expected to be higher at the end of 1980 but will not achieve the 70% objective as stated in the SHDS/CDC objective III plan.

In 1979, reported cases of measles dropped from 759/100,000 cases in 1978 to 588/100,000 in 1979. Case fatality rates for hospitalized children for measles increased from 690 in 1978 to 19% in 1979. Based on records of first consultation at the Center for Re-education of Handicapped Children of Yaounde polio rates dropped by 32% from 1978.

Mortality rates remained approximately the same in 1978 and 1979. A study was conducted in 1979 by Dr. Judith Brown to assess the sociological variable

Sub-objective 1 of Objective III continued.

A cost effectiveness study that was planned for the Ivory Coast has not yet begun. The protocol to be used in the Ivory Coast was recommended by the members of the PCC to be used as a basis for carrying out similar studies in the other SHDS 20 countries. Unfortunately funds have yet to be found to do this study.

The SHDS/CDC sub-regional epidemiologists assigned to OCCGE has been collaborating with WHO and the Government of Upper Volta in the implementation of their EPI program. This collaboration is expected to continue and possible consultancy will be carried out in Togo and Mauritania later this year. Measles vaccine in Ivory Coast and the other OCCGE countries has been received. Unfortunately all vaccines were not received as scheduled due to budgetary problems. This has since been rectified and the countries are now receiving their orders.

GAMBIA (based on reports submitted by Dr. Harry Hull and Steven Fitzgerald) The Gambia with a population of 600,000 began its operations in May of 1979, in the north Bank Division; however lack of transport and appropriately trained personnel dictated a shift to the Western Division. By September 1979 an initial start of EPI in Western Division including Banjul and Kombo St. Mary was begun.

In April of 1980 a vaccination coverage survey was performed in the Western Division. Since full operations began in October of 1979, the results after 6 months of operations were quite good.

DPT (3) - 61% coverage
Measles - 48.4%
Polio (3)- 23% (low coverage due to unavailability of vaccine)
BCG 88.7%

In May of 1980 a vaccination coverage assessment was carried out in Kombo St. Mary and Banjul in conjunction with the middle-level course. Coverage rates were as follows:

DTP (3)	53%
Polio (3)	33%
Measles	41.1%
BCG	86.8%

Problems affecting the coverage rates have been lack of vaccine and an adequate cold chain system. With improvements in both of these areas it is expected that 78% vaccination coverage should be obtained 18 months after commencement of field operations. Baseline data on morbidity and mortality of measles, polio and neonatal tetanus is being collected. A revised surveillance form has been developed and will be tested in January, 1981. A proposed health impact study to be carried out in conjunction with the EPI program agreed to by AID and the MOH, however funds have yet to be found. Measles vaccine was received, but The Gambia's request for an increase in their original requirements has not yet been responded to. A program audit (similar to the one done in Sierra Leone) is proposed for October-November in The Gambia.

Sub-objective 2: Development of training capabilities (to provide training in the region in EPI management and methodology, disease surveillance, data collection and epidemiology and to strengthen regional training capabilities in these subjects).

CAMEROON AND OCEAC COUNTRIES

A meeting with the AID Director, the Director General of OCEAC, Dr. Sentilles, SHDS/CDC sub-regional epidemiologist Dr. Heymann and the assistant director of SHDS was held in Yaounde in April 1980. At this meeting Dr. Sentilles fully supported the idea of an African assigned to OCEAC to work with and be trained by the SHDS/CDC sub-regional epidemiologist. He requested that SHDS confirm the amount budgeted and said that the selection of a counterpart would eventually replace the SHDS/CDC epidemiologist, he felt it would be best to train one national annually, and then at the end of 3 years, one from among these three would be selected.

In late June a budget for travel and perdiem for intra-African travels and CDC/Atlanta was approved for African counterparts to the OCEAC and OCCGE SHDS/CDC sub-regional epidemiologists. It is hoped that this budget will be carried over to 1981 as timing does not permit the placement of an epidemiologist in 1980. An African counterpart for the SHDS/CDC operations officer was identified and trained before the operations officer arrived. Since his arrival other persons have been trained to work with him in the implementation of the EPI.

Various in-service training programs have been conducted in Yaounde and the other three DTA's of the Cameroon. A mid-level course for personnel from Cameroon and the other 5 OCEAC countries is planned for August-September 1980. The SHDS/CDC epidemiologist has continued to train medical students a. the CUSS and conducted two 3-day seminars on cholera in Congo and Gabon.

IVORY COAST: OCCGE

Five Ivorian public health personnel received extensive training in vaccination techniques, disease surveillance program planning and program evaluation methods in order to launch the Ferkessedougou area program in early 1980. Eight medical officers from Rwanda, Algeria, Senegal, Mali, Togo, Zaire, Guinea and Madagascar, participating in the seventh international WHO sponsored epidemiologic course held in Abidjan, received formal and field training in disease surveillance and vaccination coverage assessment through EPI Ivory Coast. Health education programs on EPI were implemented this year in all the primary schools within the active EPI zones. Puppet shows on immunization live and on video tapes, radio announcements and numerous newspaper articles are ongoing activities to promote and train people and to increase public awareness of preventive health care. A mid-level mangers course for Ivorians and EPI personnel from the other OCCGE countries is planned for January 1981. In August 1980 an Ivorian counterpart, Andre Kouassi, will be assigned to be trained and eventually take over the responsibilities of the SHDS/CDC operations officer. A meeting is scheduled for August with the secretary General of OCCGE, Dr. Cheik Sow, to discuss the placement at OCCGE of an African counterpart to the SHDS/CDC medical epidemiologist assigned there.

THE GAMBIA ANGLOPHONE REGION

As there is no anglophone epidemiologic entity equivalent to OCEAC and OCCGE, contact was made in March of 1980 with the West African Health Community in

Sub-objective 1 of Objective III continued

influencing the immunization status of children. The most important variable found to influence the vaccination status of children was the ethnicity of the parties. High rates of coverage were attained by ethnic groups native to the West and North of Cameroon and low participation of those born in Yaounde and in the south Cameroon. This difference was also rated in surveys of vaccine coverage done in 1979 in the towns of Bafoussam and Bamenda.

Visits to Congo and Gabon by the SHDS/CDC medical epidemiologist have been carried out. A review of the disease surveillance system of Congo was completed and recommendations were made. Measles vaccine for the OCEAC areas has been received as requested. Based on recommendations from WHO and the USAID mission no vaccine was sent to CHAD. The Central African Republic has requested an additional 40,000 doses of vaccine following the cut in vaccine supply from UNICEF. Although the American mission and WHO agree that SHDS could supply vaccine, a decision is pending information from UNICEF as to the reason for their cut-back.

IVORY COAST

Ivory Coast with a population of 7,000,000 has developed DTA's in 3 zones as planned (Abidjan, Abengourou and Korhogo) and has enlarged the zones to increase the population served from 1.5 million people 1979 to nearly 2 million in 1980. Plans for expansion in 1981 have been developed. EPI activities were considered to be in full operation in Abidjan and Abengourou in Jan. 1979. Vaccination coverage rates for these two areas have surpassed 60% and it is expected that the rates should surpass 70% (The SHDS/CDC stated target goal in 1981). Korhogo, the third DTA which became fully operational in January of 1980 has achieved an average coverage rate of 50% and should achieve 70% 18 months after it becomes fully operational.

Morbidity and mortality reports for measles, polio and neonatal tetanus in the 2 DTA's indicated the following:

Abidjan

Measles:	Out patient measles cases up	24%
	Hospitalized cases up	44%
	Hospitalized measles deaths up	37%
Polio:	Hospitalized cases down	46%

Abengourou

Measles:	Outpatient measles cases up	32%
	Hospitalized measles cased down	5%
	Hospitalized deaths no change	
Polio:	Hospitalized cases unchanged	
	Hospitalized deaths (no change 0 in 78, 0 in 79)	
Neonatal tetanus:	Hospitalized cases unchanged	
	Hospitalized deaths down	9%

Sub-objective 2 of Objective III continued

Lagos, Nigeria, to discuss the possibility of creating an anglophone epidemiology service. The idea, was favourably received but it was felt that this idea should be developed slowly and carefully because the member countries were not able to make major committments at this time. Counterparts to both the SHDS/CDC medical epidemiologist and operations officers were selected in 1979 and continue to work closely with the SHDS/CDC personnel.

Late in June 1980, a budget was approved that would provide perdiem for intr-Africa travel for a Liberian, and Sierra Leoneon to work with, and be trained by, the SHDS/CDC medical epidemiologist. A letter has been sent to the MOH of Liberia and Sierra Leone informing them of these funds. A request was made by SHDS to the SHDS/CDC epidemiologist to collaborate with these countries in designing an appropriate training program. In May a mid-level managers course was held in The Gambia for Gambians and 6 nationals from the other SHDS anglophone countries. The purpose of the course was to help participants develop skills needed to manage immunization activities. Each of the modules listed below describes and teaches a major task that must be performed in an immunization program.

- allocate resources

- manage the cold chain

- conduct vaccination sessions

- supervise performance

— provide training

— evaluate vaccination coverage

— ensure public participation

The course managers consisted of 6 Gambians, 5 SHDS/CDC personnel working in the field, one representative from WHO/Gambia and CDC/Atlanta and the SHDS assistant project director. The teaching methodology used in this course was one of individual assistance, small group discussion, demonstrations, role playing and vaccination coverage assessments. There were 37 course participants among which 6 were from Sierra Leone, Ghana and Nigeria. Training is an essential and on-going activity of the Gambian EPI operations. Training had included such topics as repair of kerosene refrigeration units, jet gun maintenance and repair, cold chain, cluster survey methods and so on.

In April of 1980 the SHDS assistant director and an official from WHO/Geneva met with the personnel of the WHO RTC in Lagos and members of the Nigerian federal epidemiologic unit to complete a plan of operations for introducing the WHO EPI course materials into their 1981 curriculum. At this meeting the following recommendations were made:

1. To hold EPI mid-level management course for personnel involved in training of trainers course offered at the WHO Regional Training Center, Yaba. The course is scheduled for early October.

2. Dr. A.O.O. Sorungbe, senior consultant epidemiologist will be responsible for the selection of the course participant and for all the registered and administration matters. Dr. El-Neil will make available the facilities of RTC for the course.

Sub-objective 2 of Objective III continued

3. WHO/AFRO in collaboration with SHDS will provide the facilitators

4. Funding for the local subject matter committee participants will come from SHDS/AFRO budget.

5. WHO will provide the initial set of course materials. The residential course is scheduled for 6 Oct. - 16 Oct. At the end of the course a mechanism for the integration of the EPI materials into the RTC curriculum will be developed.

Sub-objective 3: Development of capability to gather information (data necessary for health planning, including demographic data.) (To strengthen regional and national systems of disease surveillance and health information gathering necessary for effective health planning.)

CAMEROON - OCEAC

An indepth study of the surveillance systems of the Cameroon and Congo was completed by the SHDS/CDC medical epidemiologist. Much thought has recently been given to the Grandes Endemies system has been written. The first draft was revised at the June 1980 OCEAC technical conference by the directors of public health of C.A.R., Gabon, Congo and Cameroon and a final draft will be submitted to the ministers of health in November. SHDS has been consulted by the secretary of OCEAC requesting aid in printing the final surveillance forms and in recycling health personnel for this system. This is in line with our objectives. The OCEAC newslette. distribution continues to g . In-vestigations of monkey pox and suspect homorrhagic fever were carried out in Cameroon early this year. The annual epidemiol conference that was be held in the Cameroon was held in The Gambia.

IVORY COAST-OCCGE

The SHDS/CDC sub-regional epidemiologist assigned to OCCGE officially assumed his responsibilities in April of 1980. He has evaluated the Upper Volta and Ivory Coast surveillance systems. Reports on these are in progress at this time. Ivory Coast began limited distribution of a quarterly EPI bulletin in May 1980. Discussions between the Director-General and the SHDS/CDC epidemiologist about publishing a sub-regional EPI bulletin were held. The preference of the Secretary General was that this bulletin should not be separate from the one they publish.

THE GAMBIA-ANGLOPHONE SUB-REGION

The Gambia epidemiologic surveillance system has been analyzed and a report submitted to the government. A new system for collection of out-patient data has been designed and will be placed in a small number of health centers for a trial period of several months.

Sierra Leone surveillance system was analyzed in part during the October 1979 EPI evaluation. A report from this visit has been submitted to the government and a request for a more complete evaluation has been made.

Liberian surveillance system will be evaluted in October of 1980. An outbreak of probably meningococcal menigitis occurred in March 1980 and was investigated by the Gambian counterpart to the SHDS/CDC epidemiologist.

Sub-objective 3 of Objective III continued

In April of 1980, the first SHDS/CDC regional meeting on disease surveillance and immunization was held in the Gambia. The intent of this originally planned Cameroon conference was to present papers for discussion by SHDS/CDC personnel in the field on the results of their work and to provide and opportunity for Africans who are involved in various disease surveillance and epidemiological activities to present and have discussion on their studies. (See Telex #972) The persons attending the conference were for the most part CDC personnel and personnel from The Gambian Ministry of Health. WHO was represented by the WHO country coordinator Dr. Akim, Dr. Ralph Henderson and Mariane Hamuman from Geneva. Personnel in the field are not often given a chance to have their work criticized. This conference provided such an occasion. The bi-monthly Gambian EPI newsletter has now published 4 issues. It serves to provide results of epidemiologic investigations, and health education lessons, and discuss policy decision with field staff. A regional newsletter is pending a more formal association of the anglophone countries.

Sub-objective 4: To develop a coordinated laboratory system to provide necessary back-up services to the disease surveillance and control systems.

CAMEROON OCEAC

Laboratory continues to develop. Equipment has arrived.

IVORY COAST - OCCGE

SHDS/CDC and WHO assisted Institute Pasteur with training of personnel and provided laboratory supplies for implementing measles vaccine testing and updating Polio vaccine titration technique. Vaccine titration will continue to be carried to EPI in 1981. Laboratory facilities at the Center Muraz have not yet been explored by the SHDS/CDC epidemiologist. A visit is planned in August 1980.

GAMBIA-ANGLOPHONE

Visits have been made to the Pasteur Institute/Dakar and the MRC/Fajara to survey current capabilities. Both insitutions have indicated a willingness to provide laboratory back up.

SUMMARY

During this 7 month period, SHDS emphasized the training aspect of this objective SHDS assistant director, operation officer assigned to the Ivory Coast and personnel who had previously attended the SHDS/Sponsored EPI African top-level managers course were chosen by WHO to be facilitat at the first worldwide top-level EPI course held in Brazzaville in March. It is expected that the trained African personnel will conduct training i their own countries. and replace the majority of international personnel as trainers of international EPI course. These courses (the top-level and mid-level one in The Gambia) have had a strong impact in the development of well organized EPI activities in the SHDS 20 countries and also in encouraging active participation in planning and implementing programs by mid-level supervisory personnel.

MID-YEAR PROGRESS REPORT, JANUARY-JULY 1980
OBJ. IV - LOW COST HEALTH DELIVERY

The 4th of the SHDS objectives has been the slowest in getting underway. However, in this 6 month reporting period much was accomplished in developing the plans forthe 1st regional applied research course as well as to develop final plans for the research program as a whole. The following was accomplished:

Sub-obj. 1 To strengthen individual and institutional capability within the region, to do applied research which will improve the functioning of low-cost (affordable) health delivery systems (in collaboration with WHO/AFRO).

In March of 1980 a trip was made to Africa by SHDS consultant Dr. Mousseau-Gershman and SHDS Boston staff person Dr. Ann Brownlee. The objectives of their trip were:

a) To meet with consultant trainers and SHDS and AFRO staff to plan the course on preparation of research protocols. The agenda for these meetings included development of the final version of the course objective, design of course schedules and identification of course materials, cases studies etc. needed.

b) To work with SHDS and AFRO staff to plan the WHO/SHDS Program of Applied Research in Health Service Delivery and Primary Health care. This involved developing appropriate program mechanisms for a) encouraging development of proposals; b) reviewing and selecting proposals for funding; c) supervising and supporting work in progress; and d) disseminating results and encouraging their utilization.

A) WHO selected two temporary advisors to be trainers along with SHDS consultant, Dr. Mousseau-Gershman and Dr. Ann Brownlee. They were Dr. Thomas Nchinda from Cameroon and Dr. Pape Soulaye N'diaye from Senegal. The course site of Ouagadougou, Upper Volta was selected, however the dates as planned 28 July - 7 August were not acceptable to the Government and new dates had to be arranged.

The SHDS consultant, and Dr. Brownlee met with AFRO staff involved in applied health services research as well as with Dr. Nchinda in the Cameroon and Dr. N'diaye in Senegal. During these meetings, it was agreed that approximately 10-15% of the course would be devoted to theory and 85-90% to practical exercises and group work. The course objectives were defined as follows:

- Give examples of major types of applied research currently used to address problems of health service delivery and primary care.

- List major donor agencies with interest in funding various types of applied research within his own country and demonstrate how a proposal may be adjusted to meet specifications of the organization to which it is addressed.

- Select an appropriate research project, considering priority health care problems, investigator skills and interests, available resources and the potential applicability of research results.

- Prepare a description of background on the problem selected for study indicating briefly what the problem is, why and how it was chosen for study, its relevanceto national and regional priorities, and what relevant findings are available from past research.

- Prepare appropriate research objectives for the project.

- Develop an appropriate research design for the project.

- Develop a project work plan adapted to local conditions, including a schedule for the research, monitoring adminstrative and evaluative activities involved.

- Prepare job descriptions with time requirements for project personnel and identify potential staff and consultants.

- Identify and describe the institutional and administrative support needed for the project.

- Prepare a realistic and appropriate budget for the project.

- Outline a post course strategy for completing the proposal and obtaining project funding.

It was decided that the course sessions would focus on the following topics:

- Definition of health services, research, types of research
- Identification of potential sources for project funding
- Discussion of problem selected for research, relevance of the research to the country's needs,
- Selection of research objectives (long,medium and short term)
- Development of research methodology (research methods, sampling variables, data collection, analysis and interpretation of results)
- Development of a plan of work, schedule for project manitoring
- Planning the administration and evaluation of the project
- Selection of project staff, use of local and internationl consultants, planning for any necessary staff training,
- Development of project budget.

During the ensuing months the trainers developed their teaching materials and these were reviewed by Dr. Brownlee who put them into instructional outline form and compiled the course book.

B) Design of the WHO/SHDS program of applied research on Health Service Delivery and Primary Health Care.

Discussions were held with WHO/AFRO staff concerning final plans and guidelines for implementation of the joint program in applied research. The attachment is the description of the mechanism for project selection that was proposed to WHO. In June of 1980 AFRO responded recommending that alternative 2 be used ie., that once SHDS reviews the proposals they submit them to the WHO designated person who would then circulate copies to the members of WHO/AFRO's Research Development Committee. This committee would be requested to respond within a designated period of time, and the majority opinion of those responding would be taken as the decision, SHDS Abidjan would then be notified.

This process was discussed with AID/W and they strongly felt that AID/W should be able to review the proposals and contact their country missions for clearance, This point will be dicussed in further detail and hopefully it will be resolved before the next P.C.C. meeting in November. Mechanisms for disseminating results and encouraging their utilization have not yet been developed as it is felt once the initial research projects are selected and implemented there would be a clearer idea concerning that type of results that will be forth coming.

Sub obJ III To develop appropriate training of personnel in the areas related to quality control, purchasing, storage and distribution of drugs and medical supplies.

No action was taken on this as no budget had been approved and there seems to be a conflict of opionion as to whether or not SHDS should be involved in this activity.

SUMMARY:

Although there were some problems in coordinating the visits of the SHDS/consultant and WHO/AFRO temporary advisors, the brief working sessions were most fruitful. Further problems entailed dates of the course and the conflict in SHDS consultants schedules. Due to the uncertainty about course dates the reproduction of course materials and administrative planning was some what impeded.

WORLD HEALTH ORGANIZATION

Regional Office for Africa

ORGANISATION MONDIALE DE LA SANTÉ

Bureau régional de l'Afrique

STRENGTHENING OF HEALTH DELIVERY SYSTEMS IN CENTRAL AND WEST AFRICA

REP/02

Meeting of the Project Review Committee

Brazzaville, 23-27 June 1980

ICP SPM 013

DRAFT FINAL REPORT

CONTENTS

		Page
1.	INTRODUCTION	1
2.	WHO/USAID JOINT MID-TERM EVALUATION	2
3.	REVIEW OF PROJECT ACTIVITIES FROM SEPTEMBER 1977 TO JUNE 1980	4
4.	SCOPE OF AID COLLABORATION	7
5.	PROPOSED ACTIVITIES FOR THE SECOND HALF OF PHASE II (JULY 1980 - DECEMBER 1982)	8
6.	DESIGNATION OF THE NEW MEMBERS TO SERVE ON THE PROJECT COORDINATION COMMITTEE	11
7.	DATE AND PLACE OF THE NEXT MEETING OF THE PROJECT COORDINATION COMMITTEE	11
8.	DATE AND PLACE OF THE NEXT MEETING OF THE PROJECT REVIEW COMMITTEE	11
9.	DATE OF NEXT EVALUATION	11
10.	CONCLUSIONS	12
11.	RECOMMENDATIONS	12

ANNEXES

1. List of participants
2. Address by the Regional Director
3. Programme of work.

1. INTRODUCTION

1.1 The Project Review Committee (PRC) for the Strengthening of Health Delivery Systems (SHDS) met in Brazzaville, People's Republic of Congo from 23 to 27 June 1980. See Annex 1 for the list of participants. The opening ceremony was chaired by Dr Comlan A. A. Quenum, Regional Director, who extended a warm welcome to the participants. He recalled that the World Health Assembly decided that the main social target of governments and of WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Projects should therefore be considered as a step for achieving this socially relevant target through the Primary Health Care (PHC) approach.

The Regional Director underlined, as a good example of international cooperation, the great victory over smallpox, a disease which spread terror for centuries. This victory was acknowledged by the last Health Assembly. Such results, he said, constitute strong stimuli for pursuing the struggle for the establishment of social justice in the field of health in Africa and the Project for Strengthening of Health Delivery Systems in Central and West Africa is one of the mechanisms for international cooperation (see Annex 2).

1.2 Election of officers

The following office bearers were elected for the meeting:

Chairman - Dr E. A. Smith (Nigeria)

Vice-Chairman - Dr L. Adande Menest (Gabon)

Rapporteur - Dr J. Wright (Niger)

1.3 Adoption of programme of work

The proposed programme of work was adopted without amendment. See Annex 3.

1.4 Method of work

The participants agreed to the following working procedure. All discussions would be held in plenary session. A summary of the principal points discussed and decisions reached would be prepared daily for the participants. Participants would make their written corrections on this summary for inclusion in the final report. The corrections which should be in line with the intent of the discussions should be handed in on the following morning. The draft final report of the meeting would be considered on the last day by the participants at the plenary session.

2. WHO/USAID JOINT MID-TERM EVALUATION

2.1 Dr Ashitey, Chairman of the joint WHO/USAID Evaluation Team presented a summary report. After recalling the overall goal and the objectives of the project, he stressed that the Project Agreement signed by WHO/AFRO and USAID in September 1977 provided for the mid-term evaluation of the second phase of the Project. This evaluation took place from 25 February to 22 April 1980. He gave the composition of the team and a short description of the evaluation methodology utilized. Dr Ashitey underlined that the evaluation report consists of a review of SHDS activities to date, the inputs, achievements, problems, and recommendations for each of the four project objectives, and also some recommendations on the overall project administration and programme support.

2.2 The following points were raised during the ensuing discussions:

(i) time allotted for the evaluation was considered too short;

(ii) results of the evaluation were not entirely satisfactory; many delegates mentioned that the lack of indicators and quantifiable objectives as well as budgetary and cost information did not allow for an in-depth and objective evaluation. They recommended the utilization of the WHO Evaluation Guidelines (document HCP/DPE/78.1) for the establishment of a system for continuous evaluation and to obtain active participation of the nationals;

(iii) absence of information on the cost of the evaluation mission;

(iv) the need for an increased utilization of national and regional resources within the framework of the project.

2.3 Certain clarifications were given to the participants:

(i) the reason for the delay of personnel recruitment; the example of the STC for Cuttington College Liberia, whose recruitment could not be finalized because of administrative delays in funding, was cited.

(ii) with regard to the improvement and expansion of training facilities in the Regional Training Centres at Lome and Lagos, it was explained that the proper role of WHO is to collaborate with the governments in mobilizing resources;

(iii) USAID indicated that timely delivery of vaccines could be assured if:

(a) there is timely notification of needs by countries;

(b) countries report the utilization of these vaccines;

(iv) the lack of information concerning SHDS activities; sharing and dissemination of information about SHDS activities do not exist except for news letters from RCI, Gambia and OCEAC

(v) as far as SHDS coordinating mechanism at country level is concerned, it was agreed that this mechanism should be country specific.

2.4 The representative of the Fund for African Cooperation (FAC) assured continued support to various countries on a bilateral basis as well as to OCEAC and OCCGE if requests were made. He further stated that his attendance at this meeting would enable him to present the PRC's recommendations to his Govenment. FAC considers its activities comlimentary to those of the project.

2.5 Finally, participants took note of the Evaluation Report but requested a better French version.

3. REVIEW OF PROJECT ACTIVITIES FROM SEPTEMBER 1977 TO JUNE 1980

The SHDS Project Director reviewed the main activities of each of the SHDS objective

3.1. Objective I: To Improve National and Regional Health Planning and Management.

3.1.1 The following activities were stressed: provision of fellowships to the Dakar Centre for Health Planning and Management; six weeks course for senior health officials; two weeks middle-level managers course; First Ministerial (top-level) Intersectoral Management workshop and expansion in training and support activities at the country level through Country Health Programming workshops and exercises.

3.1.2 The discussion of these activities noted the following:

(i) efforts are being made to reinforce national institutions of management and administration to train health programme managers, the ultimate goal being the establishment of a regional network of health management training institutions;

(ii) top-level management workshops help national decision makers better utilize national resources in particular the skills of their technical and professional staff;

(iii) Regional intersectoral management workshops should be followed up by similar activities at the country level;

(iv) a reorientation of the project activities is needed in order to attain the goal "Health for all by the year 2000".

3.2.1 The following activities were highlighted:

(i) for the Lomé and Lagos Regional Training Centers:- local development of instructional materials for training village health workers; the holding of three courses for village health worker trainers; the development of follow-up capabilities to help graduates of trainers courses to design in-country courses and adapt training materials;

(ii) for CESSI Dakar and Yaoundé: evaluation of the programmes of both institutions; continuing education programme for CESSI graduates; and revision of the curriculum to emphasize primary health care;

(iii) for the Post-basic Nursing Education Programme for The Gambia, Sierra leone and Liberia: approval given for the development of the programme in Cuttington Univetsity College. The programme started in March 1980 with (6) students.

3.2.2 The ensuing discussions drew attention to the following:

(i) there was general agreement that it is in the interest of all governments ar their responsibility to properly select ano utilize candidates for training;

(ii) all requests for follow-up activities related to graduates of the Regional Training Centres should be addressed to the WHO Regional Office;

(iii) the function of the Regional Training Centres is to offer opportunities for continuing education often unavailable in countries, and to provide training which countries are unable to organize for limited number of students and also when it is difficult to change existing programmes;

(iv) efforts should be made to train a critical core of VHW trainers for each country

(v) more detailed information should be provided on the costs and benefits of these training programmes of each country.

3.3 Objective III To Improve Regional and National Disease Surveillance and Health Demographic Data Systems and to Integrate these Systems into National Health Planning Delivery System.

3.3.1 The review of project activities stressed the development of the three demonstration and training areas (DTAs) in Ivory Coast, evaluations of the impact of EPI on mortality and morbidity, the expansion of regional and national training activities for senior and middle-level EPI personnel, and the growth in data collection capabilities;

3.3.2 The discussion relative to the above brought out the following points:

(i) the mobilization of resources to develop the Ivory Coast DTA is a (ii) model which other countries might find useful;

(ii) because of ecological diversity, 2 or 3 new sahelian DTA's should be considered;

(iii) SHDS project should consider collaborating with partcipating countries in developing cold chain systems and obtaining needed vaccines;

(iv) data colllection, and development of information systems should receive more emphasis, including special training courses; and the exchange of epidemiological data within the region in collaboration with AFRO.

3.4 Objective iv: Low Cost (Affordable) Health Delivery Systems Development.

3.4.1 The achievements mentioned during this review included the three PHC workshops held at the CUSS in Yaoundé, the compilation of workshop papers into a training manual, the eleboration of applied research guidelines, a workshop in applied research methods, and a study carried out on pharmaceutical supply, distribution and storage.

3.4.2. The following comments were made in the ensuing discussion:

(i) the delegates of the participating countries requested the Project to take responsibility for the publication in 3 volumes of the PHC manual, a revised version of which has recently been submitted to AFRO for review; taking into account recommendations made by the ad hoc committee.

(ii) with regard to development of local pharceutical industries, it was observed that as studies are being undertaken by many organizations such as ECA, ADB UNIDO, WHO, etc., it was considered an unnecessary duplication of effort for SHDS to continue with this activity;

(iii) following the reorientation of the original proposal towards health services research, emphasis should be given to the development of national research capabilities, the ultimate goal of which is the establishment of a regional network of national research centres;

(iv) applied research activities should be carried out within the context of the

4. SCOPE OF AID COLLABORATION

4.1 Mr. Ruoff, the AID representative, introduced the subject. He recalled that the project paper endorsed by the PRC in July 1977 was accepted by AID. He explained that since AID has limited funds, some activities have been selected for its contribution in the project expecting that other agencies would come forward to collaborate with the project. The AID is satisfied with the progress of the SHDS as reflected in the mid-term joint evaluation report. This, along with the Project Coordination Committee (PCC) meetings and WHO consultation, encourages them to continue supporting the project. Mr. Ruoff also explained that as the AID budgeting procedure does not permit him to make any commitment at this time, he would take the recommendation of this PRC back to Washington for consideration.

4.2 The following points were raised during the discussion:

(i) the assistance of AID through SHDS was appreciated by the participating countries with the hope that this collaboration will continue beyond 1982;

(ii) in order to achieve the objectives, the participation of other cooperating agencies is to be encouraged;

(iii) since the Cotonou Health Development Centre falls within the Objective I of the SHDS project which is considered a top regional priority, the PRC noted with concern that no explanation was given for the refusal of AID to contribute to its funding.

(iv) in view of rapid changes and new developments in the health field, the delegates requested that AID maintain a flexible funding policy in respect to the SHDS project.

4.3 The representative of ECA stated that as an observer he had no mandate to commit his organization; he would, however, submit the recommendations of the PRC to his organization for consideration.

5. PROPOSED ACTIVITIES FOR THE SECOND HALF OF PHASE II (JULY 1980 - DECEMBER 1982)

The Project Director presented the proposed activities for each of the objectives.

5.1 Objective I: To Improve National and Regional Health Planning and Management. Gestion in French

5.1.1 The proposed activities included holding further intersectoral management workshops at regional and national level, introducing planning courses related to EPI and other aspects of PHC, continuing support to country health programming exercises, providing resident internships in applied research in health planning and management and strengthening training capabilities of national management and administration institutions.

5.1.2 In the course of the discussion, the following points were brought out:

(i) the proposed Health Planning and Mangement project in Dakar is one of the collaborating institutions through which activities under Objective I could be implemented;

(ii) increased emphasis should be placed on supporting activities at country level aimed at developing national training capabilities.

5.2 Objective II: To Increase Skills and Improve Utilization of Health Personnel Providing Generalized Health Services at Supervisory and Local Levels.

5.2.1 The proposed activities included the continuation of VHW trainers courses, in-country follow-up of graduates of the Regional Training Centres, continuing education workshops and development of PHC-oriented curriculum for the CESSIs and Cuttington University College nursing programme.

5.2.2 The ensuing discussion emphasized the following points:

(i) SHDS's activities should be coordinated with bilateral programmes in the development of national PHC programmes and national training institutions;

(ii) although participating countries may require scores of VHW trainers to meet their needs, they should realize that the training of trainers needs to be carried out carefully by competent personnel;

(iii) attention should be given to the possibility of developing a regional centre for training post-basic nursing tutors; such an institution would allow for the training of CESSI teachers within the African Region.

5.3 Objective III To Improve Regional and National Disease Surveillance and Health Demographic Data Systems and to Integrate these Systems into National Health Planning Delivery Systems.

5.3.1 The proposed activities included those related to the expansion of immunization activities and the development of regional training capabilities, national data collection and laboratory back-up services to the disease surveillance and control systems.

5.3.2 Subsequent discussion made the following points:

(i) It was proposed that (regional epidemiologists adhere to scheduled visits.)

(ii) as the present DTAs attain desired levels of EPI development, consideration should be given to channelling SHDS support to other countries where EPI programmes are just beginning;

(iii) SHDS support to EPI programmes should be sufficiently flexible to respond to various national priorities in the control of transmissible diseases;

(iv) participating countries and support agencies should continue to give highest priority to ensuring that national counterparts are assigned to SHDS EPI personnel including epidemiologists and that the former are properly trained;

(v) SHDS project should support the development of the health education component of EPI programmes;

(vi) data collection systems for EPI being part of national health information systems should be developed within the context of improving national health planning and management capabilities;

(vii) nationals involved in EPI should be invited to future SHDS/WHO/CDC epidemiological conferences;

(viii) SHDS activities in regard to laboratory development are aimed at supporting the EPI

programmes through the strengthening of selected laboratory facilities while Regional Training Centres concentrate on the preparation of laboratory technician trainers for the participating countries.

5.4. Objective iv: Low Cost (Affordable) Health Delivery Systems Development.

5.4.1 The proposed activities were related to the development of capabilities to do applied health services research and to the support of regional systems for pharmaceutical production and distribution.

5.4.2 The highlights of the ensuing discussions were as follows:

(i) the delegates unanimously decided that the finalization and publication of the PHC manual produced during the SHDS-sponsored PHC workshops at the CUSS, Yaounde, should be the responsibility of the project;

(ii) whereas there is currently no apparent need for further studies, SHDS collaboration was welcomed in implementation activities;

(iii) SHDS funding for applied research projects is applicable to proposals submitted by participants of the research workshops and by nationals who wish to carry out operational research related to specific SHDS project activities in their countries, as long as they follow the applied research guidelines.

5.5 All efforts to expand the institutional base of the project as well as diversify health related activities should be developed within the existing administrative structure of SHDS and should be considered at future PCC meetings for review and approval

5.6 SHDS should submit detailed budget report to future PCC and PRC meetings, along with the annual implementation plans.

6. DESIGNATION OF THE NEW MEMBERS TO SERVE ON THE PROJECT COORDINATION COMMITTEE

6.1 The Brazzaville meeting of July k977 approved the formula for the composition of the Project Coordination Committee. Several new formulae were proposed but the members decided to continue with the one established in 1977.

6.2 As Equatorial Guinea was neither English nor French-speaking, the representative opted to join the English-speaking group.

6.3 The representative of Equatorial Guinea withdrew his country's representatic: in favour of Nigeria, the next on the list, with the understanding that Equatorial Guinea would be a member of the next PCC.

6.4 Based on the 1977 formula, the terms of office of country representatives of Benin, Chad, Gambia and Ghana came to an end. For 1980-1982, the country representatives would be Central African Republic, Congo, Liberia and Nigeria.

7.. DATE AND PLACE OF THE NEXT MEETING OF THE PROJECT COORDINATION COMMITTEE

The next meeting of this committee will be helf 10-14 November 1980, in Cotonou, People's Republic of Benin. The Government of Benin has graciously accepted and has confirmed its willingness to host this meeting.

8. DATE AND PLACE OF THE NEXT MEETING OF THE PROJECT REVIEW COMMITTEE

Regret was expressed at the Ivory Coast's inability to host this meeting this year. It was decided to hold the next meeting in Abidjan in June 1982. The exact date would be decided through correspondence.

9. DATE OF NEXT EVALUATION

the PRC opted for the utilization of the WHO guidelines for the next evaluation. The participants stressed the need for the timely preparation of the evaluation which should start as early as January 1981. Furthermore, they proposed that the composition of the joint evaluation team should be composed of representatives from WHO, AID, participating countries and external evaluators.

10. CONCLUSIONS

The SHDS project, in the three major objectives which have been operational for a significant period of time, is judged to be of value to the member

promise for fostering health service development.

The development, within the framework of TCDC, of regional networks of National Management, Training and Research Centres is a realistic approach for attaining regional self-reliance.

Delegates of participating countries to PCC and PRC meetings have an important rule to play in fostering communication between government authorities, health personnel, USAID and WHO staff in respect to SHDS project.

SHDS activities and national projects receiving USAID bilateral cooperation should be mutually supportive.

The last of quantifiable objectives, the inadequacy of the evaluation methodology and the short period given to the joint USAID/WHO joint evaluation team allow neither an indepth mid-term project review nor a review of the project's progress.

In spite of certain shortcomings of the evaluation report, the PRC has noticed that this document contains the essential elements allowing the participants to present recommendations for future action and reorientation of project activities.

Health development being a dynamic process, certain reorientations of project activities, and subsequent budgetary adjustments, are necessary.

11. RECOMMENDATIONS

The following are the recommendations:

11.1 AID collaboration should continue beyond December 1982 so that project objectives are completely attained.

11.2 WHO/AID and participating countries should do their utmost to urge other cooperating agencies to join SHDS.

11.3 For future evaluation of SHDS projects:

(i) WHO Provisional Guidelines (HCP/DPE/78) should be followed;

(ii) a questionnaire based on the above guidelines should be sent in advance to enable participating countries prepare for the evaluation;

(iii) Evaluation Team should include WHO, AID, SHDS and countries' representatives;

(iv) sufficient time should be allotted;

(v) preparation should start as soon as possible, preferably January 1981;

(vi) SHDS project should quantify objectives whenever possible for presentation to the next PCC meeting;

(vii) management information system for the project should be developed to allow for continuous evaluation of activities and monitoring of expenditure for each country.

11.4 Within the framework of the project every effort should be made to utilize optimally national and regional ersources.

11.5 The mechanism for mobilizing and coordinating resources for the Ivory Coast EPI programme is a possible model for other countries.

11.6 Every country should set up a suitable mechanism to coordinate SHDS activities.

11.7 Because of ecological diversities, SHDS should consider setting up 2 or 3 DTAs in the Sahelian region.

11.8 SHDS should take appropriate steps to extend the collaboration in the development of a cold chain system in participating countries.

11.9 Since the development of activities of the Regional Health Development Centre, Cotonou, are aimed at attaining Objective I which is top regional priority, AID/WHO should financially support the development of the Centre which is a milestone in the process of health development in Africa.

11.10 As new strategies are being developed to meet the challenge accepted by all participating countries, "Health for all by the year 2000", must have a more flexible budgetary policy in financing SHDS activities.

11.11 SHDS activities in the countries should be coordinated with bilateral and multilateral and national programmes of primary health care and health manpower development.

11.12 In the process of formulating training programmes for village health workers, provision should be made for appropriate trained personnel to be utilized for the training of trainers. The TOT should be carried out as much as possible within the countires of the countries concerned.

11.13 SHDS should develop a regional centre for the training of postbasic nursing tutors.

11.14 The appointment and training of national counterparts to regional epidemiologists and technical officers in each country should be a top priority.

11.15 The visit schedule of the regional epidemiologists should be established in advance every year and countries should be accordingly informed.

11.16 Development of information systems including epidemiological data in each country should continue. SHDS needs an independent information gathering system to aid periodic reviews by participating countries.

11.17 The delegates unanimously decided that the finalization and publication of the PHC manual produced during the SHDS-sponsored PHC workshops at the CUSS, Yaounde, should be the responsibility of the joint WHO-SHDS project.

LIST OF PARTICIPANTS
LISTE DES PARTICIPANTS

1. REPRESENTATIVES OF AFRICAN STATES
REPRESENTANTS DES ETATS AFRICAINS

BENIN

Dr F. Feliho
Directeur de la Protection sanitaire
Ministère de la Santé publique
B.P. 883
Cotonou

CENTRAL AFRICAN REPUBLIC
REPUBLIQUE CENTRAFRICAINE

Dr A. Banga Bingui
Inspecteur général de la Santé
et des Affaires sociales
Ministère de la Santé publique et des Affaires sociales
Bangui

CHAD
TCHAD

CONGO

Dr G. Ondaye
Coordonnateur national des Programmes OMS
B.P. 2465
Brazzaville

GABON

Dr L. Adande Menest
Directeur général de la Santé publique
Ministère de la Santé publique et de la Population
B.P. 50
Libreville

THE GAMBIA
LA GAMBIE

Dr E. M. Samba
Director of Medical Services
Ministry of Health, Labour and Social Welfare
Banjul

GHANA

Dr K. Ward-Brew
Deputy Director of Medical Services (International Health)
Ministry of Health
P.O. Box M.142
Acc.

EQUATORIAL GUINEA
GUINEE EQUATORIALE

Dr D. V. M. Nsue
Médecin-Chirurgien et Directeur
Hôpital général de Malabo
Malabo

GUINEA
GUINEE

M. Alhassane Baldé
Statisticien
Division Statistiques sanitaires
Ministère de la Santé publique
Conakry

IVORY COAST
COTE D'IVOIRE

Dr C. Emmou
Directeur de l'Institut d'Hygiène
B.P. V 14
Abidjan

LIBERIA

Mrs R. Marshall
Assistant Minister of Health
Ministry of Health and Social Welfare
Monrovia

MALI

Dr S. O. Diallo
Conseiller technique
Ministère de la Santé publique et des Affaires sociales
Koulouba/Bamako

MAURITANIA
MAURITANIE

Dr M. M. Hacen
Chef du Service de Médecine préventive
Ministère de la Santé publique et des Affaires sociales
Nouakchott

NIGER

Dr J. Wright
Conseiller technique/Inspecteur général de la Santé
Ministère de la Santé publique et des Affaires sociales
B.P. 10739
Niamey

NIGERIA

Dr E. A. Smith
Director of Public Health Services
Federal Ministry of Health
Ikoyi/Lagos

SENEGAL

Dr Papa Soulaye N'Diaye
Directeur de la Recherche, de la Planification
et de la Formation
Ministère de la Santé
Dakar

SIERRA LEONE

Dr M. M. Browne
Deputy Chief Medical Officer
Ministry of Health
5, Gloucester Street
Freetown

TOGO

Dr Barandao Bakele
Directeur des Services de Santé de Base
Direction générale de la Santé
B.P. 336
Lomé

UNITED REPUBLIC OF CAMEROON
REPUBLIQUE UNIE DU CAMEROUN

Dr E. Temgoua Saounde
Sous-Directeur de la Médecine hospitalière et rurale
Ministère de la Santé publique
Yaoundé

UPPER VOLTA
HAUTE-VOLTA

Dr M. Diallo
Directeur-Adjoint de la Santé publique
Ministère de la Santé publique
B.P. 7013
Ouagadougou

2. REPRESENTATIVES OF EXTERNAL SOURCES OF COOPERATION
REPRESENTANTS DES SOURCES EXTERIEURES DE COOPERATION

UNITED STATES OF AMERICA
ETATS-UNIS D'AMERIQUE

Mr Edward G. Ruoff
Deputy Regional Director, Africa Bureau, USAID
AFR/RA Room 3327 A
Agency for International Development
Department of State
Washington, D.C.
USA

Dr Thomas W. Georges
Health Adviser, AID Bureau for Africa
Agency for International Developm
Washington, D.C. 20523
USA

Ms M. Duffy
REDSO/WA
USAID
B.P. 1712
Abidjan
Côte d'Ivoire

H. E. Mr W. Swing
Ambassador of USA
Brazzaville
People's Republic of the Congo

Dr Andrew N. Agle
Chief, Field Services Branch
BSE, Center for Disease Control
Atlanta, Georgia 30333
USA

UNITED NATIONS DEVELOPMENT PROGRAMME
PROGRAMME DES NATIONS UNIES POUR LE DEVELOPPEMENT

UNICEF

M. S. Spivac
Administrateur des Programmes
B.P. 2110
Brazzaville
République populaire du Congo

ECONOMIC COMMISSION FOR AFRICA
COMMISSION ECONOMIQUE POUR L'AFRIQUE

Dr B. Badjeck
Agro-Economiste principal
MULPOC (Commission économiques des Nations Unies pour l'Afrique)
B.P. 836
Yaoundé
République unie du Cameroun

AFRICAN DEVELOPMENT BANK*
BANQUE AFRICAINE DE DEVELOPPEMENT

FUND FOR AFRICAN COOPERATION (FAC)
FONDS D'AIDE ET DE COOPERATION

Dr R. Michel
Chef des Missions médicales françaises en République populaire du Congo
Ministère de la Santé et des Affaires sociales
B.P. 78
Brazzaville
République populaire du Congo

3. SECRETARIAT

WHO REGIONAL OFFICE FOR AFRICA
OMS BUREAU REGIONAL DE L'AFRIQUE

Dr A. Franklin
Director/Directeur
Development of Health Services and Manpower/Développement des Services de Personnels de Santé

Dr C. Karamuitakis
Regional Officer/Fonctionnaire régional

* Unable to attend/Dans l'impossibilité de participer.

Dr M. Jamil Khan
Regional Officer/Fonctionnaire régional

Ms Konde Aena
Regional Officer/Fonctionnaire régional

Dr V. Mojekwu
Regional Officer/Fonctionnaire régional

Dr D. French
Director/Directeur, Project ICP SPM 013, Abidjan

Mrs M. Harvey
Assistant Director/Directrice adjointe, Project ICP SPM 013, Abidjan

Mr S. Helfenbein
Assistant Director/Directeur adjoint, Project ICP SPM 013, Abidjan

Dr G. A. Ashitey
Temporary Adviser/Conseiller temporaire
University of Ghana Medical School
P.O. Box 4236
Accra
Ghana

ADDRESS BY THE REGIONAL DIRECTOR

Ladies and gentlemen,

Dear colleagues,

It is a great pleasure for me to address you today among the flowers of Djoue and to wish you a most cordial welcome.

These meetings always give us an opportunity to exchange ideas and experiences so that we can take up the great challenges which face us. This time you will be examinig the achievements and the inadequacies of the Project for Strengthening of Public Health Delivery Systems in Central and West Africa. On the basis of this critical analysis, it is your task to define future approaches and plan new activities.

It was here in Brazzaville in 1973 that the representatives of 20 States of Central and West Africa, of the United States International Development Agency (USAID) and other organizations met with WHO to seek ways and means of redirecting their collaboration in the control of the major endemic diseases and epidemiological surveillance. One of the concerns at that time was to integrate activities for measles control and smallpox eradication into the activities of the health services. You know since the last World Health Assembly of the great victory won by the international community in eradicating disease which had spread terror for centuries. Achievements such as this are powerful incentives for continuing the struggle to establish justice in health, in Africa and throughout the world. The Project for the Strengthening of Public Health Delivery Systems in Africa is a mechanism for bringing this about.

The first phase of this Project began in April in 1975. The four objectives were the improvement of health planning and management, health manpower development, epidemiological surveillance and disease control, and finally the development of a public health delivery system that is financially and culturally accessible to all. When the objectives of this phase were achieved, an agreement for the second phase lasting five years was signed in September 1977. You know what are our major concerns since the historic Conference of Alma-Ata which recommended primary health care as an approach for achieving the target of health for all by the year 2000. For us this target is neither a dream nor an advertising slogan. It is the manifestation of a political will to make basic human rights, including the right to health, into a reality. I am convinced that you all share these concerns focused on the establishment of a new world order. We are therefore confident that the joint WHO/USAID evaluation in April 1980 will result in a reorientation of the Project activities which takes into account this essential objective of health for all by the

year 2000. I hope that when discussing the report of this joint evaluation, you will bear in mind the new programme approaches decided on collectively by the Member States.

You are all aware that WHO and its Member States make every possible effort to formulate national, regional and worldwide strategies. Within this context, the implementation of all programmes must be seen as a contribution to the strategy for achieving health for all. No action can protect and promote the quality of life in both rural and urban areas unless there is an improvement in social and health services through the intermediary of primary health care. The importance of technical cooperation among developing countries and the need to adopt an appropriate technology can never be sufficiently stressed. The urgent need to develop autonomy, both national and regional, must also be borne constantly in mind. As you can see, my own convictions have become strengthened over the years as the political struggle for health has proceeded. I remain convinced that the work of this meeting will help to consolidate the efforts we are making together to establish social justice for peace. The peace to which I refer is not just the absence of conflict, but peace in the hearts of a world community united in brotherhood. I am sure you have grasped my message, which is that of a man of goodwill. I do not believe that physical, mental, and social wellbeing can or should remain the privilege of some minority. If it is genuinely to mean anything, it must be for everyone. Let us therefore continue to work for social justice and we shall have made a contribution to world peace.

I wish you every success in your work.

PROGRAMME OF WORK

1. Opening of the meeting
2. Election of officers
3. Adoption of provisional programme of work (WP/00)
4. Method of work
5. USAID/WHO joint mid-term evaluation (WP/02)
6. Project mid-term review (WP/01)
7. Scope of USAID collaboration (WP/03)
8. Proposed plan of action for July 1980 to December 1982
9. Nomination of members of the project Coordination Committee (PCC) (WP/05)
10. Date and place of next PCC meeting
11. Date and place of next PRC meeting
12. Adoption of the final report
13. Closure of the meeting

TRAINING COURSE FOR VILLAGE HEALTH WORKERS

Course Objectives

- Sanitation
- Nutrition
- Care of Children
- Maternal Health
- First Aid
- Care of Adults
- Working in the Village

MATERNAL HEALTH

Task 1: Make sure that all pregnant women attend the health center, and follow the schedule set by the health center.

1.1 When given a woman in the village who thinks she is pregnant,
the VHW will:

- talk to the woman to persuade her to visit the health center:
  - describe the benefits of visiting the health center for her and the baby
  - tell her what will take place at the health center
- answer as best he can any questions the woman may have and refer the woman to the health center for the ones he cannot answer
- give the woman nutritional advice.

1.2 When given a woman in the village who the VHW thinks is pregnant,
the VHW will:

- visit the woman to ask if she thinks she is pregnant or has any symptoms of pregnancy such as:
  - no monthly bleeding
  - nausea and/or vomiting in the morning
  - change in breast size
- if the woman appears to be pregnant:
  - persuade her to go to the health center
  - answer any questions she may have
  - give the woman nutritional advice.

1.3 When given information from a villager that a woman in the village is pregnant,
the VHW will:

- visit the woman to:
  - persuade her to go to the health center
  - answer any questions she may have
  - give the woman nutritional advice.

1.4 When given a home visit,
the VHW will:

- discuss with the woman the reasons why she should visit the health center as soon as she thinks she is pregnant. The health center can:
  - confirm her pregnancy
  - make sure that the pregnancy is normal
  - give malaria prophylaxis to prevent an abortion due to malaria
  - help her prevent anemia
  - answer her questions and give advice

- help her when problems develop
- detect complications of pregnancy as early as possible
- acquaint her with the people that will assist her during delivery.

1.5 When given a pregnant woman in the village who refuses to visit the health center during her pregnancy, the VHW will:

. visit her to find out why she is refusing to visit the health center; if the reasons are that:
- she says she feels fine and there is no need to go:
  . explain the reasons why she should visit the health center regularly even when she feels well
  . give her some examples of what the health center may find at regular visits that may help her and the baby
  . persuade her to visit the health center
- she complains that she does not have the time to go:
  . convince her that her welfare and the welfare of the baby are more important than the lost time
  . give her some examples of what the health center can do that can be useful for her and the baby
  . persuade her to visit the health center
- she complains about the health center:
  . explain to her the problems the health center may have and ask her to try and overlook them
  . convince her that her welfare and the welfare of the baby are more important than the inconveniences at the health center
  . persuade her to visit the health center
  . talk to his supervisor about the woman's complaints
- she complains that the health center is too far away:
  . convince her that her welfare and that of the baby are more important
  . try to find some kind of transport to take her to the center
  . work with the health center on finding a solution to this problem
- she is afraid of what happens at the health center:
  . reassure her by telling her what happens during a visit to the health center
  . describe the advantages of a visit to the health center for her and the baby
  . reassure her that what happens at the health center is good for her and the baby
  . persuade her to visit the health center
  . ask another pregnant woman to talk to her and convince her to visit the health center.

1.6 When given a pregnant woman in the village who refuses to visit the health center during her pregnancy, after the VHW has tried to persuade her to go, the VHW will:

- visit her weekly to:
  - continue his efforts to persuade her to visit the health center
  - check that she is following the nutritional advice he has given her
  - check that she is not developing serious complications
  - answer questions, if he can, that she may have about her pregnancy
- talk to her husband to enlist his support in the attempts to persuade the woman to go to the health center
- talk to other women in her family to ask them to help the VHW persuade the woman to go to the health center
- ask a pregnant woman who is going to the health center to try to persuade the woman to accompany her to the health center.

Task 2: Make sure pregnant women follow the advice given by the health center.

2.1 When given a pregnant woman in the village who has returned from the health center after a routine visit, the VHW will:

- make a home visit to:
  - find out what happened at the health center
  - answer any questions she may have about what happened at the health center
  - find out what advice she was given at the health center
  - make sure she understands the advice and intends to follow it
  - answer any questions she may have about the advice
  - tell her to come to the VHW if she has any questions or problems
- visit her periodically to make sure she is following the advice
- make sure she returns to the health center at the time set by the health center.

2.2 When given a pregnant woman who is not following the advice given by the health center, the VHW will:

- visit her to find out why she is not following the advice; if the reasons are that:
  - she cannot afford the medications:
    arrange with the village committee or other health or social service agents in the village to obtain the medications for her
  - she did not understand the advice:
    - explain the health center's instructions to her
    - ask her to return to the health center for further advice if the VHW cannot clarify the instructions for her
  - she did not see the importance of the advice or does not believe it is necessary:
    - explain the reasons why the advice was given
    - convince her that such reasons are important
    - persuade her to follow the advice
  - someone has persuaded her that the advice is incorrect or even dangerous:
    - explain to her the reasons for the advice and persuade her that these reasons are important
    - persuade her that following the health center's advice will make the baby healthy and strong
    - assure her that the advice is not dangerous
    - obtain the support of the husband in persuading her to follow the advice
    - talk to the other person and persuade her to change the advice she has given
    - ask another pregnant woman who is following the advice to talk to her and persuade her to follow the advice.

2.3 When given a pregnant woman in the village who refuses to return to the health center during her pregnancy, the VHW will:

- find out why she does not want to return to the health center; if the reasons are that:
  - she did not like or understand the procedures at the health center:
    - explain the reasons for the procedures she did not understand
    - explain the importance of these procedures
    - reassure her that none of the procedures is dangerous or will hurt the baby
    - persuade her to visit the health center
    - tell the health center about her complaints in order to improve relations between health center personnel and the patients

- she complains of the waiting time and personnel at the health center:
  - . explain to her the problems the health center may have and ask her to try and overlook them
  - . convince her that her welfare and the welfare of the baby are more important than the inconveniences at the health center
  - . persuade her to go to the health center
  - . talk to his supervisor about the woman's complaints
- she complains of the distance to the health center:
  - . convince her that her welfare and the welfare of the baby are more important
  - . try to arrange transportation for her to the health center
  - . work with the health center on finding a solution to this problem
- she says she feels fine and there is no need to go:
  - . explain the reasons why she should visit the health center regularly even if she feel well
  - . give some examples of what the health center may find during regular visits that may help her and the baby
  - . persuade her to visit the health center.

Task 3: Immediately send to the health center all pregnant women who complain of symptoms indicating complications with pregnancy.

3.1 When given a pregnant woman who says she is ill, the VHW will:

- . for minor complaints:
  - refer the woman to the health center and make sure that she goes
- . for serious complaints:
  - reassure her and her family that everything will be done to help her
  - arrange for transportation to the health center and accompany her there
  - give necessary care during transportation.

3.2 When given a pregnant woman in the village who complains of soreness in the breast or too frequent urination, the VHW will:

- . send her to the health center if she has not visited it within the last month
- . if she has already visited the health center for the same complaints during the last month, reassure her and remind her of the advice that she was given at the health enter.

3.3 When given a pregnant woman who complains of nausea or vomiting in the morning, or constipation, or heartburn, the VHW will:

- find out if she has already been to the health center with the same complaint, and send her there if it is more than a month since her last visit
- assure her that these symptoms are common during pregnancy
- advise her that she can alleviate these symptoms if she:
  - eats several small meals rather than large meals
  - eats plenty of fruits and vegetables
  - does not eat too much spicy and fatty foods.

3.4 When given a pregnant woman who vomits most of her meals, and not only the morning meal, the VHW will:

- if she is not malnourished or dehydrated:
  - send her to the health center
- if she is dehydrated and malnourished:
  - make arrangements to send her to the health center
  - give her frequent sips of slightly salty water before and during transportation (if she is dehydrated).

3.5 When given a pregnant woman who complains of fatigue and backache, the VHW will:

- find out when she was last at the health center and send her there if it is more than a month since her last visit
- advise her to:
  - lie down and rest when her back aches or she feels tired
  - try and find someone to help her with the heavy work she has to do
  - not to lift heavy things
  - eat well from all the food groups.

3.6 When given a pregnant woman who complains that she is bleeding with or without pain, the VHW will:

- if the bleeding is like a small monthly period without pain, ask the woman to go to the health center immediately, and make sure that she goes
  if the bleeding is heavy, with or without pain:
  - arrange immediately for evacuation
  - go with her to the health center
  - give fruit juice or other liquids on the way
  - watch for signs of shock.

3.7 When given a pregnant woman with severe abdominal pain and a belly that hurts when it is touched, with or without bleeding from the vagina,
the VHW will:

- arrange immediately for evacuation
- go with her to the health center.

3.8 When given a pregnant woman who complains of frequent headaches, dizziness or swollen ankles, legs or hands,
the VHW will:

- tell the woman to go to the health center immediately and make sure she gets there.

3.9 When given a pregnant woman who complains that the baby has stopped moving or kicking,
the VHW will:

- if the baby was moving a great deal before the movements stopped, refer the woman to the health center
- if it is the first time that the woman has not felt her baby move for a day, refer the woman to the health center
- if there were other times she did not feel the baby moving for a day:
  - reassure the woman
  - visit her the next day, and, if the baby has not started moving again, refer the woman to the health center.

3.10 When given a pregnant woman who has had a convulsion,
the VHW will:

- immediately evacuate the woman to the health center
- go with her to the health center
- put a clean cloth between her teeth so she does not bite her tongue in case another convulsion occurs while she is being transported.

3.11 When given a home visit to a pregnant woman who has returned from the health center after a visit for complications during pregnancy,
the VHW will:

- if she is still pregnant:
  - find out what happened at the health center and answer any questions she may have
  - find out what advice she was given and explain the instructions she does not understand
  - make sure she follows the advice
- if she gave birth:
  - carry out his instructions for postnatal care of the woman and the newborn
- if she lost the baby:
  - support and reassure her
  - encourage her to follow any advice given by the health center.

Task 4: Encourage all women to give birth at the health center or to get help from a TBA who delivers babies and takes care of a newborn in a hygienic manner, and make sure they do.

4.1 When given a pregnant woman in the village, the VHW will:

- during a home visit find out where she intends to deliver and which birth attendant she intends to use during delivery; if she intends to deliver:
  - at the health center:
    - reinforce her decision
    - ask her to go to the health center before labour starts if the center is far away, or as soon as labour starts, if the health center is nearby
  - with a TBA who practices hygiene during delivery and in the care of the newborn:
    - encourage and reinforce the decision
    - tell her what arrangements to make before labour starts and when to send for the birth attendant
  - with her husband or other untrained birth attendant:
    - try to persuade her to deliver at the health center or with a trained TBA or VHW
    - explain the need for cleanliness during delivery and in care for the newborn.

4.2 When given a pregnant woman in the village who wants to deliver her baby with a birth attendant who is not trained in hygiene, after having tried to persuade her to deliver at the health center or with the help of a qualified birth attendant,
the VHW will:

- visit the woman to:
  - continue his efforts to persuade her to deliver at the health center or with the help of a qualified birth attendant
  - make her understand the need for cleanliness during the delivery and in the care of the newborn
- talk to her husband to enlist his support in the efforts to persuade the woman
- visit the birth attendant she intends to use to:
  - find out how the TBA intends to deliver the child and persuade her to take steps to ensure cleanliness
  - tell her about what signs may necessitate transfer to the health center and persuade her to send the woman to the health center if these signs appear
  - find out how she cuts and takes care of the umbilical cord and persuade her do these things in a hygienic way
- visit the woman after delivery to check the condition of the woman and child.

4.3 When given a TBA in the village who has not received any modern training,
the VHW will:

- during a visit to the TBA find out:
  - for prenatal care:
    - if she examines the woman before delivery or gives her advice
    - what advice she gives, if any
    - what she does, if anything, when complications of pregnancy occur
  - during delivery:
    - when and how she intervenes during labour
    - what she uses to cut the cord and how she treats the wound
    - what care she gives the baby
    - what advice she gives the mother
    - what she does with the afterbirth
    - what she does when complications occur
  - after delivery:
    - if she checks the baby for birth defects and other problems
    - if she visits to find out the mother's condition
    - if she refers the woman and infant to the health center if complications occur.

4.4 When given a visit to a TBA who does not practice hygiene during deliveries,
the VHW will:

- persuade the TBA to send the woman to the health center if complications occur during pregnancy or delivery, or after the baby is born; and to discuss as best he can with her:
  - when she should send the woman to the health center
  - why she should send the woman to the health center
- persuade the TBA to ensure cleanliness during delivery and to practice hygiene in:
  - caring for the woman
  - cutting the cord
  - caring for the newborn
- persuade the TBA that it would be in her own interest to get training in modern methods of delivery and tell her where she can get such training
- persuade the TBA that she and the VHW should work together to ensure proper care for pregnant women in the village.

Task 5: Make sure that women go to the health center in time to give birth there, if labour complications are expected.

5.1 When given a visit to the health center, the VHW will:

- find out from his supervisor or the nurse:
  - which women in his village have been told that they should deliver at the health center
  - the reasons for the health center's request
  - when they should go to the health center.

5.2 When given information about which women in the village have been asked to deliver at the health center, and when they should go, the VHW will:

- talk to the women to make sure that they indeed intend to deliver at the health center.

5.3 When given a woman who has been asked to deliver at the health center and who indicates that she intends to follow the health center's advice, the VHW will:

- make sure she visits the health center regularly during her pregnancy
- make sure she understands when she is supposed to leave for the health center
- find out how she intends to get to the health center
- assist her in making arrangements for transportation, if necessary.

5.4 When given a woman who has been asked to deliver at the health center and who indicates that she does not intend to follow the health center's advice, the VHW will:

- find out why she does not intend to follow this advice
- repeat and explain the health center's reasons for the the recommendation
- reassure her if she has any fears about delivering at the health center
- ask other women who have delivered at the health center to talk to her about what happens there, if necessary
- convince her that in case of complications it would be better for her and the baby to be at the health center
- talk to her husband and other family members to convince them that it would be better for her to deliver at the health center
- talk to the birth attendant that the woman has selected and explain the reasons for the health center's request to her and, if possible, enlist her support in persuading the woman to deliver at the health center.

5.5 When given a woman who should deliver at the health center, the VHW will:

- make sure that she indeed intends to leave for the health center as soon as labour starts.

5.6 When given a woman who has been asked to deliver at the health center because a premature baby is expected, and the transportation to the health center will take one hour or more,
the VHW will:

- assist the woman to make arrangements to stay near the health center during the last two months of pregnancy
- assist the family to make arrangements to have the household work done during the woman's absence
- arrange for the woman to go to the health center at the end of her seventh month of pregnancy.

5.7 When given a woman who has been asked to deliver at the health center for reasons other than that of a possible premature delivery, and it takes more than an hour to get to the health center,
the VHW will:

- assist the woman to make arrangements to stay near the health center during the last two weeks of her pregnancy
- assist the family to make arrangements to have the household work done during the woman's absence
- arrange for the woman to leave for the health center two weeks before she is due to deliver.

Task 6: Organize a system of evacuating women in labour to the clinic.

6.1 When given a plan for transporting sick and injured villagers to the health center,
the VHW will:

- review the plan to make sure that it includes:
  - transportation during all hours of the day, especially during the night
  - transportation for women in labour
- revise the plan, if necessary, to cover these conditions
- make arrangements to notify as quickly as possible the person responsible for transportation when it is necessary to evacuate someone

- check that the plan can work by:
  - making sure the vehicles are appropriate for transporting a woman in labour
  - making sure that the person responsible for transportation intends to be available at all times and that he can be trusted
- revise the plan if the current means of transport are no longer dependable.

6.2 When given a plan for transportation of sick and injured villagers to the health center,
the VHW will:

- visit all TBAs in the area to make sure that they know about the plan and how to use it.

6.3 When given a pregnant woman in the village,
the VHW will:

- during a home visit explain what transportation is available if she has complications of pregnancy or labour, and ask her to send for the VHW immediately if she thinks she needs to go to the health center.

6.4 When given a woman in the village whom he is helping to deliver,
the VHW will:

- make sure that the "village transportation" is available and can be used if complications occur
- make sure someone is available to go quickly for such transportation, if necessary.

Task 7: Evacuate immediately all women when complications with labour develop.

7.1 When given a woman in labour who has been told that she should deliver at the health center,
the VHW will:

- accompany the woman to the health center.

7.2 When given a woman in labour who is less than eight months pregnant,
the VHW will:

- accompany the woman to the health center.

7.3 When given a woman whose water breaks before labour pains start,
the VHW will:

- make sure that the woman goes immediately to deliver at the health center.

7.4 When called to attend a woman in labour with any of the following complications:

- presentation of any part other than the head
- labour that has lasted more than 24 hours
- labour pains become weaker and less frequent
- the baby's head can be seen, but cannot come through although the woman pushes
- the mother has a convulsion during labour

the VHW will:

. transport the woman to the health center or send for help
. go with the woman to the health center.

7.5 When given a TBA in the village, the VHW will:

. discuss with her the complications that may occur during labour
. convince her that it might be best to send the woman to the health center when such complications occur
. assure her that the woman will be well taken care of at the health center
. make sure she knows what arrangements have been made for emergency transportation of sick and injured people in the village
. tell her that the VHW will assist her as much as he can when it is necessary to evacuate a woman in labour.

7.6 When given a pregnant woman in the village who intends to deliver at home with the help of a relative or a traditional birth attendant, the VHW will:

. during a home visit:
  - see what arrangements have been made and stress the need for cleanliness during delivery and in the care of the baby
  - warn her that if labour happens too early, before the end of the eigth month, the baby will be weak and she should try to get to the health center before the baby is born
  - tell her and the birth attendant she has chosen to send for the VHW if there are complications during delivery.

7.7 When given the need to transport a woman who has developed complications of labour,
the VHW will:

- send a messenger to get the village transport ready
- prepare to transport the woman:
  - take his medical kit
  - take a clean cloth and put it under the woman in the vehicle
  - bring liquids to give to the woman during the trip
  - take something to wrap the baby in if born on the way
- go with the woman to the health center.

7.8 When given a woman in labour who is being transported to the health center,
the VHW will:

- reassure the woman that things may go all right and that she may be able to help at the health center
- give necessary care during transportation
- deliver the baby if necessary:
  - stop the car during delivery
  - try to make sure that the baby is breathing
  - do not cut the umbilical cord unless absolutely necessary

  proceed to the health center.

Task 8: Provide postnatal care for the first week for all women and their babies who deliver at home and refuse to go to the health center.

8.1 When given the TBAs in the village,
the VHW will:

- ask them to let him know when a woman has given birth so that he can visit her and the baby after delivery.

8.2 When given a pregnant woman in the village, who intends to deliver at home,
the VHW will:

- ask her to let him know when she has given birth so that he can visit her after the delivery.

8.3 When told that a woman has delivered a baby in the village,
the VHW will:

- visit her to:
  - check that she is feeling well
  - check that the baby is doing fine
  - see if the umbilical cord wound is healing
  - encourage the mother to breastfeed
  - give nutritional advice
  - persuade the mother to take the baby to the health center within the next four weeks for a check-up

  visit her again to check on her and the baby's condition.

8.4 When given a woman in the village who has delivered her first baby:
the VHW will:

- make sure that she knows how to care for the baby or that there is someone who can show her how.

Task 9: Evacuate immediately the woman and newborn child if postnatal complications develop.

9.1 When called to, or attending to, a woman who has just delivered,
the VHW will:

- evacuate the woman and child immediately:
  - if the woman develops any of the following complications:
    - retained placenta (after one hour)
    - heavy bleeding (more than 1/2 liter)
    - convulsions
    - large tear in the perineum
  - if the baby:
    - has trouble breathing
    - has weak arm and leg movements or does not move any of its limbs
    - is premature and smaller than normal babies
  if the mother has delivered twins who are smaller than normal babies.

9.2 When called to or attending a woman who has just delivered a baby with a birth deformity,
the VHW will:

- reassure the mother that she is not at fault
- if the birth defect can be corrected, assure her that the hospital can help the child develop normally
- transport the woman and child to the health center.

9.3 When visiting a woman who has delivered a child within the last week,
the VHW will:

- transport the woman and baby to the health center if the woman has:
  - heavy bleeding after the first two days
  - a fever
  - a heavy vaginal discharge that smells badly
  - stomach pains
  - red, swollen breasts or a swollen area in one breast
  - insufficient breast milk flow by the fourth day.

9.4 When given a newborn baby,
the VHW will:

- during a home visit:
  - check the baby for:
    - fever
    - eye infection
    - yellow eyes and skin
    - cord infection
  - make sure that the baby has:
    - passed a first stool
    - urinated
  - ask the mother if the baby:
    - is eating and sucking well
    - is vomiting (projectile versus spitting up)
  - give the mother nutritional advice for the baby.

9.5 When given a newborn baby,
the VHW will:

- evacuate the mother and baby immediately if the baby:
  - has not passed urine on the second day
  - has not passed a stool by the third day
  - has deep yellow eye whites and yellow skin
  - has infected eyes
  - has an infection in the umbilical cord
  - cries constantly and refuses to nurse
  - groans constantly
  - has a convulsion
  - has a fever
  - is vomiting forcefully after each meal
  - looks like it is dehydrated or losing weight rapidly.

9.6 When given a mother and baby who have to be evacuated because of postnatal complications,
the VHW will:

- reassure the woman's relatives that the health center will do what they can for the woman and child
- explain to the mother why evacuation is necessary and assure her that the health center can help
- accompany the woman and child to the health center.

Task 10: Encourage child spacing.

10.1 When given a visit to a mother with a newborn,
the VHW will:

- talk to the mother about her children and encourage her to wait until the baby is two years or older before having another child.

10.2 When asked by a woman or husband in the village about child spacing,
the VHW will:

- talk to the woman or husband about:
  - the risks to the baby if the woman has another child too soon
  - the risks to her from pregnancies that are too close together
  - the economic benefits of child spacing
- explain what the woman or her husband can do to make sure that she does not get pregnant too early
- advise the couple to go to the health center for more information.

10.3 When asked by a woman if there is some way she can avoid having any more children,
the VHW will:

- tell the woman that there are some ways she can make sure that she has no more children
- advise her to visit the health center with her husband to find out what to do.

10.4 When given a village meeting and the occasion warrants it, the VHW will:

- give information about how to practice child spacing and where to go to get help and advice about child spacing.

ANNEX 2

EDUCATIONAL OBJECTIVES OF THE TRAINING COURSE FOR TRAINERS OF VILLAGE HEALTH WORKERS

This course is designed for middle-level personnel in the health sector (nurses, midwives, technical officers/sanitation, etc.) and other personnel at a similar level working in development sectors which contribute to health (social affairs, agriculture, environment, etc.) who have been officials in their country's administration for at least three years and have or will have responsibility for planning, implementation, inspection and evaluation of training programmes for village health workers.

The objective of the course is to prepare the participant for training and making use of village health workers or personnel responsible for primary health care in rural areas.

Broad Objectives:

At the end of the course participants will be able to:

1. Develop a course for the training of village health workers using the method of systematic course design;
2. use such developed course to train village health workers;
3. collaborate with and work in rural communities for the improvement of community and individual health in their villages;
4. collaborate with other workers in community development to improve community and individual health in villages;
5. evaluate the performance of village health workers during their training and periodically afterwards;
6. supervise the work of trained village health workers;
7. plan and give all the necessary support to the village health workers to facilitate the delivery of health care to villages;
8. organise retraining programmes for practising village health workers as and when needed;
9. evaluate periodically the impact of the trained village health workers on village health;
10. communicate the results of such evaluation to other levels of the health care delivery system in manner which will help in the development of a coherent national health plan.

ANNEX 3

WORK SCHEDULE FOR DEVELOPMENT OF SUPERVISORY MATERIAL

1. Job Descriptions for community health assistants, etc.

   At the meeting on April 14, it was agreed that the following categories need to be developed:

   a) Community Assistants working at a health clinic
   b) Community Health Assistants working at a primary health center (PHC)
   c) Community Health Assistants working at a comprehensive health center (CHC)
   d) Community Health Officers working at a PHC
   e) Community Health Officers working at a CHC
   f) Doctors/Medical Officers working at a CHC

   It was recognised that many functions overlapped, and that job descriptions would be similar, but since the supervisory structure will be different at the different centers, the job descriptions would also have to be different.

   For the primary health center and the comprehensive health center, one of the major tasks would be to differentiate the different tasks of the doctor, officer and assistant, assuming delegation of responsibilities.

   It was agreed that the team should develop this material as much as possible before June and that Dr. Kolawole would bring the materials with him to the U.S. to discuss with Dr. Ericsson.

2. Task Analysis of the tasks in the job description

   This should be done by the end of August.

3. Educational Objectives

   These should be done by the end of November.

4. Visits to other countries

   These should take place in Novem' /December. The aim is to check the job descriptions done at the EHSS wi. the working conditions in Nigeria and other countries. Possible countries to visit would be the Benin, Nigeria, Cameroun, Sierra Leone, Gambia and the Congo.

5. Development of Training Materials

   Starting in September and continuing into the next year. Plans for next year (fieldtesting and revision) will be developed later.

ANNEX 3
SUMMARY WORK SCHEDULE

	ACTIVITY	WHEN COMPLETED	RESPONSIBILITY
1.	Job Descriptions	June 1	Development Team
2.	Review of Job Descriptions	July 1	Dr. Kolawole/Dr. Ericsson
3.	Revision, final copy of Job Descriptions	September 1	Development Team
4.	Task Analysis	September 1	Development Team
5.	Review of Task Analysis	October 1	Dr. Ericsson or other Consultant
6.	Revision, final copy of Task Analysis	December 1	Development Team
7.	Educational Objectives	December 1	Development Team
8.	Review of Objectives	January 1	Dr. Ericsson or other Consultant
9.	Revision, final copy of Educational Objectives	March 1	Development Team
10.	Visits to other countries	October to December	Dr. Kolawole/Dr. Ericsson other Consultant
11.	Development of training materials	Start in September	Development Team

Plans for next year will be made later (field-testing and revision)

For each type of material developed, the following strategy should be followed to assure maximum efficiency:

a) Development of the materials - typed copy - 10+
b) Technical review (Dr. Ericsson or other teaching technique specialist)
c) Subject matter review (management specialist, teacher, CH-officer/assistant, BSSH administrator)
d) Revisions based on the review of (b) and (c) - typed copy - stencil
e) Translation to French - typed copy - stencil
f) Duplication of French and English copies and distribution to other countries/states for review
g) Review and revision based on comments in (f)
h) Use of the materials in the field
i) Revisions of material based on field use and production of final copy
j) Dissemination.

RESOURCES NEEDED FOR THE DEVELOPMENT OF THE MATERIALS

ACTIVITY IN SUMMARY SCHEDULE	TYPE OF RESOURCE	WHEN
1. Job Description development	Typist/paper/xeroxing	April/May
3. Job Description revision	Typist/stencils/paper	July/August
4. Task Analysis development	Typist/paper/xeroxing	June/July/August
6. Task Analysis revision	Typist/stencils/paper	November/December
7. Educational Objectives development	Typist/paper/xeroxing	September/October/November
9. Educational Objectives revision	Typist/stencils/paper	January/February

It is assumed that the development team will be working on this in as much time they have and can spare from their other duties.

ASSUMPTIONS, REMARKS

1. Planning for visits to other countries should start in July/August and arrangements be made through WHO/SHDS.

2. The development of materials for the next step should start without waiting for the review results. Otherwise it will take too long. Adjustments in the materials can always be made later.

3. Based on the materials which is already available, the development team has to extract the specific tasks, objectives, etc. which apply to management and supervision, and write new ones when none are available. They also have to delineate the responsibilities between assistants, officers and doctors when these are working together.

4. If Dr. ElNeil agrees, Dr. Imade and Mrs. Adegoroye will be available for consultation and assistance.

5. Translation to French will be arranged via Lomé or Abidjan and details worked out with Mme. Sagbo who translated the VHW materials.

6. SHDS-Abidjan will investigate if it is possible to duplicate the French copy in Lomé, or in Abidjan if Lomé cannot do it.

INSTRUCTIONS GIVEN TO THE TEAM DEVELOPING THE VHW MATERIALS

1. Job Description

Job descriptions should be developed for the following categories of workers:

(a) assistants at the health center
(b) assistants at the primary health center (PHC)
(c) assistants at the comprehensive health center (CHC)
(d) officers at the PHC
(e) officers at the CHC
(f) medical officers/doctors at the CHC

Concentrate on the tasks which involve management and supervision.

Write it in terms of what they are supposed to do - their tasks; that is, do not write: responsible for maintaining drug supply, but (for the assistant):

- keeps on-going record on what drugs are available at the center
- notifies the community health officer weekly which drugs need to be ordered
- receives drugs and adds them to the stock, etc.....

(for the officer):

- orders drugs when necessary
- checks the record kept by the assistant on a regular basis (once a month)
- reminds assistant about need for report on drug status if not received when planned, etc.....

Do not worry too much about duplication or how specific the behaviours you put down are. Try to be clear about what the person has to do, given your experience and the tasks assigned to the different job categories.

Look at the categories and the training program to be sure that you have included most of the necessary tasks. Try to order them in groups - maybe the categories given in the educational objectives. Also, if you are unsure that all has been included, check with a community health assistant and/or officer to find out what they actually are doing.

The job description should, if possible, be finished before Dr. Kolawole goes to the U.S. so that he can take it there and we can discuss it. In any case, he should bring whatever is finished so that it can be discussed.

2. Task Analysis

When the job description is finished - and it is not necessary to wait until it has been approved and reviewed by other people - you should do a task analysis. Take each task which you have in the job description and try to break it down into behaviours, knowledge and attitudes. (Develop learning units). One way of doing this is to envision a situation in which the task is accomplished and set down the situation and which knowledge and attitudes are necessary.

Example: remind community health assistant that the drug status report is due.

BEHAVIOUR	KNOWLEDGE	ATTITUDE
• Note down when drug report should be on my desk	- knows when it should be - knows how to keep a reminder system - knows advantage of planning with check-points	- wants to keep a reminder system - wants to monitor the drug supply
• Check on a set date to see if the report is there		
• Wait a day to see if it is received		- accepts that delays may occur - is willing to excuse one day's delay
• Ask CHA what happened to the report	- knows reasons the CHA may have had for not turning in report - knows ways of preventing a re-occurrence	- wants to listen to CHA's point of vie - wants to resolve issue with minimum conflict - talks to CHA about non-performance in a non-threatening manner.

3. Educational Objectives

When you have the task analysis, ask yourself: which of these behaviours, knowledge and attitudes do we have to teach because they do not know them? Write objectives for these specifying (if possible):

(a) in which situation the trainee will demonstrate that he has acquired these behaviours
(b) which behaviours he should present in these situations
(c) what is the "content" of the behaviour
(d) what criteria - standards - you would use to know that he has achieved the objective.

For example: when given a case history in which a community health assistant has failed to turn in a report on drug supplies (and another student) (a), the student will:

- discuss (b) with the other student why the report was not turned in (c)
- decide (b) with the other student how to make sure it is turned in as planned (c) using the communication methods he has been taught in the course (d).

You can also write an objective which tests only the knowledge without testing the student's actual skills in communication:

When given questions (a), the student will:
- describe (b) what he will do when a CHA fails to turn in a drug status report on time (c), listing at least five of the seven required behaviours (d).

Which way you select will depend on the constraints you have in the course and which objectives you want to measure. Note that in general, the closer you teach and evaluate the actual behaviour you want the person to perform in his job, the more likely you are to be sure that he will perform as you wish on the job. Thus, it may be better to simulate the actual behaviour at least in some of the objectives, at the same time as for others you are testing only knowledge. You have to decide in which situations and for which behaviours it is more important to demonstrate the actual performance and write your objectives accordingly.

You will probably find that different tasks may be combined and result in only one objective, for instance: whatever report the CHA has failed to turn in (drug status, available equipment, maintenance performed, work schedule, etc.), the CHO will have to do the same thing.

4. Teaching Modules

When the job description is done, I will help you develop models for how the teaching units can be done and how job aides can be developed to fit the project.

NOTE: This looks like plenty of work. However, the main task for you is to extract from the materials you have available, the supervisory, management and administrative tasks and put them together in a job description for the categories of workers mentioned above. The other main task is to differentiate between the different posts and, for the PHC and CHC, to decide which task is done by which category of worker.

Only when the task, learning unit and educational objective is not available in the materials you have, do you need to construct new ones. You may also in some cases have to rewrite objectives, but that should not be difficult either. Use already working CHAs and CHOs, other health personnel, MHSS people and others to help you when needed in your work.

MANAGEMENT AREAS AS DEFINED IN THE OBJECTIVES FOR COMMUNITY HEALTH PERSONNEL

Areas of Management for Community Health Aides

1. Management of time, scheduling of activities
2. Management and control of assigned drugs, materials and equipment
3. Report to supervisor including record-keeping
4. Community work in village, school, and clinic
5. Communication skills
6. Health education
7. Self-evaluation of achievement of job objectives.

Areas of Management for Community Health Assistants and Officers

NOTE: They are both responsible for this but on different levels at different types of health centers. One of the tasks is to differentiate between the responsibilities to assign to the assistant and that to be assigned to the officer at the different types of health centers.

1. Planning activities of the health center personnel:
   a) set objectives
   b) plan for resources
   c) budget.
2. Time management and scheduling.
3. Make sure plans are carried out:
   a) develop resources, find resources (including personnel)
   b) supervise personnel to make sure tasks are carried out
   c) evaluate achievements against objectives on an on-going basis.
4. Administrative functions:
   a) monitor use of equipment and personnel
   b) monitor supply of drugs, materials, equipment, etc.
   c) maintain equipment, drug supply, hygiene, etc. (ensure maintenance)
   d) cost control, monitor budget
   e) work flow at the clinic.
5. Develop and monitor patient register, family health register and follow-up care (reminder system).
6. Organise and plan community out-reach activities (mobile services) with other personnel at the center - village, school, etc.
7. Plan, organise and deliver health education activities with help of MCH personnel.
8. Develop and use a recording system for the clinic which can provide information about health conditions and health activities in the area.
9. Evaluate personnel according to their job descriptions and provide:
   a) feedback
   b) assistance with resolving practical problems
   c) additional on-the-job training as necessary.
10. Report on clinic activities to his supervisor.
11. Problem-solving: how to deal with non-achievement of objectives; communication problems; personnel problems; equipment failure; lack of drugs; epidemics; crisis situations.

MEETING - 1'. APRIL, 1980

DR. KOLAWOLE, DR. SOLANKE, DR. ERICSSON

Points discussed during the meeting

1. Personnel available to work on the materials are in Nigeria: Dr. Kolawole, Dr. Solanke, Mrs. Gbadamosi, Mr. Doula. Hopefully Mrs. Adegoroye and Dr. Imade will also be available to assist them.

   Miss Tinubu will be too busy with the National Health Service Corps training to participate.

   Dr. Solanke has just graduated from the university and has had no experience with systematic course design. However, it will probably not be difficult for her to learn while working with the others.

   Mrs. Gbadamosi participated in the course given in October and has developed materials for community health aides based on her work in that course. She seems to understand the principles and be able to work with the approach.

   The team that Dr. Kolawole has assembled seems to me to be very capable and able to develop this material.

2. Dr. Kolawole indicated that he would prefer that I provide the technical input supposed to be given by an outside Consultant. This should be explored, since I think it may be difficult at this time to introduce a new person.

3. Dr. Kolawole suggested the cooperation with another project in his unit funded by the UN Fund for Population Activities. (See separate Memo).

4. Dr. Kolawole indicated that what they needed more than anything at this point was someone who could steer their thinking in the right direction. After much discussion, the following tentative assignments were agreed on:

   A. Dr. Ericsson should review the already available materials and draw up a work schedule based on the availability of personnel and time.

   B. When the schedule is developed, Dr. Kolawole will review it and provide estimated costs for the development of materials. He will send this budget to Saul Helfenbein in Abidjan.

   C. Dr. Ericsson will develop guidelines and discuss them with the development team on Monday, April 14, before she leaves for Lomé.

5. A tentative work schedule was worked out (see attached materials).

6. Dr. Kolawole will be in the U.S. from June 8 to 28 and probably also in July. He will be in Boston from June 28 to July 5 (because he has relatives there) and would be willing to discuss the progress of the project at that time with me.

SE/ll.

...n Central and West Africa
Immeuble « Le Général »
Angle Avenue Général de Gaulle et Rue Botreau Roussel
04 B. P. 799 ABIDJAN 04, Ivory Coast
Tél 32-58-21 / 33-15-39 - Télex 2366

9 May 1980

MEMORANDUM

TO: Dr. M. Hacen, Director of Preventive Medicine
MOH/WS/L/Mauritania

Ms. Linda Neuhausen, Health Officer, USAID/Mauritania

Dr. B.S.F. Adjou-Moumouni, Coordinator of Studies
WHO Regional Training Center, Lome

WHO Coordinator, Mauritania

Dr. A. Franklin, DSM, WHO/AFRO

FROM: Saul Helfenbein, Asst. SHDS Project Director SH
Sif Ericsson, SHDS Project Educational Coordinator pp SH

SUBJECT: SHDS Project Assistance to Training Component of Rural Medical Assistance Project (Project Trarza)

1. The objective of the visit of Ericsson and Helfenbein was to review the possibilities for collaboration between the WHO Regional Training Center/Lome and the MOH in adapting the RTC VHW training materials to local conditions and establishing in-country training programs for trainers of VHWs. This visit was organized in collaboration with the Ministry of Health and USAID/Mauritania who are jointly developing a Primary Health Care program in the Trarza Region of Mauritania. This visit was the first step of a possible follow-up activity to the 3-month training of VHW trainers course at the RTC/Lome. I. Diouf and M. Moctar who have been assigned by the MOH to be in charge of the training component of this project participated in the first 3-month training of VHW trainers course in Lome (July-Oct. 1979).

2. This memo summarizes suggestions for follow-up collaboration with the MOH PHC program in the Trarza Region: that is, a viable training strategy for this project and the optimal approach for adapting the RTC training materials to local conditions. A more detailed report will [illegible] by Dr. [illegible].

3. During this visit Helfenbein and Ericsson reviewed the proposed Trarza Primary Health Care project, with MOH and AID officials, had lengthy discussions with I. Diouf and A. Moctar, met with other government project personnel involved in village level training programs, and briefly visited several villages and training sites in the Trarza Region to acquaint themselves with conditions.

4. The results of discussions and visits indicated:

1. The approach to training in the Trarza project still requires some definition and clarification. Three levels of training are involved:

a) Continued on the job training of the training program directors

b) The training of VHW trainers both as trainers and supervisors

c) The training of VHWs.

2. Program constraints need to be clearly and exhaustively identified as these will affect the training component of the Trarza project. Several constraints can be identified in the "course outline" which accompanies the RTC training materials. Specific issues that we noted which have to be taken into account are:

a) The skills knowledge, experience (both with respect to training and Primary Health Care) of the PMI nurses and midwives who will be responsible for training and supervision of the VHWs.

b) The logistical problems of training 192 VHW and maintaining effective supervision.

c) The need for adequate supervision of the training program for VHWs in order to control the quality of the training given by largely inexperienced trainers.

d) The diversity of local conditions that have to be taken into account in adapting the VHW training materials and in preparing training courses.

3. The following table presents a suggested approach to the training component. The strategy takes into account the above mentioned training objectives, current status of the training component, and constraints. It identifies phases where we believe the RTC can provide effective input in working with former participants of the Lome Center Trainers' course.

It uses the same training approach of the Lome Center. Since the Trarza project training directors are familiar with it, it will allow them to begin to apply what they have been taught at Lome to developing a training component for the Trarza project. In addition, working with the collaboration of RTC staff members, the training directors will [illegible] at the same time as they develop training programs to be used to train the VHWs.

Model of a Training Program

For Tutors*, VHW Trainers and VHWs

* Tutors are training program directors - i.e. Lome RTC participants and others of similar background and experience assigned to the program

Phase	Time	Objectives	Responsibilities
1. Preparation of PMI nurses/ midwives for role as VHW Trainers This will serve as a first phase refresher course for the tutors as well	5 days	1. To give VHW trainers an understanding of PHC, goals of the Tranza Project, the role of trainers in training and supervision.	MOH tutors
		2. To give VHW trainers an understanding of how training programs for VHW are developed with special emphasis on the village diagnostique and identification of VHW tasks.	MOH tutors. RTC staff will deal specifically with method of village diagnostique
2. Village Diagnostique This is the key phase in the adaptation of the RTC training materials	1-2 months	1. To expose VHW trainers in a systematic way to village conditions, so as to identify health problems and decide what VHWs can do about them.	Under direction and guidance of MOH tutors
		2. To work with animators in training village health committees, and selecting VHWs so as to begin to develop a working relationship with the villages and VHWs whom they will teach and supervise.	

Phase	Time	Objectives	Responsibilities
3. **Adaptation of RTC Training Materials** The adaption of the program should be undertaken following the village diagnosis. This will constitute the second phase of training of the Lome RTC participants i.e. on the job training in adapting the materials to conditions of PHC program locality. The training of VHW trainers will be carried out concurrently Emphasis will be placed on giving VHW trainers (PMI nurses and midwives) teaching practice with the materials as they are adapted.	25 days	1. To select tasks, course objectives, session plans and modify them according to conditions and realities of village life, referral system, logistic support and other constraints. 2. To organize session plans in a training program on basis of allocated training time, training logistics and facilities, possibilities of supervision, refresher courses. 3. To give VHW trainers opportunity to practice teaching with adapted session plans and visual aids.	MOH tutors working with input from VHW trainers. RTC staff will provide guidance and direction.
4. **Training program for VHWs** At least the first two cycles of training should be done primarily by the MOH tutors. The VHW trainers will work with the tutors and teach selected sessions as part of intensive teaching practice. They should be given as much supervised teaching practice in order to assure quality of teaching when they begin to teach on their own. The MOH tutors will find it easier to supervise them if they have first [illegible] with the course	Recommended maximum 1 month	1. To give tutors opportunity to test and evaluate training programs so as to determine what further modifications are necessary. 2. To permit VHW trainers to observe training program for VHW. 3. To give VHW trainers increased opportunities for teaching practice under real training conditions so as to give them familiarity with materials and teaching methods before taking full responsibility for training VHWs.	MOH tutors. RTC staff will collaborate with MOH tutors in supervising teaching practice of VHW trainers and in evaluating trainers and course results

Phase	Time	Objectives	Responsibilities
5.. Recyclage for VHW Trainers It is suggested that a regular recyclage program be instituted for VHW trainers to upgrade capabilities in training and supervision and to discuss program problems.	5 days	To review training and supervision methods.	RTC staff

ANNEX 5

04 04, Ivory Coast

June 16, 1980

M E M O R A N D U M

TO: Dr. B.S.F. Adjou-Moumouni
Coordinator of Studies
WHO Training Center, Lomé

FROM: S. Helfenbein
Assistant SHDS Project Director

SUBJECT: RTC Lagos Follow-up Visit to the Gambia

1. Please find enclosed a copy of the report Dr. El-Neil and I submitted to the MOH/Banjul on proposed plan of collaboration between the RTC Lagos and Gambian PHC program. There are some differences in approach from that proposed for Mauritania, but the overall pattern remains the same. You will be interested to know that the two Gambian graduates of the Lagos RTC who are developing their own session plans are using the WHO training materials as a guide for form, content and just generally for ideas whenever they run into a problem of formulating performance objectives or developing a session plan. We have had so far two approaches to follow-up and I imagine as this program develops, there will be many more to experiment with. I think there is probably not a single model to fit all needs and expectations.

2. I am also enclosing a copy of our latest memo to AID/W regarding the outstanding equipment. I hope we will obtain the waiver by the end of this month. If so, the equipment can be shipped by the end of July.

3. We had quite a history with the equipment for Lagos. On Dr. El-Neil's request, we shipped them via Lomé as he wanted to ensure a safe arrival. I appreciate everything that you and Mr. Lalo have done to expedite clearance from customs.

SH:ba

Enclosures: as stated

REPORT OF FOLLOW-UP MISSION TO THE GAMBIA OF THE WHO RTC TRAINING OF TRAINERS (TOT) OF VILLAGE HEALTH WORKERS (VHW) COURSE. 10 - 14 JUNE 1980.

Submitted by Dr. H. El Neil, Coordinator of Studies; WHO Regional Training Center (RTC), Yaba, Lagos

S. Helfenbein, Assistant SHDS Project Director for training , Abidjan, The Ivory Coast.

1. The objective of this mission was to determine and plan a programme of follow-up collaboration to Gambian participants in the above course in developing an in-country training programme for village health workers. Collaboration between the RTC and the Government of The Gambia was to be rendered in the context of SHDS Project objective II activities in the Regional Training Centers (RTC) Lome and Lagos towards the facilitation of the implementation of the Gambian Action Plan for Primary Health Care (PHC).

2. Consultations were held with Dr. E. M. Samba, Director of Medical Services, Dr. F. Oldfield, Deputy to Director of Medical Services, Dr. N. B. Akim, WPC, Banjul, Dr. P. Gowers, Medical Officer of Health, Dr. P. Parekh, Representative of Project Concern International, Mr. John Spring, UNICEF, Dakar, Mr. T. D. Smart, Mrs E. Mboge, Mr. M. Marenah, graduates of the Lagos RTC TOT Course, and Mrs A. Stafford, Trainer of traditional birth attendents (TBAs).

3. The training programme for VHW has been re-scheduled for January 1981. 18 villages in Lower River Division have been selected. Visits by the PHC training team have been made to several villages in a programme of "sensitization" to inform villages about the PHC programme request their participation and nomination of a village health worker trainee. The Primary Health Team has begun to develop a job description for village health workers. Tasks were identified in five areas. The RTC Lagos graduates have begun to do a task analysis, and prepare session plans for the training programme

4. The expressed needs for collaboration from the RTC through the SHDS project were in the following areas -

(i) collaboration in the development of the curricula of the VHW training programme

/....

(ii) provision of critical material resources in regard to the above;

(iii) provision of some collaboration in the development of a training programme for TBAs;

(iv) development of a programme to reorient the Gambian health workers to Primary Health Care.

5. The following recommendations were made with regard to the above expressed needs.

(i) Collaboration in the Development of a Curriculum for the VHW Training Programme.

Four possible areas of collaboration were identified to facilitate the development of a curriculum and its articulation for the first training programme of VHWs in The Gambia;

(a) Consultation by the RTC staff in the eleboration of a detailed operational plan for the training programme. Dr. U. O. Imade STC in Management will be available in July 1980 for this mission.

(b) Review of the task analysis and session plans prepared by RTC graduates and collaboration in any necessary revision. Mrs Anu Adegoroye, STC in curriculum development will be available in December 1980 for this mission.

(c) Collaboration in conducting, and administration of the training programme and preparation of the final field tested package for training VHWs in subsequent phases of the Gambian PHC programme. Dr. S. Ericson, SHDS educational Technologist will be available in January 1981 for this mission.

(d) Collaboration in evaluating the VHW training programme and in preparing an operational plan for further training and supervision. RTC and SHDS staff will be available for this mission.

(ii) Provision of resources to Develop the VHW Training Curriculum

(a) Funds would be available from the SHDS project through

/....

the WPC Banjul to defray directs costs associated with the development, production and adaption of VHW training materials.

(b) It was understood that either WHO/AFRO, UNICEF or other agencies, would furnish a vehicle to the Primary Health Care training team for the proposed extensive pre-training, sensitization of village communities, follow-up training and supervision.

(c) Consultants mentioned in point (i) would be financed completely by the SHDS project.

(iii) Provision of collaboration in Development of Curriculum for Training of TBAs.

Possibility of sending Sister Stafford to the Lagos RTC and the WHO collaborative programme for the training of TBAs in Sokoto, Nigeria preferably in August 1980, was suggested. Alternative funding possibilities including that of AFRO/SHDS funds would be explored.

(iv) Development of a programme to reorient Gambian Health Workers to PHC.

(a) It was suggested that such a programme could be linked to the already planned SHDS continuing education workshop for Nurses in The Gambia to reorient practising nurses to PHC. (This workshop is part of the Post basic Nursing education programme for The Gambia, Sierr-Leone and Liberia, approved under SHDS Project Objective II)

(b) Dr. V. O. Imade would be available during his proposed July visit to discuss the administration and management implications of The Gambian Primary Health Care programme for further workshops to reach the estimated 700 health workers in The Gambia.

6. We gratefully acknowledge the kind invitation of The Government of The Gambia to follow-up the products of the WHO Regional Training Center Course for the training of trainers of Village Health Workers, and we very much appreciated the collaboration of all who made available their time to meet with us and discuss the Gambian PHC programme and the possible modalities of continued collaboration.

Health Policy Institute
53 Bay State Road
Boston, Massachusetts 02215
617/353-4386

Center for Strengthening Health
Delivery Systems in Africa

Bos 1.
AID
TL Lome

May 27, 1980

Mr. Earl Yates
Office of Regional Affairs
Africa Bureau
Agency for International Development
Department of State
Washington, D.C. 20523

Dear Earl:

We are writing to you concerning our requests for waivers to purchase equipment for use in the WHO Regional Training Center in Lome, Togo. We have requested a waiver to purchase a Gestetner table model offset machine and also to purchase video equipment from TeleTape Video Company of London. We have searched thoroughly and found that this equipment cannot be purchased in the U.S. with the proper 220 voltage and wiring requirements needed for use in Lome. The video equipment is not available in Togo, and the cost of the offset machine is considerably higher if purchased in Togo rather than in London. Therefore we would like to purchase all of this equipment in London for export to Togo.

We have written to Mr. Kenyon in November 1979 and again in January 1980 to request approval for these waivers. We have recently received several urgent inquiries from the Lome RTC as to the status of this equipment. The teaching activities at the Center are being hampered by the lack of this equipment which we had hoped would be in place by early this year. Since there is a time lapse of several weeks between the time an order is placed and delivery of the equipment to Togo, it is most important that we receive approval for these waivers as quick as possible.

If you need any further information about this equipment, please let me know. We look forward to hearing from you soon regarding this matter.

Sincerely,

Mary E. Grandfield
SHDS Project

cc: S. Helfenbein
S. Ericsson
J. Montague

ANNEX 6

EVALUATION DU MATERIEL PEDAGOGIQUE POUR LA FORMATION DES ASV (revisé Avril, 1980)

1. Quels problèmes ont été identifiés dans le village?

2. Quelles tâches ont été sélectionnées pour la formation de l'ASV?

Hygiène du Milieu:
Nutrition:
Santé de la Mère:
Soins aux Enfants:
Soins aux Adultes:
Soins d'Urgence:
Méthodes de Travail:

2.1 Avez-vous éprouvé des difficultés dans la sélection des tâches? (Si oui, décrivez les modifications vous avez faites).

2.2 Avez-vous eu besoin de modifier des tâches sélectionnées? (Si oui, décrivez les modifications que vous avez faites).

3. Quelles tâches ont été développées parce que vous n'avez pas trouvé quelques unes qui correspondent aux problèmes identifiés? (Si vous avez pu sélectionner toutes les tâches, continuez avec question 4).

3.1 Avez-vous éprouvé des difficultés dans la formulation des tâches? (Si oui, décrivez les difficultés que vous avez rencontrées).

4. Quels objectifs avez-vous sélectionnés? (Si vous avez formulez vous-même tous les objectifs sans sélectionner, continuez avec question 6).

Hygiène du Milieu:
Nutrition:
Santé de la Mère:
Soins aux Enfants:
Soins aux Adultes:
Soins d'Urgence:
Méthodes de Travail:

4.1 Avez-vous rencontré des difficultés en sélectionnant les objectifs? (Si non, continuez avec question 5).

4.1.1 La façon dont les objectifs ont été formulés les a rendus difficiles à comprendre. (Donnez des exemples qui le démontrent).

4.1.2 Les objectifs n'étaient pas suffisamment détaillés. (Donnez des exemples).

4.1.3 Les conditions employées n'ont pas été décrites suffisamment en détail. (Donnez des exemples).

4.1.4 Les conditions décrites ne correspondaient pas au milieu dans lequel je travaillais. (Donnez des exemples).

4.1.5 Les comportements inclus n'étaient pas ceux que je désirais apprendre aux AIV. (Donnez des exemples).

4.1.6 Le contenu des objectifs n'était pas correct. (Donnez des exemples).

4.1.7 Autres difficultés (donnez des exemples de chacune d'elles).

5. Avez-vous eu besoin de modifier les objectifs sélectionnés? (Si non, continuez avec question 6).

5.1 Pourquoi avez-vous modifié les objectifs?

5.1.1 Les conditions décrites dans les objectifs n'étaient pas correctes. (Donnez des exemples).

5.1.2 Les comportements énoncé dans les objectifs n'étaient pas nécessaires ou il fallait ajouter de nouveaux comportements. (Donnez des exemples).

5.1.3 Le contenu des objectifs a dû être changé. (Donnez des exemples).

5.1.4 Les objectifs n'étaient pas suffisamment détaillés. (Donnez des exemples).

5.1.5 Autres raisons. (Donnez des exemples).

6. Quels objectifs avez-vous dû formuler? (Si vous n'avez formuler aucun objectif, continuez avec question 7).

6.1 Avez-vous pu utiliser le format employé dans le livre? (Décrivez les difficultés que vous avez rencontrées).

6.2 Pourquoi avez-vous dû formuler vos propres objectifs?

6.2.1 Les conditions que je voulais ne se trouvaient pas dans les objectifs. (Donnez des exemples).

6.2.2 Les comportements que je voulais ne se trouvaient pas dans les objectifs. (Donnez des exemples).

6.2.3 Autres raisons. (Donnez des exemples).

PLANS DES UNITES DE COURS

7. Quels plans d'unité avez-vous employés? (Si vous avez formulé vous-même tous vos plans d'unité, continuez avec question 10).

Hygiène du Milieu:
Nutrition:
Santé de la Mère:
Soins aux Enfants:
Soins aux Adultes:
Soins d'Urgence:
Méthodes de Travail:

8. Avez-vous eu des difficultés en sélectionnant des plans d'unité? (Si non, continuez avec question 9).

8.1 Quelles difficultés avez-vous rencontrées en choisissant les plans d'unité appropriés pour les objectifs retenus?

8.1.1 L'objectif de performance donné dans les plans d'unité ne correspondait pas aux objectifs de cours (pour les modules: Hygiène du Milieu, Nutrition, Soins aux Enfants et Soins d'Urgence).

Je ne savais donc pas quel objectif devait être atteint à travers les différents plans d'unité.

8.1.2 Les plans d'unité n'ont pas été disposés dans le même ordre que les objectifs.

8.1.3 Autres raisons. (Donnez des exemples).

9. Avez-vous modifié vos plans d'unité? (Si non, continuez avec question 10).

9.1 Quelles difficultés avez-vous éprouvés en essayant de modifier les plans d'unité?

9.1.1 Je ne pouvais pas utiliser les activités parce que je ne savais pas comment les mener (donner des exemples).

698-0398

6780378005302

PD-AAK-066

(2)

PROJECT FOR

STRENGTHENING HEALTH DELIVERY SYSTEMS

IN WEST AND CENTRAL AFRICA

698-0398

SEMI-ANNUAL PROGRESS REPORT

JANUARY-JUNE 1980

TABLE OF CONTENTS

	Page No.
OBJECTIVE I.....	1
OBJECTIVE II.....	7
OBJECTIVE III.....	21
OBJECTIVE IV.....	28

Final Draft Report of Project Review Committee Meeting June 23-27, 1980

ANNEXES

OBJECTIVE I

1. List of Documents used in Multi-sectorial Management Workshop
2. List of Participants for Ministerial Workshop
3. List of Participants for Ministerial Workshop
4. Case Studies for Top Level Interministerial Management Workshop

OBJECTIVE II

1. Course Objectives for Each Training Course
2. Educational Objectives of The Training Course for Trainers of Village Health Workers
3. Work Schedule for Development of Supervisory Material
4. Government of The Gambia Request
5. RTC Lagos Follow-up
6. Lome Course Questionnaire

OBJECTIVE III

No Attachments

OBJECTIVE IV

1. Background Related to the Assignment
2. Trip Itinerary
3. AFRO Memorandum
4. Course Methodology
5. Course Objectives
6. Course Schedule
7. WHO/SHDS Guidelines for Applied Research on Health Service Delivery and Primary Health Care

OBJECTIVE I

To improve national and regional health planning and management.

Sub-objective 1: To strengthen health planning, programming and management training programs given by the Dakar and other collaborating Centers.

This subobjective concerns the 6 week planning and management course given annually at the Dakar Health Planning, Programming and Management Center. No direct action was taken regarding curriculum revision because of the crowded schedule of the center staff and the preparation needed for the top level multisectorial management workshop scheduled for April. However, as a result of the top level course, it is expected that the staff will increase the management content and employ training techniques used in the workshop (see subobjective 2). During the preparatory period for the workshop, SHDS consultants, Professor Bruce MacKenzie and Aliou Samba Diallo, revieweu management content and training techniques with the Dakar staff. This activity was undertaken during the week before the workshop and during the interval between the two sessions of the workshop. Thus, a total of 7 days was spent in staff training on management related activities.

In preparation for the workshop, SHDS provided the Dakar project with a small library of educational materials on management (see Annex 1 for list of materials). These will be used for the other training programs carried out by the Center.

Sub-objective 2: To improve intersectorial management capabilities of planners from the West and Central African countries in development of health programs.

The principal activity in this subobjective was the top level intersectorial management workshop and in-country follow-up. Originally, two (one Francophone and one Anglophone) workshops were planned, the former for March and the latter for November. However, final budgetary discussions resulted in funding for only one workshop for the Francophone countries during 1980.

The workshop was hosted by the Ministry of Health of Senegal, organized by SHDS and AFRO and held as a residential workshop in Aldiana, Senegal from 13-17 and 20-23 April. It was originally scheduled for the end of March; however, dates were changed because accommodations were not available in March. As a result, ministers from Togo and Niger were unable to attend.

Invitations were originally sent out in December 1979 to nine countries (Senegal, Guinea, Mali, Ivory Coast, Benin, Togo, Mauritania, Niger and Upper Volta). During the preparatory session for senior officials, eight countries (excepting Upper Volta) sent representatives for a total of 16 participants (see Annex 2 for list of participants and their positions). In the second session, six ministers from Senegal, Mali, Mauritania and Benin attended (See Annex 3 for list of ministerial participants).

The two workshop sessions were conducted by SHDS consultants, M. Aliou Samba Diallo of the Dakar Office of Organizational Management (Bureau d'Organization et Methodes), Prof. Bruce MacKenzie, and Dakar Project Management Specialist, M.M. Mena. Other staff members participated as resource persons. In addition, Prof. MacKenzie invited two information systems specialists to complete the roster of resource persons.

The objectives of the workshop were as follows:

a. To promote interministerial and intersectorial cooperation among those ministers principally concerned with social and economic development;

Sub-objective 2 of Objective I Continued.

b. Familiarize the senior officials with the broad spectrum of management themes related to multisectorial development and to identify the interests and priorities of the participating ministers;

c. Develop and edit a number of composite case studies which would represent priority problems relating to public health, social well being and productivity. These would ideally present problems of management, coordination and the coherent use of human and economic resources from several sectors;

d. Prepare a briefing for the participating ministers, either to be given to them before their arrival in Senegal or at the opening of the Top Level Workshop;

e. Sample and test certain of the materials, documents, questionnaires and cases from other workshops to ascertain their suitability and relevance.

Several broad categories of problems were first identified by the directors, following the introduction and discussion of all of the major themes: motivation, communication, delegation, styles of management and conflict resolution. Problem categories included:

1. Structural and Organizational Problems

   a. Lack of interministerial coordination
   b. Poor intraministerial coordination
   c. Overly personal nature of interministerial relations.

2. Functional, Operating Problems

   a. Excessive concentration of decision-making power

   b. Insufficient, fuzzy job and position descriptions

   c. Confusion of roles and job duplication

   d. Inadequate definition of objectives

   e. Lack of importance given to evaluation and appraisals

   f. Poor utilization of resources

   g. Poor program planning and execution

   h. Decision-making based on erroneous information

   i. Decision-making without previous study or information

   j. Ignoring reporting or organizational lines

   k. Weakness in resisting outside pressures and influences

   l. Lack of follow-through

   m. Insufficient contacts throughout the organizational structure

Sub-objective 2 of Obj. I Continued.

n. Hostility and distrust among managers and between managers and their subordinates.

3. Personnel Problems

a. Lack of training programs and trained manpower.

b. Disparity of motivation and rewards between the public and private sectors, and among different sectors or the public sector.

c. Under-utilization and misuse of trained manpower, including over-concentration of skilled manpower in the urban areas.

After an introduction to the case method, analysis of several cases and a discussion period, small teams of directors worked together for the rest of the three and one half days in preparing five management case studies which formed the working materials of the ministers during their meeting the following week.

These five cases covered problems related to various aspects of the management cycle:

a. Functions of Management: Case No. 1 -- Self-sufficiency in Food.

b. Organizational Diagnosis: Case No. 2 -- "I Have to Stay in the Capital!"

c. Human Resources Management and Resolution of Conflicts: Case No. 3 -- "Why Doesn't He Mind his own Business?"

d. Planning and Coordination: Case No. 4 -- Doing Everything Means Losing Everything (Qui trop embrasse, mal etreint!).

(See Annex 4 for case studies and other documents used during the workshops.)

Top Level Interministerial Management Workshop

The preparatory workshop was followed by a 3 1/2 day workshop for ministers. The six participating ministers represented health, social welfare, rural development, science and research, and communication development sectors. Their program consisted of analysis of the case studies and discussion of the major themes of modern management. A synopsis of the program follows.

Sunday p.m. - 20/4/80

First working meeting. Explanation of the methodology, materials and provisional agenda for the week. Discussion and suggestions by the participants and trainers with some revisions and changes in times of planned plenary sessions and individual, non-structured time. First projection of Turning Point.

Monday - 21/4/80

Overview of modern management processes, attitudes and latest trends as related to multisectoral development. Use of B. MacKenzie's Management in Three Dimensions reprint from the Harvard Business Review as basis of

Sub-objective 2 of Obj. I Continued

discussion of the management cycle: planning, organization, resource mobilization, execution and control.

Analysis and presentation of the various management functions through study and analysis of Case No. 1. Diagnostic techniques applied to organizational environments. Discussion of problem identification and tools available such as Likert's organizational profiling and his various systems 1-4.

Human aspects of management in larger organizations: delegation, motivation, communications, styles of management and stress minimization. Videodisc presentation of Turning Point with interactive participation by ministers with use of thematic booklets.

Study and analysis of Case No. 2. Problems of team building and conflict resolution. Use of schematic on negotiation and conflict resolution.

Tuesday - 22/4/80

Advanced technologies andmanagement tools available for multisectorial management in the African context. Presentations and discussions of management information systems, tele-analysis for rural development and interactive videodisc for training of health agents, rural development workers and management development.

Intersectorial collaboration and decision-making. Analysis and presentation of Case No. 3 and Case No. 4.

Styles of management and attitudinal change. Case study and analysis: The Day of Mr. Sarr. Use of Task-People Questionnaire and the Blake-Mouton Managerial Grid.

Presentations and discussions with reference to cases of motivation and delegation problems in management.

Individual analysis and demonstration of management styles with viewing and discussion of a recent management film: Adult, Where are You?. This includes a discussion of transactional analysis and its applications to modern management.

Wednesday - 23/4/80

Marketing and the public sector: its relevance to the various services needed or desired by different publics in a developing country. Presentation and analysis of marketing problems, the marketing mix and marketing attitudes in the creation and diffusion of goods and services.

Review and discussion of key themes for multisectorial management as seen through the composite cases. Distribution and brief discussion of additional documentation, diagnostic tools for use in back-home organization and individual plans for management action.

Open forum, discussion and evaluation of the Top Level Workshop with recommendations, for further training.

The Ministers proposed a series of recommendations for the continuation and expansion of management training in the region, which reflected an appreciation of management's role in development and the need for a variety of short

Sub-objective 2 of Obj. I Continued.

and long term approaches to training managers. Recommendations included the following:

I. Institutional Recommendations

- Creation of national and regional institutions specializing in modern management processes and techniques; and the strengthening of such institutions already in existence;

- Introduction of management courses in training institutions and faculities;

- Orientation of such courses and programs towards specific, real and timely administrative problems.

II. Organizational and In-Service Recommendations

- Regular, planned programs of management development and re-cycling for middle management and above through seminars, workshops and courses;

- Development and education in management for future managers in the various professional schools of each country;

- Development of an action plan aimed at overcoming the difficulities due to lack of qualified management trainers.

In this last point, sectoral leaders should study:

- Possibilities of inter-African cooperation through pooling qualified resource people by way of the organization for technical cooperation among developing countries (TCDC);

- Increased training of trainers in management in specialized graduate schools and institutions both in Africa and in other geographic areas.

This subobjective also included the development of an in-country follow-up program to the workshops. The Ministers indicated immediate interest in such a program, as reflected in their recommendations. The possibility of follow-up workshops was explored in Senegal and Mauritania. In Senegal, moreover, the USAID Mission also expressed interest in collaborating with the SHDS Project in a follow-up program. Meetings were held with USAID mission personnel and several information cables exchanged. Further meetings were planned for August following an official request by the GOS for a follow-up program. In this regard, the SHDS staff discussed follow-up activity with Senegalese participants. They indicated that the GOS was highly satisfied with the workshop and wished to hold a similar one for member ministries of the proposed National Health Council. A meeting in August in Senegal was planned to discuss this further. Participants from Mauritania expressed similar interest. Formal request to AFRO to follow-up are expected during the next reporting period.

In order to systematize the training methodology for further top level workshops as well as for follow-up programs, the facilitators proposed to develop a set of training modules based on the organization, content and teaching techniques of this workshop. The modules would be used to train other national facilitators to use the concepts and techniques of executive management training, and

Sub-objective 2 of Obj. I Continued

would serve as a guide or model for management workshops for government and private management training or development institutions. The proposal was submitted to AFRO, which responded favorably. It is planned to begin developing the modules during the next reporting period.

Sub-Objective 3: To strengthen the Dakar and other collaborating centers' capabilities to participate in and follow-up CHP exercises and facilitate the implementation of national health development programs.

No action was taken during this period for the following reasons.

a. Budgetary uncertainty precluded the development of specific plans, until well into April; and

b. The CHP exercises scheduled for 1980 will all be in countries outside of the SHDS Project region.

This activity will be carried over to 1981.

Sub-Objective 4: To develop health planning, programming and management capabilitie of selected national education institutions.

The SHDS Project was invited to participate in the secretariat of the first AFRO consultation on health management training in Arusha, Tanzania. It was held 21-25 July, 1980. Further planning in this area is contingent upon the recommendations emanating from the Arusha Conference.

SHDS will provide 15 fellowships for non-degree study in health planning and management at the 6 week course in Dakar. This course is being run for English speaking countries this year. Funds were not provided for fellowships leading to degrees or to other collaborating centers.

OBJECTIVE II

Lome/Lagos

To increase the skills and improve the utilization of health personnel providing generalized health services at the supervisory and local levels.

Sub-objective 1: To develop, improve and harmonize methods of course design and implementation at the Lome and Lagos Centers.

The principal activities under this subobjective were 1) continuing education for center staff in systematic course design, 2) subject matter committee review of course content and 3) training of VHW trainers and middle level EPI personnel.

1) Further training in systematic course design was carried out informally during the on-going process of revision of existing and preparation of new courses. SHDS Project Educational Coordinator worked with staff of both centers on the design of courses during her April-May consultation.

2) Both centers continued to convene local subject matter committees for review of course content. In general, this is carried out on an ad hoc basis, and "committees" may consist of one to several persons. These persons not only review course content and prepare new materials, but also serve as course facilitators, further consolidating national involvement in the centers' teaching programs.

3) Lome held its second Training of Trainers course, and Lagos, its first.

Lome

There were 30 participants at the Lome course, 22 of whom came from SHDS countries (Cameroon - 2, Central African Republic - 2, Congo - 2, Gabon - 2 Guinea - 2 Equatorial Guinea - 1, Upper Volta - 2, Mali - 2, Niger - 2, Senegal - 2, and Togo - 3). The rest came from Burundi, Comores, Guinea-Bissau and Rwanda. To date, 47 persons have been trained from 15 French speaking countries. The SHDS Project was unable to provide consultant assistance to the course as needed because the public health nurse short term consultant had not yet been replaced. AID/W had refused to provide funding for such consultation. SHDS attempted to engage a former TOT course participant from Cameroon recommended by the Director of the Lome RTC. However, it was not possible to secure government permission in time. There were 7 instructors, the regular teaching staff of the center and three additional persons who have frequently been members of local subject matter committees or previous course participants.

The year's course was revised in consultation with the SHDS Educational Coordinator during her visit to Lome in October-December 1979 to complete the VHW training modules. The course itself was divided into 6 modules - two which dealt with study habits and group dynamics and 4 which dealt with course design and the use of the VHW training materials, teacher training, management and evaluation.

Lagos

There were 27 participants at the 13-week Lagos TOT course of whom 14 were from the SHDS Project region (Cameroon - 1, Gambia - 2, Ghana - 2, Nigeria 7, and Sierra Leone - 2). The remaining were from Ethiopia, Kenya, Lesotho, Malawi, Namibia, Swaziland and Tanzania. A SHDS consultant was engaged to assist the RTC staff which included short term (11 month) consultants provided by the Project - a management specialist and a public health nurse.

Sub-objective 1 of Obj. II Continued

There were a total of six facilitators for the course including the Director of the center. The course was divided into five modules including systematic course design, working with the community (community mobilization and program management), teacher training practice and evaluation. The participants were divided into 5 groups, each having the responsibility of developing part of the VHW training program for environmental health, control of communicable diseases, maternal child health, nutrition, first aid and evaluation (see Annex 1 for course objectives of each course).

A total of 61 persons from SHDS countries have been trained in the three TOT courses. Both courses stress the participant's role in training, supervision and evaluation of the VHW during training and village work, teach the participants to define educational objectives and teaching activities, and give 15 days of practice teaching to show participants how to teach session plans which they have developed. Although the objectives of the courses are similar, differences in teaching approaches, previous background and training of participants, and field work resources result in special characteristics for each of the training programs.

Lome

1. Tightly organized, specifies each day the objectives, content, activities to be covered.

2. Follows teaching pattern established through experience in other courses.

3. Teach participants how to adapt VHW training materials, plan primary health care projects and administer and supervise a training program for VHWs.

Lagos

1. Gives more responsibility to teaching staff and plans courses on a weekly basis, specifying how many days are taken up by certain course units.

2. Emphasizes development of individual session plans rather than methods of adapting existing VHW training materials.

3. Permits participants to work in villages doing community development work with villagers and relating this work to VHW training.

The main difference in the two programs is access to PHC field sites. Lome RTC field practice is carried out in a mission run program for health "catechistes", who are generally more educated and knowledgeable than VHWs would likely be. This field practice does not afford opportunity to work with the community. The Lagos RTC, on the other hand, is in the process of developing a primary health care program and thus leads the participants through an active process of developing real VHW programs. Participants provided the training for 18 village health workers from 13 villages in the Badagary area.

The report of the SHDS Educational Coordinator made the following observation in this regard.

> The graduate of the Lagos course will be a better trainer of VHWs. He will be able to go into the village, work with the villagers on community projects, help select the VHW and train him probably with more assurance than the Lome graduate. Since he has more practical experience of these tasks they will be

Sub-objective 1 of Obj. II Continued.

easier for him. He will also have a good understanding for the problems facing the VHW and probably also be able to provide a good supervision of this VHW.

The graduate of the Lome course, although capable of doing these tasks will probably not do them with the same ease that the Lagos graduate has. He has had considerably less practical experience in working with the villagers, selecting the VHW, and with the conditions in the villages during the training. On the other hand, he may be more capable of planning, implementing and evaluating a program in primary health care, including the training of VHWs than the Lagos graduate, since that has been one focus of his training.

No further training materials were produced during this period. However, work still continued on the development of an Instructors' Manual to guide trainers in adapting the VHW training materials. The French version of three modules completed in 1979 were reproduced at the Lome Center, used in the course and distributed to past course and workshop participants as well.

The center reproduced the materials on a mimeograph machine which left much to be desired as far as quality was concerned. This was unavoidable as the SHDS Project still has not yet obtained the long promised waivers to purchase the planned offset printing equipment. Several verbal promises were given during this period by AFR/RA officials, but no action was taken. The same is true for the remaining equipment originally requested for Lome 18 months ago.

Offset printing equipment ordered for Lagos had not yet arrived owing to problems with the distributor and as the center's own mimeographing equipment was no longer functioning, the English version of the remaining modules was not reproduced. It is hoped that equipment will arrive early on during the next reporting period and the modules will be duplicated by September.

See Objective III for a discussion of the introduction of a TOT for middle level EPI personnel.

Sub-objective 2: To develop training materials at the Lome and Lagos RTCs for community health workers and supporting personnel.

This subobjective concerned 1) the field testing of the VHW training materials and 2) the production of materials to train VHW supervisors.

1) Field Testing

During discussions in December 1979 with RTC Directors regarding the field testing and the response to in-country requests, the following decisions had been made:

- The main objective of the field testing should be to test the adaptibility of the VHW materials and specify the instructions necessary for easy use of the materials. Specific issues such as the accuracy of the materials should be of secondary importance during the field testing and generally resolved through consultation with subject matter experts.

- The field testing should take place before the end of 1980.

- Since the field testing would consist of; 1) assisting the trainers of village health workers with the adaptation of the training materials, 2) helping the graduates of the TOT course to train others to use the materials and train village health workers, it seemed optimal to combine the field testing with responses to in-country requests.

- The field testing should be done in the first two countries which requested help with adapting the materials to in-country conditions. If after adapting the materials in these two-countries there is still insufficient information available for the production of a final copy, field testing would continue in the next country that requested assistance. The Gambia and Mauritania had indicated that they are interested in receiving assistance in developing village health worker programs with the use of the VHW materials. These two countries have tentatively been designated as field test sites. This would allow for field testing in both an anglophone and a francophone country under different environmental conditions. Liberia and Gambia also indicated their interest in adaptation of the VHW training materials. These countries will be included in the 1981 program.

During this period, it was recommended that the field testing and in-country assistance cover the following areas:

- assistance with the planning of village health worker programs;

- assistance with the adaptation of the VHW materials; and

- assistance with giving courses for trainers of village health workers.

Together with Dr. Adjou-Moumouni, a plan to give in-country courses for trainers of village health workers was drawn up (See Annex 2). This course program assumes that the RTC would be able to send two people to assist the graduates of the course in Lome/Lagos to give a three week course in the country for trainers of village health workers. The course would include adaptation of the materials to conditions in the country. It was assumed that the SHDS Project would be responsible for providing the two people and also copies of the VHW materials, while the country would assume responsibility for all other personnel and materials.

Sub-objective 2 of Obj. II Continued.

The assistance from the two centers may be given differently. The structure of the assistance from the Lome center would be focused on giving a course tailored to the use of the materials and with a strict adherence to the methods used to give courses at the center. Since the Lome center has given in-country courses arranged by WHO already, it appears that such experience will be useful for the project.

The Lagos center on the other hand has not developed such expertise and has not really considered which methods to use for the in-country assistance. Since the Lagos staff members have not used the VHW training materials in their course they might have difficulty making these central to an in-country course. This fact may make field testing of the materials in anglophone countries a bit more difficult.

A pool of consultants should be set up which can be used by the different countries on request for assistance with their primary health care programs. The consultants should mainly be African with experience in primary health care, primarily graduates of the courses at the Lagos/Lome centers and/or the CESSIs.

When assistance is requested from the SHDS Project via WHO, consultants from this pool would be used together with RTC staff to assist with the planning and implementation of primary health care programs. Time limits should be established for the maximum use of a given consultant to avoid conflicts with his own country's need for his services. However, the use of consultants from other countries in the region would increase the cooperation between such countries and also lead to a sharing of experiences in this regard which can only have beneficial effects on the primary health care program.

See subobjective 3 for further discussion on adaptation and field testing of VHW training materials.

1). <u>Training Materials for VHW Supervisors:</u>

The next step in the development of training materials on primary health care concerns the need for training supervisors of VHWs. Discussions were held in June 1979 regarding the development of such materials with the directors of the two training centers. Since the VHW materials were developed in Lome, it was felt that it would be better to develop the supervisory materials under the guidance of the Lagos center since the revision of the VHW materials would create demands on the Lome center staff. Dr. El Neil also pointed out that the Nigeria Basic Health Services Scheme (BHSS) for the last two years, worked on the development of instructional materials for the training of community health aides and assistants. Part of this material includes management materials for the supervisory functions at the health centers in Nigeria. Thus, in the earlier discussions it had been decided that the SHDS project should assist with the development of such materials and provide technical assistance with the adaptation of this materials for use in other countries.

The BHSS staff has been trained in systematic course design in October 1979. The staff participates regularly as subject matter committee members and as facilitators in the RTC courses. In this project activity staff members would continue in the same capacity.

Since the budget negotiations had taken such a long time, it had been impossible to start the SHDS involvement in the development of the materials before this

Sub-objective 2 of Obj. II Continued.

time. The SHDS Educational Coordinator reviewed the materials which had been developed to this point, reviewed the need for technical assistance, and set up a work schedule for the project (see Annex 3 for the work plan).

In summary, the following decisions were made:

- BHSS would develop the educational objectives for the supervisory materials for three different types of health centers, and with three levels of personnel.
- Dr. Kolawole, who was planning a trip to the U.S. in June, would bring these objectives with him and the objectives would be reviewed by me at that time.
- Further discussions would be held at that time and decisions regarding technical assistance would be made.

Thus, major activity in the development of these materials will begin during the next reporting period.

Sub-objective 3: To develop RTC consulting capabilities to collaborate with countries of West and Central Africa in the development of effective training programs for village health workers and other personnel and test them in the field.

This subobjective concerns 1) the adaptation of the VHW training materials and 2) the evaluation of the RTC TOT participants on return to their home countries.

Adaptation of VHW Materials

1) As indicated in the discussion of subobjective 2, Mauritania and the Gambia requested follow-up from the Lome and Lagos RTCs in the development of their respective VHW training programs. In May, the SHDS Assistant Project Director and the SHDS Educational Coordinator visited Nouakchott to identify the modalities for such collaborative assistance. Owing to illness, the RTC Director could not join this visit.

RTC collaborative assistance was requested jointly by the MOH and USAID Mission which are sponsoring a PHC program in the Trarza region of Mauritania. (This is the USAID/Mauritania Rural Medical Assistance Project.) The Director of Preventive Medicine had been a participant in the June 1979 VHW training workshop conducted in Lome and had decided to adapt the SHDS Project training materials for the PHC program. Two Mauritanians were subsequently sent to the RTC TOT course in 1979.

The SHDS mission identified 5 stages for the development of VHW training for the Mauritania PHC project: 1) preparation of nurses/midwives as VHW trainers 2) assessment of village health conditions in relation to VHW tasks, 3) adaptation of VHW training materials, 4) the development of a village health worker training program, and 5) the development of a retraining program for VHWs and indicated where collaboration with the RTC would be most effective (see Annex 4 for the proposed follow-up strategy.) This plan was reviewed by the MOH and the USAID Mission and with appropriate modifications approved. During the PRC meeting, the Assistant SHDS Project Director and the Mauritanian representative to the PRC discussed the plan with AFRO officials. General agreements were reached. The MOH plans to make an official request to AFRO for collaborative assistance from the RTC scheduled to start in September-October 1980.

A similar planning visit was carried out in the Gambia by the Director of the RTC Lagos and the Assitant SHDS Project Director in June. The Gambian program was developed in cooperation with an AFRO-WHO general task force. It is a multi-donor project. Two Gambians participated in the RTC Lagos TOT course and on return to the Gambia were assigned the responsibility of developing a VHW training program. Four areas for follow-up were identified: 1) development of an operational plan for the VHW training program, 2) review of the task analysis and session plans, 3) assistance in conducting and administering the training program, and 4) development of an evaluation, supervision and retraining program. These recommendations were approved by the MOH and an official request was made to AFRO for follow-up the first stage of which is scheduled to begin in July (see Annex-for follow-up plan/memo regarding the GOG official request for collaboration from RTC Lagos).

Subobjective 3 of Objective II Continued

As mentioned in subobjective 2, the centers have different strengths and have placed different emphasis in their TOT courses. This will affect what they can offer in follow-up programs as well as the kinds of assistance which is likely to be expected and requested. In addition, it is clear that both centers will have to maintain a flexible approach to follow-up as the needs of the countries will vary owing to special characteristics of their PHC programs, the varying stages of development of these programs, the competencies of the TOT graduates, and the other training programs and expertise which is locally available. In general, both RTCs believe they can offer assistance within the three areas specified above in subobjective 2. While it is too early to develop a model for such collaboration, the basic approach as proposed in the implementation plan appears to be desirable on site visits to review PHC program and develop a plan of action in consultation with the MOH and TOT graduates to match needs and resources within the context of the SHDS program possibilities. At present, informing countries of the availability of collaborative assistance is carried out on a personal basis through meeting with government officials and bilateral missions. As the number of countries with PHC program grows as the RTCs gain experience, it is hoped that a more formal system can be instituted. In pursuing this objective, a balance will have to be maintained between the two goals of adapting the training materials and developing consultative capabilities of the two RTCs.

2) Evaluation of RTC TOT course Participants

The following plan for evaluation has been developed:

-- The graduates will be sent a questionnaire which will provide some information about their own evaluation of the use they have made of what they learned in the course and how relevant they felt the course to be to course-related work on the job.

-- When in-country assistance is provided with the help of graduates from a course at the center, an evaluation will be made at the same time of how well they are able to use the knowledge and skills they had acquired at the center.

-- Visits to different countries for in-country evaluation of the graduates' work was also discussed, but no decision was made regarding the feasibility of such an evaluation. It was assumed that due to budget constraints such visits, if incorporated in the evaluation program, could not be made. before 1981.

A questionnaire has been developed for the Lome course and sent out to past participants (see Annex 6). Lagos RTC has maintained informal communication with course participants but plans to formalize an evaluation system for the course in 1981. The competencies of the TOT graduates will be best evaluated as they begin to work on VHW training courses.

OBJECTIVE II

CESSI Dakar and Yaounde

Sub-objective 1: Reformulate the CESSI curriculum in order to strengthen the programs' ability to train nurses and midwives for assuming effective roles in primary health care programs in light of new emphasis on PHC.

CESSI Dakar

The first phase of reformulating the curriculum for CESSI Dakar was carried out in 1979 with the evaluation of the CESSI program (see progress report for July - December 1979). The second phase was undertaken from March to May by SHDS consultant Dr. G. Vansintejan in collaboration with the CESSI/Dakar staff. Each step of the curriculum development process was carried out by a small task force and then discussed by the faculty as a whole to arrive at a consensus. The steps in the curriculum development process used were as follows:

1. Definition of the philosophy of CESSI with respect to primary health care, and the selection of institutional objectives;

2. Development of a conceptual model to articulate the philosophy and institutional objectives and to structure intermediate objectives and course intent;

3. Definition of intermediate objectives, to describe the knowledge, attitudes and skills to be attained by CESSI graduates. Faculty members then developed course descriptions corresponding to each intermediate objective. Primary health care approach as defined by the Alma Ata Declaration was integrated throughout. The curriculum is presently in the final stages of development and will be submitted to the CESSI technical Review Board (Composed of representatives of the University of Dakar and the Minister of Health) and WHO/AFRO. Implementation of the new curriculum is planned for October 1980. The teaching program for the new curriculum is currently being prepared. This will be done on a trimester basis including:

    1. translation of content to a trimester syllabus.

    2. meetings with outside lecturers, facilitators, and specialists in primary health care to fill in details of course content.

    3. development of a program of PHC-related practical field work.

    4. development of evaluation tools.

Planning for these steps begins during the next reporting period.

CESSI Yaounde

The first phase of the reformulation of the curriculum, i.e. evaluation of the CESSI program, continued during this period. The implementation of the evaluation questionnaires for CESSI graduates and their employers was completed in Cameroon in January. The SHDS consultant, Jeanne Carriere, began the analysis in collaboration with faculty members. As in the case of Dakar, each step requires involvement and commitment of the institution's faculty. In Yaounde, tabulation and analysis of results proceed slowly because of the complexity of the evaluation (two different groups are involved) and the acute staff shortage which limits the amount of time staff can devote to non-teaching activities. By June the tabulation and analysis were completed and the report was being prepared for typing. This will be the basis

Subobjective 1 of Obj. II - CESSI/Yaounde

for phase two reformulation of the curriculum.

The pace of activity in the CESSIs is determined by the staffing situation. While the staff is committed to program development, it's principal mandate is teaching. The staff situation in CESSI Dakar had improved this year with the continuation of an SHDS sponsored short term consultant, the addition of two Senegalese faculty, and a WHO faculty position. The situation in Yaounde was aggravated by the loss of two faculty positions. Hence, the SHDS consultant had to assume some teaching responsibilities.

Subobjectives 2 & 3 of Objective II

Sub-objective 2: To develop programs of continuing education, follow-up and evaluation for CESSI faculty and graduates in order to better respond to nursing services needs of the participating countries.

The first continuing education program will be held in December for 25 CESSI staff members and graduates who are currently teaching in basic schools of nursing. Two workshops were planned, but due to budgetary limitations only one was held. This workshop will be coordinated by AFRO and held at the RTC in Lome. A workshop program has been developed and approved by AFRO. The program will introduce the concepts of teaching primary health care, using EPI as an example. Further evaluation of CESSI graduates will be carried out during the next reporting period.

Sub-objective 3: To strengthen instructions in basic research methods which CESSI graduates can systemmatically apply in their work in identifying health service problems and finding solutions in the context of multi-disciplinary health teams especially those related to primary health care.

This subobjective is depended on the reformulation of the curriculum. However, during this period, a research program was developed by CESSI/Yaounde faculty members. This is being reviewed by CUSS, AFRO and SHDS, and may provide the context in which to train students to carry out PHC related research, as well as to carry out operational research related to health service and training. Further development of this approach is planned for the next report period.

Sub-objective 4: To continue to prepare nationals to assume responsibility of the total CESSI Program.

Following are criteria established for the award of a fellowship:

1. The candidate must be a national graduate of the CESSI.

2. The candidate must return to CESSI faculty position upon graduation.

3. The government accepts commitment to assigning the candidate to a faculty position.

Three fellows meeting these criteria for the 4 available fellowships, were identified, two from CESSI Dakar and one from CESSI Yaounde. This award of the fellowships was to be administered by SHDS, AFRO, AID/W and the respective USAID missions. The Boston University nursing coordinator worked out procedures with the AFR/RA office in this regard. SHDS and AFRO notified the CESSIs. In December, 1979 on the basis of a request by AFRO, USAID agreed to allow two of the four fellows to go to French speaking Nursing education programs at the University of Montreal. CESSI Yaounde nominated a current intern, M. Andre Noumssi as a candidate for the fellowship. Noumssi had previously been accepted to the nursing program at the University of Montreal. CESSI Dakar informed SHDS and AFRO that nominations would be determined through a national exam. The exam took place in mid-April. However, as results of the exam were not available by mid-May (deadline for most admissions to 1980-1981 programs), the GOS proposed two candidates who had been admitted to the nursing program in Montreal for 1979-80, but who had not been able to go because of the unavilability of fellowships. The candidates were M. Jean Baptiste Thiam and M. Moctar Baidy Niang, both former CESSI graduates and teachers in the Basic School of Nursing. Owing to: 1) previous admission to the University of Montreal; 2) the lack of time to apply to U.S. Schools of Nursing and 3) the lack of English language proficiency of the two CESSI Dakar candidates, AFRO and SHDS agreed to request a third waiver for study at Montreal. In a preliminary discussion with the AID/Washington representative on this matter during the SHDS PRC meeting in Brazzaville, AFRO officer was told this was possible and that an official request should be made.

In the next reporting period the remaining procedures will be implemented. SHDS has informed the Regional Affairs Office which will administer the fellowship award from AID. According to the procedures established, Washington will notify the USAID Missions, prepare the necessary PIO/P and request missions to provide medical exams as necessary. SHDS will furnish tickets and stipend advances. It is hoped that these procedures, worked out in advance, will function smoothly.

Post Basic Nursing Education in Liberia, Sierra Leone and The Gambia

Sub-objective 1: Develop and implement a continuation program in primary health care for graduates of the Basic Schools of Nursing in Liberia, Sierra Leone and The Gambia.

This subobjective, as originally planned included three activities:

1. the development of a non-degree post basic course at TNIMA (Tubman National Institute of Medical Arts) in Liberia.

2. one workshop in The Gambia, on curriculum development and,

3. a 2 week workshop, also in The Gambia, on the role of nursing in primary health care.

The first two activities could not be undertaken because a budget was not provided. The third will be carried out during the next reporting period. A workshop planning session has been scheduled for mid-July. The SHDS nursing program coordinator and AFRO temporary advisor, Professor E.O. Adebo, who served as a facilitator in the 1979 curriculum development workshop will collaborate with nursing education and service personnel in The Gambia to develop the workshop objectives, program and materials.

Sub-objective 2: To strengthen nursing service and education programs in Liberia, Sierra Leone and The Gambia through education of nurse trainers and primary health care program supervisors and managers.

The principal activities envisioned under this objective concerned the development of the nursing program at Cuttington University College. This was to be undertaken by a SHDS Field Consultant working in collaboration with the nursing faculty of Cuttington and two short term consultants recruited by AFRO to supplement the teaching staff for this program.

As originally conceived, the curriculum for the new program at Cuttington was to have been developed in the period between the first curriculum workshop and the start of classes at Cuttington in March 1980. Although consultation for this purpose had been budgeted, SHDS was not authorized by AID/W to proceed with recruitment until the proposal for this project had been approved. Following the approval of the project by the PCC meeting in Monrovia in 1979, SHDS proceeded to recruit for a field consultant position. However, the completion of this process was delayed because: 1) no action was taken on the 1980 budget until after the first quarter of the year, 2) Boston University could not make commitments to engage a field consultant for 2 years without contractual and budgetary assurances, 3) AID/W insisted that the candidate have past or present affiliation with B.U. School of Nursing. The first candidate recruited for this position was rejected by AID/W. The second candidate, Dr. Charlotte Ferguson, head of the Department of Community Health at the B.U. School of Nursing, has been approved, but no action can be taken until this position is explicitly provided for the Boston University contract with AID/W for the project during the 1981-82 period.

Subobjective 2 of Obj. II - Post Basic Nursing

Assurances are expected to be forthcoming and it is hoped the consultant will be in place early on in the next reporting period.

Four fellowships to Cuttington were provided to participants from The Gambia and Liberia. Although the AFRO/SHDS budget had not yet been approved, AFR/RA authorized AFRO to provide the fellowships. It is hoped that these 4 participants will be able to take advantage of the new curriculum during the second year of study. At present they are following the existing post-basic curriculum. Because of the political events in Liberia, no candidates could be nominated for masters degree fellowships for the 1980-1981 school year.

OBJECTIVE III

To improve regional and national disease surveillance and health information systems and to integrate these systems in the national planning delivery systems.

Although the statement of the four subobjectives of Objective III was somewhat different, the goal and purpose of SHDS Project objective III, as presented to the 1979 PCC Committee Members meeting in Liberia, remained the same. What was strengthened in the re-statement of the subobjective for 1980 was the emphasis on development of the training and information gather aspects of Obj. III. The accomplishments during the January-July 1980 period with respect to the subobjective and recommendations made by the 1979 PCC members are as follows:

Sub-objective 1: To expand immunization activities (multiple antigen) in the region.

Continued progress is being made in the expansion of immunization activities in the 3 demonstration and training countries. (Cameroon, Ivory Coast, Gambia)

Cameroon (Based on Heyman and Murphy monthly reports and studies)

Cameroon with a population of 7,663,246 selected 3 DTA's. They are Yaounde Eseka and Bamenda - Bafoussaum. (total popultation 716,'80). Although multiple antigen immunization activities began in 1977, a full time SHDS/CDC operations officer was not assigned to the Ministry of Health until March 1979 and a revised 5 year EPI plan was adopted in September of 1979. Therefore, in evaluating this program the date of September 1979 will be used. Excepting Eseka, the other 2 DTA's are now fully operational and plans to expand, beginning in July of 80 to 1981, to the towns and surrounding areas of Douala, Maroua, Garoua, Ebolowa, Sangnelina M'Balmayo, Bafia and Bentoua have been made. This would mean 1,875,145 of the total population would be covered. An immunization survey was conducted in Yaounde in November, December 1979. 209 infants between the ages of 12-23 months were selected at random according to the EPI cluster sampling method. Of the 209 infants surveyed, 31% had received all of the indicated vaccines.

Vaccination coverage surveys conducted in the other 3 areas were:

Area	Vaccines BCG	Measles	DPT(2)	Polio (3)
Eseka	56.810	11.4%	9%	3%
Bamenda	65.2%	47.8%	48%	10%
Bafoussam	66.5%	29.4%	40%	28.9%

Vaccination coverage is expected to be higher at the end of 1980 but will not achieve the 70% objective as stated in the SHDS/CDC objective III plan.

In 1979, reported cases of measles dropped from 759/100,000 cases in 1978 to 588/100,000 in 1979. Case fatality rates for hospitalized children for measles increased from 690 in 1978 to 19% in 1979. Based on records of first consultation at the Center for Re-education of Handicapped Children of Yaounde polio rates dropped by 32% from 1978.

Mortality rates remained approximately the same in 1978 and 1979. A study was conducted in 1979 by Dr. Judith Brown to assess the sociological variable

Sub-objective 1 of Objective III continued.

A cost effectiveness study that was planned for the Ivory Coast has not yet begun. The protocol to be used in the Ivory Coast was recommended by the members of the PCC to be used as a basis for carrying out similar studies in the other SHDS 20 countries. Unfortunately funds have yet to be found to do this study.

The SHDS/CDC sub-regional epidemiologists assigned to OCCGE has been collaborating with WHO and the Government of Upper Volta in the implementation of their EPI program. This collaboration is expected to continue and possible consultancy will be carried out in Togo and Mauritania later this year. Measles vaccine in Ivory Coast and the other OCCGE countries has been received. Unfortunately all vaccines were not received as scheduled due to budgetary problems. This has since been rectified and the countries are now receiving their orders.

GAMBIA (based on reports submitted by Dr. Harry Hull and Steven Fitzgerald)
The Gambia with a population of 600,000 began its operations in May of 1979, in the north Bank Division; however lack of transport and appropriately trained personnel dictated a shift to the Western Division. By September 1979 an initial start of EPI in Western Division including Banjul and Kombo St. Mary was begun.

In April of 1980 a vaccination coverage survey was performed in the Western Division. Since full operations began in October of 1979, the results after 6 months of operations were quite good.

DPT (3) - 61% coverage
Measles - 48.4%
Polio (3)- 23% (low coverage due to unavailability of vaccine)
BCG 88.7%

In May of 1980 a vaccination coverage assessment was carried out in Kombo St. Mary and Banjul in conjunction with the middle-level course. Coverage rates were as follows:

DTP (3)	53%
Polio (3)	33%
Measles	41.1%
BCG	86.8%

Problems affecting the coverage rates have been lack of vaccine and an adequate cold chain system. With improvements in both of these areas it is expected that 78% vaccination coverage should be obtained 18 months after commencement of field operations. Baseline data on morbidity and mortality of measles, polio and neonatal tetanus is being collected. A revised surveillance form has been developed and will be tested in January, 1981.
A proposed health impact study to be carried out in conjunction with the EPI program agreed to by AID and the MOH, however funds have yet to be found. Measles vaccine was received, but The Gambia's request for an increase in their original requirements has not yet been responded to. A program audit (similar to the one done in Sierra Leone) is proposed for October-November in The Gambia.

Sub-objective 2: Development of training capabilities (to provide training in the region in EPI management and methodology, disease surveillance, data collection and epidemiology and to strengthen regional training capabilities in these subjects).

CAMEROON AND OCEAC COUNTRIES

A meeting with the AID Director, the Director General of OCEAC, Dr. Sentilles, SHDS/CDC sub-regional epidemiologist Dr. Heymann and the assistant director of SHDS was held in Yaounde in April 1980. At this meeting Dr. Sentilles fully supported the idea of an African assigned to OCEAC to work with and be trained by the SHDS/CDC sub-regional epidemiologist. He requested that SHDS confirm the amount budgeted and said that the selection of a counterpart would eventually replace the SHDS/CDC epidemiologist, he felt it would be best to train one national annually, and then at the end of 3 years, one from among these three would be selected.

In late June a budget for travel and perdiem for intra-African travels and CDC/Atlanta was approved for African counterparts to the OCEAC and OCCGE SHDS/CDC sub-regional epidemiologists. It is hoped that this budget will be carried over to 1981 as timing does not permit the placement of an epidemiologist in 1980. An African counterpart for the SHDS/CDC operations officer was identified and trained before the operations officer arrived. Since his arrival other persons have been trained to work with him in the implementation of the EPI.

Various in-service training programs have been conducted in Yaounde and the other three DTA's of the Cameroon. A mid-level course for personnel from Cameroon and the other 5 OCEAC countries is planned for August-September 1980. The SHDS/CDC epidemiologist has continued to train medical students at the CUSS and conducted two 3-day seminars on cholera in Congo and Gabon.

IVORY COAST: OCCGE

Five Ivorian public health personnel received extensive training in vaccination techniques, disease surveillance program planning and program evaluation methods in order to launch the Ferkessedougou area program in early 1980. Eight medical officers from Rwanda, Algeria, Senegal, Mali, Togo, Zaire, Guinea and Madagascar, participating in the seventh international WHO sponsored epidemiologic course held in Abidjan, received formal and field training in disease surveillance and vaccination coverage assessment through EPI Ivory Coast. Health education programs on EPI were implemented this year in all the primary schools within the active EPI zones. Puppet shows on immunization live and on video tapes, radio announcements and numerous newspaper articles are ongoing activities to promote and train people and to increase public awareness of preventive health care. A mid-level mangers course for Ivorians and EPI personnel from the other OCCGE countries is planned for January 1981. In August 1980 an Ivorian counterpart, Andre Kouassi, will be assigned to be trained and eventually take over the responsibilities of the SHDS/CDC operations officer. A meeting is scheduled for August with the secretary General of OCCGE, Dr. Cheik Sow, to discuss the placement at OCCGE of an African counterpart to the SHDS/CDC medical epidemiologist assigned there.

THE GAMBIA ANGLOPHONE REGION

As there is no anglophone epidemiologic entity equivalent to OCEAC and OCCGE, contact was made in March of 1980 with the West African Health Community in

Sub-objective 1 of Objective III continued

influencing the immunization status of children. The most important variable found to influence the vaccination status of children was the ethnicity of the parties. High rates of coverage were attained by ethnic groups native to the West and North of Cameroon and low participation of those born in Yaounde and in the south Cameroon. This difference was also rated in surveys of vaccine coverage done in 1979 in the towns of Bafoussam and Bamenda.

Visits to Congo and Gabon by the SHDS/CDC medical epidemiologist have been carried out. A review of the disease surveillance system of Congo was completed and recommendations were made. Measles vaccine for the OCEAC areas has been received as requested. Based on recommendations from WHO and the USAID mission no vaccine was sent to CHAD. The Central African Republic has requested an additional 40,000 doses of vaccine following the cut in vaccine supply from UNICEF. Although the American mission and WHO agree that SHDS could supply vaccine, a decision is pending information from UNICEF as to the reason for their cut-back.

IVORY COAST

Ivory Coast with a population of 7,000,000 has developed DTA's in 3 zones as planned (Abidjan, Abengourou and Korhogo) and has enlarged the zones to increase the population served from 1.5 million people 1979 to nearly 2 million in 1980. Plans for expansion in 1981 have been developed. EPI activities were considered to be in full operation in Abidjan and Abengourou in Jan. 1979. Vaccination coverage rates for these two areas have surpassed 60% and it is expected that the rates should surpass 70% (The SHDS/CDC stated target goal in 1981). Korhogo, the third DTA which became fully operational in January of 1980 has achieved an average coverage rate of 50% and should achieve 70% 18 months after it becomes fully operational.

Morbidity and mortality reports for measles, polio and neonatal tetanus in the 2 DTA's indicated the following:

Abidjan

Measles:	Out patient measles cases up	24%
	Hospitalized cases up	44%
	Hospitalized measles deaths up	37%
Polio:	Hospitalized cases down	46%

Abengourou

Measles:	Outpatient measles cases up	32%
	Hospitalized measles cased down	5%
	Hospitalized deaths no change	
Polio:	Hospitalized cases unchanged	
	Hospitalized deaths (no change 0 in 78, 0 in 79)	
Neonatal tetanus:	Hospitalized cases unchanged	
	Hospitalized deaths down	9%

Sub-objective 2 of Objective III continued

Lagos, Nigeria, to discuss the possibility of creating an anglophone epidemiology service. The idea, was favourably received but it was felt that this idea should be developed slowly and carefully because the member countries were not able to make major committments ac this time. Counterparts to both the SHDS/CDC medical epidemiologist and operations officers were selected in 1979 and continue to work closely with the SHDS/CDC personnel.

Late in June 1980, a budget was approved that would provide perdiem for intr-Africa travel for a Liberian, and Sierra Leoneon to work with, and be trained by, the SHDS/CDC medical epidemiologist. A letter has been sent to the MOH of Liberia and Sierra Leone informing them of these funds. A request was made by SHDS to the SHDS/CDC epidemiologist to collaborate with these countries in designing an appropriate training program. In May a mid-level managers course was held in The Gambia for Gambians and 6 nationals from the other SHDS anglophone countries. The purpose of the course was to help participants develop skills needed to manage immunization activities. Each of the modules listed below describes and teaches a major task that must be performed in an immunization program.

- allocate resources
- manage the cold chain
- conduct vaccination sessions
- supervise performance
- provide training
- evaluate vaccination coverage
- ensure public participation

The course managers consisted of 6 Gambians, 5 SHDS/CDC personnel working in the field, one representative from WHO/Gambia and CDC/Atlanta and the SHDS assistant project director. The teaching methodology used in this course was one of individual assistance, small group discussion, demonstrations, role playing and vaccination coverage assessments. There were 37 course participants among which 6 were from Sierra Leone, Ghana and Nigeria. Training is an essential and on-going activity of the Gambian EPI operations. Training had included such topics as repair of kerosene refrigeration units, jet gun maintenance and repair, cold chain, cluster survey methods and so on.

In April of 1980 the SHDS assistant director and an official from WHO/Geneva met with the personnel of the WHO RTC in Lagos and members of the Nigerian federal epidemiologic unit to complete a plan of operations for introducing the WHO EPI course materials into their 1981 curriculum. At this meeting the following recommendations were made:

1. To hold EPI mid-level management course for personnel involved in training of trainers course offered at the WHO Regional Training Center, Yaba. The course is scheduled for early October.

2. Dr. A.O.O. Sorungbe, senior consultant epidemiologist will be responsible for the selection of the course participant and for all the registered and administration matters. Dr. El-Neil will make available the facilities of RTC for the course.

Sub-objective 2 of Objective III continued

3. WHO/AFRO in collaboration with SHDS will provide the facilitators

4. Funding for the local subject matter committee participants will come from SHDS/AFRO budget.

5. WHO will provide the initial set of course materials. The residential course is scheduled for 6 Oct. - 16 Oct. At the end of the course a mechanism for the integration of the EPI materials into the RTC curriculum will be developed.

Sub-objective 3: Development of capability to gather information (data necessary for health planning, including demographic data.) (To strengthen regional and national systems of disease surveillance and health information gathering necessary for effective health planning.)

CAMEROON - OCEAC

An indepth study of the surveillance systems of the Cameroon and Congo was completed by the SHDS/CDC medical epidemiologist. Much thought has recently been given to the Grandes Endemies system has been written. The first draft was revised at the June 1980 OCEAC technical conference by the directors of public health of C.A.R., Gabon, Congo and Cameroon and a final draft will be submitted to the ministers of health in November. SHDS has been consulted by the secretary of OCEAC requesting aid in printing the final surveillance forms and in recycling health personnel for this system. This is in line with our objectives. The OCEAC newsletter distribution continues to grow. Investigations of monkey pox and suspect homorrhagic fever were carried out in Cameroon early this year. The annual epidemiol conference that was be held in the Cameroon was held in The Gambia.

IVORY COAST-OCCGE

The SHDS/CDC sub-regional epidemiologist assigned to OCCGE officially assumed his responsibilities in April of 1980. He has evaluated the Upper Volta and Ivory Coast surveillance systems. Reports on these are in progress at this time. Ivory Coast began limited distribution of a quarterly EPI bulletin in May 1980. Discussions between the Director-General and the SHDS/CDC epidemiologist about publishing a sub-regional EPI bulletin were held. The preference of the Secretary General was that this bulletin should not be separate from the one they publish.

THE GAMBIA-ANGLOPHONE SUB-REGION

The Gambia epidemiologic surveillance system has been analyzed and a report submitted to the government. A new system for collection of out-patient data has been designed and will be placed in a small number of health centers for a trial period of several months.

Sierra Leone surveillance system was analyzed in part during the October 1979 EPI evaluation. A report from this visit has been submitted to the government and a request for a more complete evaluation has been made.

Liberian surveillance system will be evaluted in October of 1980. An outbreak of probably meningococcal menigitis occurred in March 1980 and was investigated by the Gambian counterpart to the SHDS/CDC epidemiologist.

Sub-objective 3 of Objective III continued

In April of 1980, the first SHDS/CDC regional meeting on disease surveillance and immunization was held in the Gambia. The intent of this originally planned Cameroon conference was to present papers for discussion by SHDS/CDC personnel in the field on the results of their work and to provide and opportunity for Africans who are involved in various disease surveillance and epidemiological activities to present and have discussion on their studies. (See Telex #972) The persons attending the conference were for the most part CDC personnel and personnel from The Gambian Ministry of Health. WHO was represented by the WHO country coordinator Dr. Akim, Dr. Ralph Henderson and Mariane Hamuman from Geneva. Personnel in the field are not often given a chance to have their work criticized. This conference provided such an occasion. The bi-monthly Gambian EPI newsletter has now published 4 issues. It serves to provide results of epidemiologic investigations, and health education lessons, and discuss policy decision with field staff. A regional newsletter is pending a more formal association of the anglophone countries.

Sub-objective 4: To develop a coordinated laboratory system to provide necessary back-up services to the disease surveillance and control systems.

CAMEROON OCEAC

Laboratory continues to develop. Equipment has arrived.

IVORY COAST - OCCGE

SHDS/CDC and WHO assisted Institute Pasteur with training of personnel and provided laboratory supplies for implementing measles vaccine testing and updating Polio vaccine titration technique. Vaccine titration will continue to be carried to EPI in 1981. Laboratory facilities at the Center Muraz have not yet been explored by the SHDS/CDC epidemiologist. A visit is planned in August 1980.

GAMBIA-ANGLOPHONE

Visits have been made to the Pasteur Institute/Dakar and the MRC/Fajara to survey current capabilities. Both insitutions have indicated a willingness to provide laboratory back up.

SUMMARY

During this 7 month period, SHDS emphasized the training aspect of this objective SHDS assistant director, operation officer assigned to the Ivory Coast and personnel who had previously attended the SHDS/Sponsored EPI African top-level managers course were chosen by WHO to be facilitat at the first worldwide top-level EPI course held in Brazzaville in March It is expected that the trained African personnel will conduct training i their own countries. and replace the majority of international personnel as trainers of international EPI course. These courses (the top-level and mid-level one in The Gambia) have had a strong impact in the development of well organized EPI activities in the SHDS 20 countries and also in encouraging active participation in planning and implementing programs by mid-level supervisory personnel.

MID-YEAR PROGRESS REPORT, JANUARY-JULY 1980
OBJ. IV - LOW COST HEALTH DELIVERY

The 4th of the SHDS objectives has been the slowest in getting underway. However, in this 6 month reporting period much was accomplished in developing the plans forthe 1st regional applied research course as well as to develop final pl ns for the research program as a whole. The following was accomplished:

Sub-obj. 1 To strengthen individual and institutional capability within the region, to do applied research which will improve the functioning of low-cost (affordable) health delivery systems (in collaboration with WHO/AFRO).

In March of 1980 a trip was made to Africa by SHDS consultant Dr. Mousseau-Gershman and SHDS Boston staff person Dr. Ann Brownlee. The objectives of their trip were:

a) To meet with consultant trainers and SHDS and AFRO staff to plan the course on preparation of research protocols. The agenda for these meetings included development of the final version of the course objective, design of course schedules and identification of course materials, cases studies etc. needed.

b) To work with SHDS and AFRO staff to plan the WHO/SHDS Program of Applied Research in Health Service Delivery and Primary Health care. This involved developing appropriate program mechanisms for a) encouraging development of proposals; b) reviewing and selecting proposals for funding; c) supervising and supporting work in progress; and d) disseminating results and encouraging their utilization.

A) WHO selected two temporary advisors to be trainers along with SHDS consultant, Dr. Mousseau-Gershman and Dr. Ann Brownlee. They were Dr. Thomas Nchinda from Cameroon and Dr. Pape Soulaye N'diaye from Senegal. The course site of Ouagadougou, Upper Volta was selected, however the dates as planned 28 July - 7 August were not acceptable to the Government and new dates had to be arranged.

The SHDS consultant, and Dr. Brownlee met with AFRO staff involved in applied health services research as well as with Dr. Nchinda in the Cameroon and Dr. N'diaye in Senegal. During these meetings, it was agreed that approximately 10-15% of the course would be devoted to theory and 85-90% to practical exercises and group work. The course objectives were defined as follows:

- Give examples of major types of applied research currently used to address problems of health service delivery and primary care.

- List major donor agencies with interest in funding various types of applied research within his own country and demonstrate how a proposal may be adjusted to meet specifications of the organization to which it is addressed.

- Select an appropriate research project, considering priority health care problems, investigator skills and interests, available resources and the potential applicability of research results.

- Prepare a description of background on the problem selected for study indicating briefly what the problem is, why and how it was chosen for study, its relevanceto national and regional priorities, and what relevant findings are available from past research.

- Prepare appropriate research objectives for the project.

- Develop an appropriate research design for the project.

- Develop a project work plan adapted to local conditions, including a schedule for the research, monitoring adminstrative and evaluative activities involved.

- Prepare job descriptions with time requirements for project personnel and identify potential staff and consultants.

- Identify and describe the institutional and administrative support needed for the project.

- Prepare a realistic and appropriate budget for the project.

- Outline a post course strategy for completing the proposal and obtaining project funding.

It was decided that the course sessions would focus on the following topics:

- Definition of health services, research, types of research
- Identification of potential sources for project funding
- Discussion of problem selected for research, relevance of the research to the country's needs,
- Selection of research objectives (long, medium and short term)
- Development of research methodology (research methods, sampling variables, data collection, analysis and interpretation of results)
- Development of a plan of work, schedule for project monitoring
- Planning the administration and evaluation of the project
- Selection of project staff, use of local and international consultants, planning for any necessary staff training,
- Development of project budget.

During the ensuing months the trainers developed their teaching materials and these were reviewed by Dr. Brownlee who put them into instructional outline form and compiled the course book.

B) Design of the WHO/SHDS program of applied research on Health Service Delivery and Primary Health Care.

Discussions were held with WHO/AFRO staff concerning final plans and guidelines for implementation of the joint program in applied research. The attachment is the description of the mechanism for project selection that was proposed to WHO. In June of 1980 AFRO responded recommending that alternative 2 be used ie., that once SHDS reviews the proposals they submit them to the WHO designated person who would then circulate copies to the members of WHO/AFRO's Research Development Committee. This committee would be requested to respond within a designated period of time, and the majority opinion of those responding would be taken as the decision, SHDS Abidjan would then be notified.

This process was discussed with AID/W and they strongly felt that AID/W should be able to review the proposals and contact their country missions for clearance, This point will be dicussed in further detail and hopefully it will be resolved before the next P.C.C. meeting in November. Mechanisms for disseminating results and encouraging their utilization have not yet been developed as it is felt once the initial research projects are selected and implemented there would be a clearer idea concerning that type of results that will be forth coming.

Sub obJ III To develop appropriate training of personnel in the areas related to quality control, purchasing, storage and distribution of drugs and medical supplies.

No action was taken on this as no budget had been approved and there seems to be a conflict of opionion as to whether or not SHDS should be involved in this activity.

SUMMARY:

Although there were some problems in coordinating the visits of the SHDS/consultant and WHO/AFRO temporary advisors, the brief working sessions were most fruitful. Further problems entailed dates of the course and the conflict in SHDS consultants schedules. Due to the uncertainty about course dates the reproduction of course materials and administrative planning was some what impeded.

WORLD HEALTH ORGANIZATION

Regional Office for Africa

ORGANISATION MONDIALE DE LA SANTÉ

Bureau régional de l'Afrique

STRENGTHENING OF HEALTH DELIVERY SYSTEMS IN CENTRAL AND WEST AFRICA

REP/02

Meeting of the Project Review Committee

Brazzaville, 23-27 June 1980

ICP SPM 013

DRAFT FINAL REPORT

CONTENTS

		Page
1.	INTRODUCTION	1
2.	WHO/USAID JOINT MID-TERM EVALUATION	2
3.	REVIEW OF PROJECT ACTIVITIES FROM SEPTEMBER 1977 TO JUNE 1980	4
4.	SCOPE OF AID COLLABORATION	7
5.	PROPOSED ACTIVITIES FOR THE SECOND HALF OF PHASE II (JULY 1980 - DECEMBER 1982)	8
6.	DESIGNATION OF THE NEW MEMBERS TO SERVE ON THE PROJECT COORDINATION COMMITTEE	11
7.	DATE AND PLACE OF THE NEXT MEETING OF THE PROJECT COORDINATION COMMITTEE	11
8.	DATE AND PLACE OF THE NEXT MEETING OF THE PROJECT REVIEW COMMITTEE	11
9.	DATE OF NEXT EVALUATION	11
10.	CONCLUSIONS	12
11.	RECOMMENDATIONS	12

ANNEXES

1. List of participants
2. Address by the Regional Director
3. Programme of work.

1. INTRODUCTION

1.1 The Project Review Committee (PRC) for the Strengthening of Health Delivery Systems (SHDS) met in Brazzaville, People's Republic of Congo from 23 to 27 June 1980. See Annex 1 for the list of participants. The opening ceremony was chaired by Dr Comlan A. A. Quenum, Regional Director, who extended a warm welcome to the participants. He recalled that the World Health Assembly decided that the main social target of governments and of WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Projects should therefore be considered as a step for achieving this socially relevant target through the Primary Health Care (PHC) approach.

The Regional Director underlined, as a good example of international cooperation, the great victory over smallpox, a disease which spread terror for centuries. This victory was acknowledged by the last Health Assembly. Such results, he said, constitute strong stimuli for pursuing the struggle for the establishment of social justice in the field of health in Africa and the Project for Strengthening of Health Delivery Systems in Central and West Africa is one of the mechanisms for international cooperation (see Annex 2).

1.2 Election of officers

The following office bearers were elected for the meeting:

Chairman - Dr E. A. Smith (Nigeria)

Vice-Chairman - Dr L. Adande Menest (Gabon)

Rapporteur - Dr J. Wright (Niger)

1.3 Adoption of programme of work

The proposed programme of work was adopted without amendment. See Annex 3.

1.4 Method of work

The participants agreed to the following working procedure. All discussions would be held in plenary session. A summary of the principal points discussed and decisions reached would be prepared daily for the participants. Participants would make their written corrections on this summary for inclusion in the final report. The corrections which should be in line with the intent of the discussions should be handed in on the following morning. The draft final report of the meeting would be considered on the last day by the participants at the plenary session.

2. WHO/USAID JOINT MID-TERM EVALUATION

2.1 Dr Ashitey, Chairman of the joint WHO/USAID Evaluation Team presented a summary report. After recalling the overall goal and the objectives of the project, he stressed that the Project Agreement signed by WHO/AFRO and USAID in September 1977 provided for the mid-term evaluation of the second phase of the Project. This evaluation took place from 25 February to 22 April 1980. He gave the composition of the team and a short description of the evaluation methodology utilized. Dr Ashitey underlined that the evaluation report consists of a review of SHDS activities to date, the inputs, achievements, problems, and recommendations for each of the four project objectives, and also some recommendations on the overall project administration and programme support.

2.2 The following points were raised during the ensuing discussions:

(i) time allotted for the evaluation was considered too short;

(ii) results of the evaluation were not entirely satisfactory; many delegates mentioned that the lack of indicators and quantifiable objectives as well as budgetary and cost information did not allow for an in-depth and objective evaluation. They recommended the utilization of the WHO Evaluation Guidelines (document HCP/DPE/78.1) for the establishment of a system for continuous evaluation and to obtain active participation of the nationals;

[illegible]

(iii) absence of information on the cost of the evaluation mission;

(iv) the need for an increased utilization of national and regional resources within the framework of the project.

[illegible]

2.3 Certain clarifications were given to the participants:

(i) the reason for the delay of personnel recruitment; the example of the STC for Cuttington College Liberia, whose recruitment could not be finalized because of administrative delays in funding, was cited.

(ii) with regard to the improvement and expansion of training facilities in the Regional Training Centres at Lome and Lagos, it was explained that the proper role of WHO is to collaborate with the governments in mobilizing resources;

(iii) USAID indicated that timely delivery of vaccines could be assured if:

(a) there is timely notification of needs by countries;

(b) countries report the utilization of these vaccines;

(iv) the lack of information concerning SHDS activities; sharing and dissemination of information about SHDS activities do not exist except for news letters from RCI, Gambia and OCEAC

(v) as far as SHDS coordinating mechanism at country level is concerned, it was agreed that this mechanism should be country specific.

2.4 The representative of the Fund for African Cooperation (FAC) assured continued support to various countries on a bilateral basis as well as to OCEAC and OCCGE if requests were made. He further stated that his attendance at this meeting would enable him to present the PRC's recommendations to his Govenment. FAC considers its activities comlimentary to those of the project.

2.5 Finally, participants took note of the Evaluation Report but requested a better French version.

3. REVIEW OF PROJECT ACTIVITIES FROM SEPTEMBER 1977 TO JUNE 1980

The SHDS Project Director reviewed the main activities of each of the SHDS objective

3.1 Objective I: To Improve National and Regional Health Planning and Management.

3.1.1 The following activities were stressed: provision of fellowships to the Dakar Centre for Health Planning and Management; six weeks course for senior health officials; two weeks middle-level managers course; First Ministerial (top-level) Intersectoral Management workshop and expansion in training and support activities at the country level through Country Health Programming workshops and exercises.

3.1.2 The discussion of these activities noted the following:

(i) efforts are being made to reinforce national institutions of management and administration to train health programme managers, the ultimate goal being the establishment of a regional network of health management training institutions;

(ii) top-level management workshops help national decision makers better utilize national resources in particular the skills of their technical and professional staff;

(iii) Regional intersectoral management workshops should be followed up by similar activities at the country level;

(iv) a reorientation of the project activities is needed in order to attain the goal "Health for all by the year 2000".

3.2.1 The following activities were highlighted:

(i) for the Lomé and Lagos Regional Training Centers:- local development of instructional materials for training village health workers; the holding of three courses for village health worker trainers; the development of follow-up capabilities to help graduates of trainers courses to design in-country courses and adapt training materials;

(ii) for CESSI Dakar and Yaoundé: evaluation of the programmes of both institutions; continuing education programme for CESSI graduates: and revision of the curriculum to emphasize primary health care;

(iii) for the Post-basic Nursing Education Programme for The Gambia, Sierra leone and Liberia: approval given for the development of the programme in Cuttington Univetsity College. The programme started in March 1980 with (6) students.

3.2.2 The ensuing discussions drew attention to the following:

(i) there was general agreement that it is in the interest of all governments ar their responsibility to properly select and utilize candidates for training;

(ii) all requests for follow-up activities related to graduates of the Regional Training Centres should be addressed to the WHO Regional Office;

(iii) the function of the Regional Training Centres is to offer opportunities for continuing education often unavailable in countries, and to provide training which countries are unable to organize for limited number of students and also when it is difficult to change existing programmes;

(iv) efforts should be made to train a critical core of VHW trainers for each country;

(v) more detailed information should be provided on the costs and benefits of these training programmes of each country

3.3 Objective III To Improve Regional and National Disease Surveillance and Health Demographic Data Systems and to Integrate these Systems into National Health Planning Delivery System.

3.3.1 The review of project activities stressed the development of the three demonstration and training areas (DTAs) in Ivory Coast, evaluations of the impact of EPI on mortality and morbidity, the expansion of regional and national training activities for senior and middle-level EPI personnel, and the growth in data collection capabilities;

3.3.2 The discussion relative to the above brought out the following points:

(i) the mobilization of resources to develop the Ivory Coast DTA is a model which other countries might find useful;

(ii) because of ecological diversity, 2 or 3 new sahelian DTA's should be considered;

(iii) SHDS project should consider collaborating with partcipating countries in developing cold chain systems and obtaining needed vaccines;

(iv) data colllection, and development of information systems should receive more emphasis, including special training courses; and the exchange of epidemiological data within the region in collaboration with AFRO.

3.4 Objective iv: Low Cost (Affordable) Health Delivery Systems Development.

3.4.1 The achievements mentioned during this review included the three PHC workshops held at the CUSS in Yaoundé, the compilation of workshop papers into a training manual, the eleboration of applied research guidelines, a workshop in applied research methods, and a study carried out on pharmaceutical supply distribution and storage.

3.4.2. The following comments were made in the ensuing discussion:

(i) the delegates of the participating countries requested the Project to take responsibility for the publication in 3 volumes of the PHC manual, a revised version of which has recently been submitted to AFRO for review; taking into account recommendations made by the ad hoc committee.

(ii) with regard to development of local pharceutical industries, it was observed that as studies are being undertaken by many organizations such as ECA, ADB UNIDO, WHO, etc., it was considered an unnecessary duplication of effort for SHDS to continue with this activity;

(iii) following the reorientation of the original proposal towards health services research, emphasis should be given to the development of national research capabilities the ultimate goal of which is the establishment of a regional network of national research centres;

(iv) applied research activities should be carried out within the context of the

4. SCOPE OF AID COLLABORATION

4.1 Mr. Ruoff, the AID representative, introduced the subject. He recalled that the project paper endorsed by the PRC in July 1977 was accepted by AID. He explained that since AID has limited funds, some activities have been selected for its contribution in the project expecting that other agencies would come forward to collaborate with the project. The AID is satisfied with the progress of the SHDS as reflected in the mid-term joint evaluation report. This, along with the Project Coordination Committee (PCC) meetings and WHO consultation, encourages them to continue supporting the project. Mr. Ruoff also explained that as the AID budgeting procedure does not permit him to make any commitment at this time, he would take the recommendation of this PRC back to Washington for consideration.

4.2 The following points were raised during the discussion:

(i) the assistance of AID through SHDS was appreciated by the participating countries with the hope that this collaboration will continue beyond 1982;

(ii) in order to achieve the objectives, the participation of other cooperating agencies is to be encouraged;

(iii) since the Cotonou Health Development Centre falls within the Objective I of the SHDS project which is considered a top regional priority, the PRC noted with concern that no explanation was given for the refusal of AID to contribute to its funding.

(iv) in view of rapid changes and new developments in the health field, the delegates requested that AID maintain a flexible funding policy in respect to the SHDS project.

4.3 The representative of ECA stated that as an observer he had no mandate to commit his organization; he would, however, submit the recommendations of the PRC to his organization for consideration.

5. PROPOSED ACTIVITIES FOR THE SECOND HALF OF PHASE II (JULY 1980 - DECEMBER 1982)

The Project Director presented the proposed activities for each of the objectives.

5.1 Objective I: To Improve National and Regional Health Planning and Management. Gestion in French

5.1.1 The proposed activities included holding further intersectoral management workshops at regional and national level, introducing planning courses related to EPI and other aspects of PHC, continuing support to country health programming exercises, providing resident internships in applied research in health planning and management and strengthening training capabilities of national management and administration institutions.

5.1.2 In the course of the discussion, the following points were brought out:

(i) the proposed Health Planning and Mangement project in Dakar is one of the collaborating institutions through which activities under Objective I could be implemented;

(ii) increased emphasis should be placed on supporting activities at country level aimed at developing national training capabilities.

5.2 Objective II: To Increase Skills and Improve Utilization of Health Personnel Providing Generalized Health Services at Supervisory and Local Levels.

5.2.1 The proposed activities included the continuation of VHW trainers courses, in-country follow-up of graduates of the Regional Training Centres, continuing education workshops and development of PHC-oriented curriculum for the CESSIs and Cuttington University College nursing programme.

5.2.2 The ensuing discussion emphasized the following points:

(i) SHDS's activities should be coordinated with bilateral programmes in the development of national PHC programmes and national training institutions;

(ii) although participating countries may require scores of VHW trainers to meet their needs, they should realize that the training of trainers needs to be carried out carefully by competent personnel;

(iii) attention should be given to the possibility of developing a regional centre for training post-basic nursing tutors; such an institution would allow for the training of CESSI teachers within the African Region.

5.3 Objective III To Improve Regional and National Disease Surveillance and Health Demographic Data Systems and to Integrate these Systems into National Health Planning Delivery Systems.

5.3.1 The proposed activities included those related to the expansion of immunization activities and the development of regional training capabilities, national data collection and laboratory back-up services to the disease surveillance and control systems.

5.3.2 Subsequent discussion made the following points:

(i) It was proposed that (regional epidemiologists adhere to scheduled visits.)

(ii) as the present DTAs attain desired levels of EPI development, consideration should be given to channelling SHDS support to other countries where EPI programmes are just beginning;

(iii) SHDS support to EPI programmes should be sufficiently flexible to respond to various national priorities in the control of transmissible diseases;

(iv) participating countries and support agencies should continue to give highest priority to ensuring that national counterparts are assigned to SHDS EPI personnel including epidemiologists and that the former are properly trained;

(v) SHDS project should support the development of the health education component of EPI programmes;

(vi) data collection systems for EPI being part of national health information systems should be developed within the context of improving national health planning and management capabilities;

(vii) nationals involved in EPI should be invited to future SHDS/WHO/CDC epidemiological conferences;

(viii) SHDS activities in regard to laboratory development are aimed at supporting the EPI

programmes through the strengthening of selected laboratory facilities while Regional Training Centres concentrate on the preparation of laboratory technician trainers for the participating countries.

5.4. Objective iv: Low Cost (Affordable) Health Delivery Systems Development.

5.4.1 The proposed activities were related to the development of capabilities to do applied health services research and to the support of regional systems for pharmaceutical production and distribution.

5.4.2 The highlights of the ensuing discussions were as follows:

(i) the delegates unanimously decided that the finalization and publication of the PHC manual produced during the SHDS-sponsored PHC workshops at the CUSS, Yaounde, should be the responsibility of the project;

(ii) whereas there is currently no apparent need for further studies, SHDS collaboration was welcomed in implementation activities;

(iii) SHDS funding for applied research projects is applicable to proposals submitted by participants of the research workshops and by nationals who wish to carry out operational research related to specific SHDS project activities in their countries, as long as they follow the applied research guidelines.

5.5 All efforts to expand the institutional base of the project as well as diversify health related activities should be developed within the existing administrative structure of SHDS and should be considered at future PCC meetings for review and approval

5.6 SHDS should submit detailed budget report to future PCC and PRC meetings, along with the annual implementation plans.

6. DESIGNATION OF THE NEW MEMBERS TO SERVE ON THE PROJECT COORDINATION COMMITTEE

6.1 The Brazzaville meeting of July k977 approved the formula for the composition of the Project Coordination Committee. Several new formulae were proposed but the members decided to continue with the one established in 1977.

6.2 As Equatorial Guinea was neither English nor French-speaking, the representative opted to join the English-speaking group.

6.3 The representative of Equatorial Guinea withdrew his country's representatic: in favour of Nigeria, the next on the list, with the understanding that Equatorial Guinea would be a member of the next PCC.

6.4 Based on the 1977 formula, the terms of office of country representatives of Benin, Chad, Gambia and Ghana came to an end. For 1980-1982, the country representatives would be Central African Republic, Congo, Liberia and Nigeria.

7. DATE AND PLACE OF THE NEXT MEETING OF THE PROJECT COORDINATION COMMITTEE

The next meeting of this committee will be helf 10-14 November 1980, in Cotonou, People's Republic of Benin. The Government of Benin has graciously accepted and has confirmed its willingness to host this meeting.

8. DATE AND PLACE OF THE NEXT MEETING OF THE PROJECT REVIEW COMMITTEE

Regret was expressed at the Ivory Coast's inability to host this meeting this year. It was decided to hold the next meeting in Abidjan in June 1982. The exact date would be decided through correspondence.

9. DATE OF NEXT EVALUATION

the PRC opted for the utilization of the WHO guidelines for the next evaluation. The participants stressed the need for the timely preparation of the evaluation which should start as early as January 1981. Furthermore, they proposed that the composition of the joint evaluation team should be composed of representatives from WHO, AID, participating countries and external evaluators.

10. CONCLUSIONS

The SHDS project, in the three major objectives which have been operational for a significant period of time, is judged to be of value to the member

promise for fostering health service development.

The development, within the framework of TCDC, of regional networks of National Management, Training and Research Centres is a realistic approach for attaining regional self-reliance.

Delegates of participating countries to PCC and PRC meetings have an important rule to play in fostering communication between government authorities, health personnel, USAID and WHO staff in respect to SHDS project.

SHDS activities and national projects receiving USAID bilateral cooperation should be mutually supportive.

The last of quantifiable objectives, the inadequacy of the evaluation methodology and the short period given to the joint USAID/WHO joint evaluation team allow neither an indepth mid-term project review nor a review of the project's progress.

In spite of certain shortcomings of the evaluation report, the PRC has noticed that this document contains the essential elements allowing the participants to present recommendations for future action and reorientation of project activities.

Health development being a dynamic process, certain reorientations of project activities, and subsequent budgetary adjustments, are necessary.

11. RECOMMENDATIONS

The following are the recommendations:

11.1 AID collaboration should continue beyond December 1982 so that project objectives are completely attained.

11.2 WHO/AID and participating countries should do their utmost to urge other cooperating agencies to join SHDS.

11.3 For future evaluation of SHDS projects:

(i) WHO Provisional Guidelines (HCP/DPE/78) should be followed;

(ii) a questionnaire based on the above guidelines should be sent in advance to enable participating countries prepare for the evaluation;

(iii) Evaluation Team should include WHO, AID, SHDS and countries' representatives;

(iv) sufficient time should be allotted;

(v) preparation should start as soon as possible, preferably January 1981;

(vi) SHDS project should quantify objectives whenever possible for presentation to the next PCC meeting;

(vii) management information system for the project should be developed to allow for continuous evaluation of activities and monitoring of expenditure for each country.

11.4 Within the framework of the project every effort should be made to utilize optimally national and regional ersources.

11.5 The mechanism for mobilizing and coordinating resources for the Ivory Coast EPI programme is a possible model for other countries.

11.6 Every country should set up a suitable mechanism to coordinate SHDS activities.

11.7 Because of ecological diversities, SHDS should consider setting up 2 or 3 DTAs in the Sahelian region.

11.8 SHDS should take appropriate steps to extend the collaboration in the development of a cold chain system in participating countries.

11.9 Since the development of activities of the Regional Health Development Centre, Cotonou, are aimed at attaining Objective I which is top regional priority, AID/WHO should financially support the development of the Centre which is a milestone in the process of health development in Africa.

11.10 As new strategies are being developed to meet the challenge accepted by all participating countries, "Health for all by the year 2000", must have a more flexible budgetary policy in financing SHDS activities.

11.11 SHDS activities in the countries should be coordinated with bilateral and multilateral and national programmes of primary health care and health manpower development.

11.12 In the process of formulating training programmes for village health workers, provision should be made for appropriate trained personnel to be utilized for the training of trainers. The TOT should be carried out as much as possible within the countires of the countries concerned.

11.13 SHDS should develop a regional centre for the training of postbasic nursing tutors.

11.14 The appointment and training of national counterparts to regional epidemiologists and technical officers in each country should be a top priority.

11.15 The visit schedule of the regional epidemiologists should be established in advance every year and countries should be accordingly informed.

11.16 Development of information systems including epidemiological data in each country should continue. SHDS needs an independent information gathering system to aid periodic reviews by participating countries.

11.17 The delegates unanimously decided that the finalization and publication of the PHC manual produced during the SHDS-sponsored PHC workshops at the CUSS, Yaounde, should be the responsibility of the joint WHO-SHDS project.

LIST OF PARTICIPANTS
LISTE DES PARTICIPANTS

1. REPRESENTATIVES OF AFRICAN STATES
REPRESENTANTS DES ETATS AFRICAINS

BENIN

Dr F. Feliho
Directeur de la Protection sanitaire
Ministère de la Santé publique
B.P. 883
Cotonou

CENTRAL AFRICAN REPUBLIC
REPUBLIQUE CENTRAFRICAINE

Dr A. Banga Bingui
Inspecteur général de la Santé
et des Affaires sociales
Ministère de la Santé publique et des Affaires sociales
Bangui

*CHAD
TCHAD

CONGO

Dr G. Ondaye
Coordonnateur national des Programmes OMS
B.P. 2465
Brazzaville

GABON

Dr L. Adande Menest
Directeur général de la Santé publique
Ministère de la Santé publique et de la Population
B.P. 50
Libreville

THE GAMBIA
LA GAMBIE

Dr E. M. Samba
Director of Medical Services
Ministry of Health, Labour and Social Welfare
Banjul

GHANA

Dr K. Ward-Brew
Deputy Director of Medical Services (International Health)
Ministry of Health
P.O. Box M.142
Acc.

EQUATORIAL GUINEA
GUINEE EQUATORIALE

Dr D. V. M. Nsue
Médecin-Chirurgien et Directeur
Hôpital général de Malabo
Malabo

GUINEA
GUINEE

M. Alhassane Baldé
Statisticien
Division Statistiques sanitaires
Ministère de la Santé publique
Conakry

IVORY COAST
COTE D'IVOIRE

Dr C. Emmou
Directeur de l'Institut d'Hygiène
B.P. V 14
Abidjan

LIBERIA

Mrs R. Marshall
Assistant Minister of Health
Ministry of Health and Social Welfare
Monrovia

MALI

Dr S. O. Diallo
Conseiller technique
Ministère de la Santé publique et des Affaires sociales
Koulouba/Bamako

MAURITANIA
MAURITANIE

Dr M. M. Hacen
Chef du Service de Médecine préventive
Ministère de la Santé publique et des Affaires sociales
Nouakchott

NIGER

Dr J. Wright
Conseiller technique/Inspecteur général de la Santé
Ministère de la Santé publique et des Affaires sociales
B.P. 10739
Niamey

NIGERIA

Dr E. A. Smith
Director of Public Health Services
Federal Ministry of Health
Ikoyi/Lagos

SENEGAL

Dr Papa Soulaye N'Diaye
Directeur de la Recherche, de la Planification
et de la Formation
Ministère de la Santé
Dakar

SIERRA LEONE

Dr M. M. Browne
Deputy Chief Medical Officer
Ministry of Health
5, Gloucester Street
Freetown

TOGO

Dr Barandao Bakele
Directeur des Services de Santé de Base
Direction générale de la Santé
B.P. 336
Lomé

UNITED REPUBLIC OF CAMEROON
REPUBLIQUE UNIE DU CAMEROUN

Dr E. Temgoua Saounde
Sous-Directeur de la Médecine hospitalière et rurale
Ministère de la Santé publique
Yaoundé

UPPER VOLTA
HAUTE-VOLTA

Dr M. Diallo
Directeur-Adjoint de la Santé publique
Ministère de la Santé publique
B.P. 7013
Ouagadougou

2. REPRESENTATIVES OF EXTERNAL SOURCES OF COOPERATION
REPRESENTANTS DES SOURCES EXTERIEURES DE COOPERATION

UNITED STATES OF AMERICA
ETATS-UNIS D'AMERIQUE

Mr Edward G. Ruoff
Deputy Regional Director, Africa Bureau, USAID
AFR/RA Room 3327 A
Agency for International Development
Department of State
Washington, D.C.
USA

Dr Thomas W. Georges
Health Adviser, AID Bureau for Africa
Agency for International Development
Washington, D.C. 20523
USA

Ms M. Duffy
REDSO/WA
USAID
B.P. 1712
Abidjan
Côte d'Ivoire

H. E. Mr W. Swing
Ambassador of USA
Brazzaville
People's Republic of the Congo

Dr Andrew N. Agle
Chief, Field Services Branch
BSE, Center for Disease Control
Atlanta, Georgia 30333
USA

UNITED NATIONS DEVELOPMENT PROGRAMME
PROGRAMME DES NATIONS UNIES POUR LE DEVELOPPEMENT

UNICEF

M. S. Spivac
Administrateur des Programmes
B.P. 2110
Brazzaville
République populaire du Congo

ECONOMIC COMMISSION FOR AFRICA
COMMISSION ECONOMIQUE POUR L'AFRIQUE

Dr B. Badjeck
Agro-Economiste principal
MULPOC (Commission économiques des Nations Unies pour l'Afrique)
B.P. 836
Yaoundé
République unie du Cameroun

AFRICAN DEVELOPMENT BANK*
BANQUE AFRICAINE DE DEVELOPPEMENT

FUND FOR AFRICAN COOPERATION (FAC)
FONDS D'AIDE ET DE COOPERATION

Dr R. Michel
Chef des Missions médicales françaises en République populaire du Congo
Ministère de la Santé et des Affaires sociales
B.P. 78
Brazzaville
République populaire du Congo

3. SECRETARIAT

WHO REGIONAL OFFICE FOR AFRICA
OMS BUREAU REGIONAL DE L'AFRIQUE

Dr A. Franklin
Director/Directeur
Development of Health Services and Manpower/Développement des Services de Personnels de Santé

Dr C. Karamustakis
Regional Officer/Fonctionnaire régional

Unable to attend/Dans l'impossibilité de participer.

Dr M. Jamil Khan
Regional Officer/Fonctionnaire régional

Ms Konde Aena
Regional Officer/Fonctionnaire régional

Dr V. Mojekwu
Regional Officer/Fonctionnaire régional

Dr D. French
Director/Directeur, Project ICP SPM 013, Abidjan

Mrs M. Harvey
Assistant Director/Directrice adjointe, Project ICP SPM 013, Abidjan

Mr S. Helfenbein
Assistant Director/Directeur adjoint, Project ICP SPM 013, Abidjan

Dr G. A. Ashitey
Temporary Adviser/Conseiller temporaire
University of Ghana Medical School
P.O. Box 4236
Accra
Ghana

ADDRESS BY THE REGIONAL DIRECTOR

Ladies and gentlemen,

Dear colleagues,

It is a great pleasure for me to address you today among the flowers of Djoue and to wish you a most cordial welcome.

These meetings always give us an opportunity to exchange ideas and experiences so that we can take up the great challenges which face us. This time you will be examinig the achievements and the inadequacies of the Project for Strengthening of Public Health Delivery Systems in Central and West Africa. On the basis of this critical analysis, it is your task to define future approaches and plan new activities.

It was here in Brazzaville in 1973 that the representatives of 20 States of Central and West Africa, of the United States International Development Agency (USAID) and other organi..ions met with WHO to seek ways and means of redirecting their collaboration in the control of the major endemic diseases and epidemiological surveillance. One of the concerns at that time was to integrate activities for measles control and smallpox eradication into the activities of the health services. You know since the last World Health Assembly of the great victory won by the international community in eradicating a disease which had spread terror for centuries. Achievements such as this are powerful incentives for continuing the struggle to establish justice in health, in Africa and throughout the world. The Project for the Strengthening of Public Health Delivery Systems in Africa is a mechanism for bringing this about.

The first phase of this Project began in April in 1975. The four objectives were the improvement of health planning and management, health manpower development, epidemiological surveillance and disease control, and finally the development of a public health delivery system that is financially and culturally accessible to all. When the objectives of this phase were achieved, an agreement for the second phase lasting five years was signed in September 1977. You know what are our major concerns since the historic Conference of Alma-Ata which recommended primary health care as an approach for achieving the target of health for all by the year 2000. For us this target is neither a dream nor an advertising slogan. It is the manifestation of a political will to make basic human rights, including the right to health, into a reality. I am convinced that you all share these concerns focused on the establishment of a new world order. We are therefore confident that the joint WHO/USAID evaluation in April 1980 will result in a reorientation of the Project activities which takes into account this essential objective of health for all by the

year 2000. I hope that when discussing the report of this joint evaluation, you will bear in mind the new programme approaches decided on collectively by the Member States.

You are all aware that WHO and its Member States make every possible effort to formulate national, regional and worldwide strategies. Within this context, the implementation of all programmes must be seen as a contribution to the strategy for achieving health for all. No action can protect and promote the quality of life in both rural and urban areas unless there is an improvement in social and health services through the intermediary of primary health care. The importance of technical cooperation among developing countries and the need to adopt an appropriate technology can never be sufficiently stressed. The urgent need to develop autonomy, both national and regional, must also be borne constantly in mind. As you can see, my own convictions have become strengthened over the years as the political struggle for health has proceeded. I remain convinced that the work of this meeting will help to consolidate the efforts we are making together to establish social justice for peace. The peace to which I refer is not just the absence of conflict, but peace in the hearts of a world community united in brotherhood. I am sure you have grasped my message, which is that of a man of goodwill. I do not believe that physical, mental, and social wellbeing can or should remain the privilege of some minority. If it is genuinely to mean anything, it must be for everyone. Let us therefore continue to work for social justice and we shall have made a contribution to world peace.

I wish you every success in your work.

PROGRAMME OF WORK

1. Opening of the meeting
2. Election of officers
3. Adoption of provisional programme of work (WP/00)
4. Method of work
5. USAID/WHO joint mid-term evaluation (WP/02)
6. Project mid-term review (WP/01)
7. Scope of USAID collaboration (WP/03)
8. Proposed plan of action for July 1980 to December 1982
9. Nomination of members of the project Coordination Committee (PCC) (WP/05)
10. Date and place of next PCC meeting
11. Date and place of next PRC meeting
12. Adoption of the final report
13. Closure of the meeting

ANNEX 1

TRAINING COURSE FOR VILLAGE HEALTH WORKERS

Course Objectives

- Sanitation
- Nutrition
- Care of Children
- Maternal Health
- First Aid
- Care of Adults
- Working in the Village

MATERNAL HEALTH

Task 1: Make sure that all pregnant women attend the health center, and follow the schedule set by the health center.

1.1 When given a woman in the village who thinks she is pregnant,
the VHW will:

- talk to the woman to persuade her to visit the health center:
  - describe the benefits of visiting the health center for her and the baby
  - tell her what will take place at the health center
- answer as best he can any questions the woman may have and refer the woman to the health center for the ones he cannot answer
- give the woman nutritional advice.

1.2 When given a woman in the village who the VHW thinks is pregnant,
the VHW will:

- visit the woman to ask if she thinks she is pregnant or has any symptoms of pregnancy such as:
  - no monthly bleeding
  - nausea and/or vomiting in the morning
  - change in breast size
- if the woman appears to be pregnant:
  - persuade her to go to the health center
  - answer any questions she may have
  - give the woman nutritional advice.

1.3 When given information from a villager that a women in the village is pregnant,
the VHW will:

- visit the woman to:
  - persuade her to go to the health center
  - answer any questions she may have
  - give the woman nutritional advice.

1.4 When given a home visit,
the VHW will:

- discuss with the woman the reasons why she should visit the health center as soon as she thinks she is pregnant. The health center can:
  - confirm her pregnancy
  - make sure that the pregnancy is normal
  - give malaria prophylaxis to prevent an abortion due to malaria
  - help her prevent anemia
  - answer her questions and give advice

- help her when problems develop
- detect complications of pregnancy as early as possible
- acquaint her with the people that will assist her during delivery.

1.5 When given a pregnant woman in the village who refuses to visit the health center during her pregnancy, the VHW will:

• visit her to find out why she is refusing to visit the health center; if the reasons are that:
  - she says she feels fine and there is no need to go:
    . explain the reasons why she should visit the health center regularly even when she feels well
    . give her some examples of what the health center may find at regular visits that may help her and the baby
    . persuade her to visit the health center
  - she complains that she does not have the time to go:
    . convince her that her welfare and the welfare of the baby are more important than the lost time
    . give her some examples of what the health center can do that can be useful for her and the baby
    . persuade her to visit the health center
  - she complains about the health center:
    . explain to her the problems the health center may have and ask her to try and overlook them
    . convince her that her welfare and the welfare of the baby are more important than the inconveniences at the health center
    . persuade her to visit the health center
    . talk to his supervisor about the woman's complaints
  - she complains that the health center is too far away:
    . convince her that her welfare and that of the baby are more important
    . try to find some kind of transport to take her to the center
    . work with the health center on finding a solution to this problem
  - she is afraid of what happens at the health center:
    . reassure her by telling her what happens during a visit to the health center
    . describe the advantages of a visit to the health center for her and the baby
    . reassure her that what happens at the health center is good for her and the baby
    . persuade her to visit the health center
    . ask another pregnant woman to talk to her and convince her to visit the health center.

1.6 When given a pregnant woman in the village who refuses to visit the health center during her pregnancy, after the VHW has tried to persuade her to go, the VHW will:

- visit her weekly to:
  - continue his efforts to persuade her to visit the health center
  - check that she is following the nutritional advice he has given her
  - check that she is not developing serious complications
  - answer questions, if he can, that she may have about her pregnancy
- talk to her husband to enlist his support in the attempts to persuade the woman to go to the health center
- talk to other women in her family to ask them to help the VHW persuade the woman to go to the health center
- ask a pregnant woman who is going to the health center to try to persuade the woman to accompany her to the health center.

Task 2: Make sure pregnant women follow the advice given by the health center.

2.1 When given a pregnant woman in the village who has returned from the health center after a routine visit, the VHW will:

- make a home visit to:
  - find out what happened at the health center
  - answer any questions she may have about what happened at the health center
  - find out what advice she was given at the health center
  - make sure she understands the advice and intends to follow it
  - answer any questions she may have about the advice
  - tell her to come to the VHW if she has any questions or problems
- visit her periodically to make sure she is following the advice
- make sure she returns to the health center at the time set by the health center.

2.2 When given a pregnant woman who is not following the advice given by the health center, the VHW will:

- visit her to find out why she is not following the advice; if the reasons are that:
  - she cannot afford the medications:
    - arrange with the village committee or other health or social service agents in the village to obtain the medications for her
  - she did not understand the advice:
    - explain the health center's instructions to her
    - ask her to return to the health center for further advice if the VHW cannot clarify the instructions for her
  - she did not see the importance of the advice or does not believe it is necessary:
    - explain the reasons why the advice was given
    - convince her that such reasons are important
    - persuade her to follow the advice
  - someone has persuaded her that the advice is incorrect or even dangerous:
    - explain to her the reasons for the advice and persuade her that these reasons are important
    - persuade her that following the health center's advice will make the baby healthy and strong
    - assure her that the advice is not dangerous
    - obtain the support of the husband in persuading her to follow the advice
    - talk to the other person and persuade her to change the advice she has given
    - ask another pregnant woman who is following the advice to talk to her and persuade her to follow the advice.

2.3 When given a pregnant woman in the village who refuses to return to the health center during her pregnancy, the VHW will:

- find out why she does not want to return to the health center; if the reasons are that:
  - she did not like or understand the procedures at the health center:
    - explain the reasons for the procedures she did not understand
    - explain the importance of these procedures
    - reassure her that none of the procedures is dangerous or will hurt the baby
    - persuade her to visit the health center
    - tell the health center about her complaints in order to improve relations between health center personnel and the patients

- she complains of the waiting time and personnel at the health center:
  - . explain to her the problems the health center may have and ask her to try and overlook them
  - . convince her that her welfare and the welfare of the baby are more important than the inconveniences at the health center
  - . persuade her to go to the health center
  - . talk to his supervisor about the woman's complaints
- she complains of the distance to the health center:
  - . convince her that her welfare and the welfare of the baby are more important
  - . try to arrange transportation for her to the health center
  - . work with the health center on finding a solution to this problem
- she says she feels fine and there is no need to go:
  - . explain the reasons why she should visit the health center regularly even if she feel well
  - . give some examples of what the health center may find during regular visits that may help her and the baby
  - . persuade her to visit the health center.

Task 3: Immediately send to the health center all pregnant women who complain of symptoms indicating complications with pregnancy.

3.1 When given a pregnant woman who says she is ill, the VHW will:

- . for minor complaints:
  - refer the woman to the health center and make sure that she goes
- . for serious complaints:
  - reassure her and her family that everything will be done to help her
  - arrange for transportation to the health center and accompany her there
  - give necessary care during transportation.

3.2 When given a pregnant woman in the village who complains of soreness in the breast or too frequent urination, the VHW will:

- . send her to the health center if she has not visited it within the last month
- . if she has already visited the health center for the same complaints during the last month, reassure her and remind her of the advice that she was given at the health enter.

3.3 When given a pregnant woman who complains of nausea or vomiting in the morning, or constipation, or heartburn, the VHW will:

- find out if she has already been to the health center with the same complaint, and send her there if it is more than a month since her last visit
- assure her that these symptoms are common during pregnancy
- advise her that she can alleviate these symptoms if she:
  - eats several small meals rather than large meals
  - eats plenty of fruits and vegetables
  - does not eat too much spicy and fatty foods.

3.4 When given a pregnant woman who vomits most of her meals, and not only the morning meal, the VHW will:

- if she is not malnourished or dehydrated:
  - send her to the health center
- if she is dehydrated and malnourished:
  - make arrangements to send her to the health center
  - give her frequent sips of slightly salty water before and during transportation (if she is dehydrated).

3.5 When given a pregnant woman who complains of fatigue and backache, the VHW will:

- find out when she was last at the health center and send her there if it is more than a month since her last visit
- advise her to:
  - lie down and rest when her back aches or she feels tired
  - try and find someone to help her with the heavy work she has to do
  - not to lift heavy things
  - eat well from all the food groups.

3.6 When given a pregnant woman who complains that she is bleeding with or without pain, the VHW will:

- if the bleeding is like a small monthly period without pain, ask the woman to go to the health center immediately, and make sure that she goes
- if the bleeding is heavy, with or without pain:
  - arrange immediately for evacuation
  - go with her to the health center
  - give fruit juice or other liquids on the way
  - watch for signs of shock.

3.7 When given a pregnant woman with severe abdominal pain and a belly that hurts when it is touched, with or without bleeding from the vagina,
the VHW will:

- arrange immediately for evacuation
- go with her to the health center.

3.8 When given a pregnant woman who complains of frequent headaches, dizziness or swollen ankles, legs or hands,
the VHW will:

- tell the woman to go to the health center immediately and make sure she gets there.

3.9 When given a pregnant woman who complains that the baby has stopped moving or kicking,
the VHW will:

- if the baby was moving a great deal before the movements stopped, refer the woman to the health center
- if it is the first time that the woman has not felt her baby move for a day, refer the woman to the health center
- if there were other times she did not feel the baby moving for a day:
  - reassure the woman
  - visit her the next day, and, if the baby has not started moving again, refer the woman to the health center.

3.10 When given a pregnant woman who has had a convulsion,
the VHW will:

- immediately evacuate the woman to the health center
- go with her to the health center
- put a clean cloth between her teeth so she does not bite her tongue in case another convulsion occurs while she is being transported.

3.11 When given a home visit to a pregnant woman who has returned from the health center after a visit for complications during pregnancy,
the VHW will:

- if she is still pregnant:
  - find out what happened at the health center and answer any questions she may have
  - find out what advice she was given and explain the instructions she does not understand
  - make sure she follows the advice
- if she gave birth:
  - carry out his instructions for postnatal care of the woman and the newborn
- if she lost the baby:
  - support and reassure her
  - encourage her to follow any advice given by the health center.

Task 4: Encourage all women to give birth at the health center or to get help from a TBA who delivers babies and takes care of a newborn in a hygienic manner, and make sure they do.

4.1 When given a pregnant woman in the village, the VHW will:

- during a home visit find out where she intends to deliver and which birth attendant she intends to use during delivery; if she intends to deliver:
  - at the health center:
    - reinforce her decision
    - ask her to go to the health center before labour starts if the center is far away, or as soon as labour starts, if the health center is nearby
  - with a TBA who practices hygiene during delivery and in the care of the newborn:
    - encourage and reinforce the decision
    - tell her what arrangements to make before labour starts and when to send for the birth attendant
  - with her husband or other untrained birth attendant:
    - try to persuade her to deliver at the health center or with a trained TBA or VHW
    - explain the need for cleanliness during delivery and in care for the newborn.

4.2 When given a pregnant woman in the village who wants to deliver her baby with a birth attendant who is not trained in hygiene, after having tried to persuade her to deliver at the health center or with the help of a qualified birth attendant,
the VHW will:

- visit the woman to:
  - continue his efforts to persuade her to deliver at the health center or with the help of a qualified birth attendant
  - make her understand the need for cleanliness during the delivery and in the care of the newborn
- talk to her husband to enlist his support in the efforts to persuade the woman
- visit the birth attendant she intends to use to:
  - find out how the TBA intends to deliver the child and persuade her to take steps to ensure cleanliness
  - tell her about what signs may necessitate transfer to the health center and persuade her to send the woman to the health center if these signs appear
  - find out how she cuts and takes care of the umbilical cord and persuade her do these things in a hygienic way
- visit the woman after delivery to check the condition of the woman and child.

4.3 When given a TBA in the village who has not received any modern training,
the VHW will:

- during a visit to the TBA find out:
  - for prenatal care:
    - if she examines the woman before delivery or gives her advice
    - what advice she gives, if any
    - what she does, if anything, when complications of pregnancy occur
  - during delivery:
    - when and how she intervenes during labour
    - what she uses to cut the cord and how she treats the wound
    - what care she gives the baby
    - what advice she gives the mother
    - what she does with the afterbirth
    - what she does when complications occur
  - after delivery:
    - if she checks the baby for birth defects and other problems
    - if she visits to find out the mother's condition
    - if she refers the woman and infant to the health center if complications occur.

4.4 When given a visit to a TBA who does not practice hygiene during deliveries,
the VHW will:

- persuade the TBA to send the woman to the health center if complications occur during pregnancy or delivery, or after the baby is born; and to discuss as best he can with her:
  - when she should send the woman to the health center
  - why she should send the woman to the health center
- persuade the TBA to ensure cleanliness during delivery and to practice hygiene in:
  - caring for the woman
  - cutting the cord
  - caring for the newborn
- persuade the TBA that it would be in her own interest to get training in modern methods of delivery and tell her where she can get such training
- persuade the TBA that she and the VHW should work together to ensure proper care for pregnant women in the village.

Task 5: Make sure that women go to the health center in time to give birth there, if labour complications are expected.

5.1 When given a visit to the health center, the VHW will:

- find out from his supervisor or the nurse:
  - which women in his village have been told that they should deliver at the health center
  - the reasons for the health center's request
  - when they should go to the health center.

5.2 When given information about which women in the village have been asked to deliver at the health center, and when they should go, the VHW will:

- talk to the women to make sure that they indeed intend to deliver at the health center.

5.3 When given a woman who has been asked to deliver at the health center and who indicates that she intends to follow the health center's advice, the VHW will:

- make sure she visits the health center regularly during her pregnancy
- make sure she understands when she is supposed to leave for the health center
- find out how she intends to get to the health center
- assist her in making arrangements for transportation, if necessary.

5.4 When given a woman who has been asked to deliver at the health center and who indicates that she does not intend to follow the health center's advice, the VHW will:

- find out why she does not intend to follow this advice
- repeat and explain the health center's reasons for the the recommendation
- reassure her if she has any fears about delivering at the health center
- ask other women who have delivered at the health center to talk to her about what happens there, if necessary
- convince her that in case of complications it would be better for her and the baby to be at the health center
- talk to her husband and other family members to convince them that it would be better for her to deliver at the health center
- talk to the birth attendant that the woman has selected and explain the reasons for the health center's request to her and, if possible, enlist her support in persuading the woman to deliver at the health center.

5.5 When given a woman who should deliver at the health center, the VHW will:

- make sure that she indeed intends to leave for the health center as soon as labour starts.

5.6 When given a woman who has been asked to deliver at the health center because a premature baby is expected, and the transportation to the health center will take one hour or more,
the VHW will:

- assist the woman to make arrangements to stay near the health center during the last two months of pregnancy
- assist the family to make arrangements to have the household work done during the woman's absence
- arrange for the woman to go to the health center at the end of her seventh month of pregnancy.

5.7 When given a woman who has been asked to deliver at the health center for reasons other than that of a possible premature delivery, and it takes more than an hour to get to the health center,
the VHW will:

- assist the woman to make arrangements to stay near the health center during the last two weeks of her pregnancy
- assist the family to make arrangements to have the household work done during the woman's absence
- arrange for the woman to leave for the health center two weeks before she is due to deliver.

Task 6: Organize a system of evacuating women in labour to the clinic.

6.1 When given a plan for transporting sick and injured villagers to the health center,
the VHW will:

- review the plan to make sure that it includes:
  - transportation during all hours of the day, especially during the night
  - transportation for women in labour
- revise the plan, if necessary, to cover these conditions
- make arrangements to notify as quickly as possible the person responsible for transportation when it is necessary to evacuate someone

- check that the plan can work by:
  - making sure the vehicles are appropriate for transporting a woman in labour
  - making sure that the person responsible for transportation intends to be available at all times and that he can be trusted
- revise the plan if the current means of transport are no longer dependable.

6.2 When given a plan for transportation of sick and injured villagers to the health center,
the VHW will:

- visit all TBAs in the area to make sure that they know about the plan and how to use it.

6.3 When given a pregnant woman in the village,
the VHW will:

- during a home visit explain what transportation is available if she has complications of pregnancy or labour, and ask her to send for the VHW immediately if she thinks she needs to go to the health center.

6.4 When given a woman in the village whom he is helping to deliver,
the VHW will:

- make sure that the "village transportation" is available and can be used if complications occur
- make sure someone is available to go quickly for such transportation, if necessary.

Task 7: Evacuate immediately all women when complications with labour develop.

7.1 When given a woman in labour who has been told that she should deliver at the health center,
the VHW will:

- accompany the woman to the health center.

7.2 When given a woman in labour who is less than eight months pregnant,
the VHW will:

- accompany the woman to the health center.

7.3 When given a woman whose water breaks before labour pains start,
the VHW will:

- make sure that the woman goes immediately to deliver at the health center.

7.4 When called to attend a woman in labour with any of the following complications:

- presentation of any part other than the head
- labour that has lasted more than 24 hours
- labour pains become weaker and less frequent
- the baby's head can be seen, but cannot come through although the woman pushes
- the mother has a convulsion during labour

the VHW will:

- transport the woman to the health center or send for help
- go with the woman to the health center.

7.5 When given a TBA in the village, the VHW will:

- discuss with her the complications that may occur during labour
- convince her that it might be best to send the woman to the health center when such complications occur
- assure her that the woman will be well taken care of at the health center
- make sure she knows what arrangements have been made for emergency transportation of sick and injured people in the village
- tell her that the VHW will assist her as much as he can when it is necessary to evacuate a woman in labour.

7.6 When given a pregnant woman in the village who intends to deliver at home with the help of a relative or a traditional birth attendant, he VHW will:

- during a home visit:
  - see what arrangements have been made and stress the need for cleanliness during delivery and in the care of the baby
  - warn her that if labour happens too early, before the end of the eigth month, the baby will be weak and she should try to get to the health center before the baby is born
  - tell her and the birth attendant she has chosen to send for the VHW if there are complications during delivery.

7.7 When given the need to transport a woman who has developed complications of labour,
the VHW will:

- send a messenger to get the village transport ready
- prepare to transport the woman:
  - take his medical kit
  - take a clean cloth and put it under the woman in the vehicle
  - bring liquids to give to the woman during the trip
  - take something to wrap the baby in if born on the way

  go with the woman to the health center.

7.8 When given a woman in labour who is being transported to the health center,
the VHW will:

- reassure the woman that things may go all right and that she may be able to help at the health center
- give necessary care during transportation
- deliver the baby if necessary:
  - stop the car during delivery
  - try to make sure that the baby is breathing
  - do not cut the umbilical cord unless absolutely necessary

  proceed to the health center.

Task 8: Provide postnatal care for the first week for all women and their babies who deliver at home and refuse to go to the health center.

8.1 When given the TBAs in the village,
the VHW will:

- ask them to let him know when a woman has given birth so that he can visit her and the baby after delivery.

8.2 When given a pregnant woman in the village, who intends to deliver at home,
the VHW will:

- ask her to let him know when she has given birth so that he can visit her after the delivery.

8.3 When told that a woman has delivered a baby in the village,
the VHW will:

- visit her to:
  - check that she is feeling well
  - check that the baby is doing fine
  - see if the umbilical cord wound is healing
  - encourage the mother to breastfeed
  - give nutritional advice
  - persuade the mother to take the baby to the health center within the next four weeks for a check-up
- visit her again to check on her and the baby's condition.

8.4 . When given a woman in the village who has delivered her first baby:
the VHW will:

make sure that she knows how to care for the baby or that there is someone who can show her how.

Task 9: Evacuate immediately the woman and newborn child if postnatal complications develop.

9.1 When called to, or attending to, a woman who has just delivered,
the VHW will:

- evacuate the woman and child immediately:
  - if the woman develops any of the following complications:
    - retained placenta (after one hour)
    - heavy bleeding (more than 1/2 liter)
    - convulsions
    - large tear in the perineum
  - if the baby:
    - has trouble breathing
    - has weak arm and leg movements or does not move any of its limbs
    - is premature and smaller than normal babies
  if the mother has delivered twins who are smaller than normal babies.

9.2 When called to or attending a woman who has just delivered a baby with a birth deformity,
the VHW will:

- reassure the mother that she is not at fault
- if the birth defect can be corrected, assure her that the hospital can help the child develop normally
- transport the woman and child to the health center.

9.3 When visiting a woman who has delivered a child within the last week,
the VHW will:

- transport the woman and baby to the health center if the woman has:
  - heavy bleeding after the first two days
  - a fever
  - a heavy vaginal discharge that smells badly
  - stomach pains
  - red, swollen breasts or a swollen area in one breast
  - insufficient breast milk flow by the fourth day.

9.4 When given a newborn baby,
the VHW will:

- during a home visit:
  - check the baby for:
    - fever
    - eye infection
    - yellow eyes and skin
    - cord infection
  - make sure that the baby has:
    - passed a first stool
    - urinated
  - ask the mother if the baby:
    - is eating and sucking well
    - is vomiting (projectile versus spitting up)
  - give the mother nutritional advice for the baby.

9.5 When given a newborn baby,
the VHW will:

- evacuate the mother and baby immediately if the baby:
  - has not passed urine on the second day
  - has not passed a stool by the third day
  - has deep yellow eye whites and yellow skin
  - has infected eyes
  - has an infection in the umbilical cord
  - cries constantly and refuses to nurse
  - groans constantly
  - has a convulsion
  - has a fever
  - is vomiting forcefully after each meal
  - looks like it is dehydrated or losing weight rapidly.

9.6 When given a mother and baby who have to be evacuated because of postnatal complications,
the VHW will:

- reassure the woman's relatives that the health center will do what they can for the woman and child
- explain to the mother why evacuation is necessary and assure her that the health center can help
- accompany the woman and child to the health center.

Task 10: Encourage child spacing.

10.1 When given a visit to a mother with a newborn,
the VHW will:

- talk to the mother about her children and encourage her to wait until the baby is two years or older before having another child.

10.2 When asked by a woman or husband in the village about child spacing,
the VHW will:

- talk to the woman or husband about:
  - the risks to the baby if the woman has another child too soon
  - the risks to her from pregnancies that are too close together
  - the economic benefits of child spacing
- explain what the woman or her husband can do to make sure that she does not get pregnant too early
- advise the couple to go to the health center for more information.

10.3 When asked by a woman if there is some way she can avoid having any more children,
the VHW will:

- tell the woman that there are some ways she can make sure that she has no more children
- advise her to visit the health center with her husband to find out what to do.

10.4 When given a village meeting and the occasion warrants it, the VHW will:

- give information about how to practice child spacing and where to go to get help and advice about child spacing.

ANNEX 2

EDUCATIONAL OBJECTIVES OF THE TRAINING COURSE FOR TRAINERS OF VILLAGE HEALTH WORKERS

This course is designed for middle-level personnel in the health sector (nurses, midwives, technical officers/sanitation, etc.) and other personnel at a similar level working in development sectors which contribute to health (social affairs, agriculture, environment, etc.) who have been officials in their country's administration for at least three years and have or will have responsibility for planning, implementation, inspection and evaluation of training programmes for village health workers.

The objective of the course is to prepare the participant for training and making use of village health workers or personnel responsible for primary health care in rural areas.

Broad Objectives:

At the end of the course participants will be able to:

1. Develop a course for the training of village health workers using the method of systematic course design;
2. use such developed course to train village health workers;
3. collaborate with and work in rural communities for the improvement of community and individual health in their villages;
4. collaborate with other workers in community development to improve community and individual health in villages;
5. evaluate the performance of village health workers during their training and periodically afterwards;
6. supervise the work of trained village health workers;
7. plan and give all the necessary support to the village health workers to facilitate the delivery of health care to villages;
8. organise retraining programmes for practising village health workers as and when needed;
9. evaluate periodically the impact of the trained village health workers on village health;
10. communicate the results of such evaluation to other levels of the health care delivery system in manner which will help in the development of a coherent national health plan.

ANNEX 3

WORK SCHEDULE FOR DEVELOPMENT OF SUPERVISORY MATERIAL

1. Job Descriptions for community health assistants, etc.

At the meeting on April 14, it was agreed that the following categories need to be developed:

a) Community Assistants working at a health clinic
b) Community Health Assistants working at a primary health center (PHC)
c) Community Health Assistants working at a comprehensive health center (CHC)
d) Community Health Officers working at a PHC
e) Community Health Officers working at a CHC
f) Doctors/Medical Officers working at a CHC

It was recognised that many functions overlapped, and that job descriptions would be similar, but since the supervisory structure will be different at the different centers, the job descriptions would also have to be different.

For the primary health center and the comprehensive health center, one of the major tasks would be to differentiate the different tasks of the doctor, officer and assistant, assuming delegation of responsibilities.

It was agreed that the team should develop this material as much as possible before June and that Dr. Kolawole would bring the materials with him to the U.S. to discuss with Dr. Ericsson.

2. Task Analysis of the tasks in the job description

This should be done by the end of August.

3. Educational Objectives

These should be done by the end of November.

4. Visits to other countries

These should take place in Novem[illegible] /December. The aim is to check the job descriptions done at the EHSS wi[illegible] the working conditions in Nigeria and other countries. Possible countries to visit would be the Benin, Nigeria, Cameroun, Sierra Leone, Gambia and the Congo.

5. Development of Training Materials

Starting in September and continuing into the next year. Plans for next year (fieldtesting and revision) will be developed later.

ANNEX 3
SUMMARY WORK SCHEDULE

	ACTIVITY	WHEN COMPLETED	RESPONSIBILITY
1.	Job Descriptions	June 1	Development Team
2.	Review of Job Descriptions	July 1	Dr. Kolawole/Dr. Ericsson
3.	Revision, final copy of Job Descriptions	September 1	Development Team
4.	Task Analysis	September 1	Development Team
5.	Review of Task Analysis	October 1	Dr. Ericsson or other Consultant
6.	Revision, final copy of Task Analysis	December 1	Development Team
7.	Educational Objectives	December 1	Development Team
8.	Review of Objectives	January 1	Dr. Ericsson or other Consultant
9.	Revision, final copy of Educational Objectives	March 1	Development Team
10.	Visits to other countries	October to December	Dr. Kolawole/Dr. Ericsson other Consultant
11.	Development of training materials	Start in September	Development Team

Plans for next year will be made later (field-testing and revision)

For each type of material developed, the following strategy should be followed to assure maximum efficiency:

a) Development of the materials - typed copy - 10+
b) Technical review (Dr. Ericsson or other teaching technique specialist)
c) Subject matter review (management specialist, teacher, CH-officer/assistant, BSSH administrator)
d) Revisions based on the review of (b) and (c) - typed copy - stencil
e) Translation to French - typed copy - stencil
f) Duplication of French and English copies and distribution to other countries/states for review
g) Review and revision based on comments in (f)
h) Use of the materials in the field
i) Revisions of material based on field use and production of final copy
j) Dissemination.

RESOURCES NEEDED FOR THE DEVELOPMENT OF THE MATERIALS

ACTIVITY IN SUMMARY SCHEDULE	TYPE OF RESOURCE	WHEN
1. Job Description development	Typist/paper/xeroxing	April/May
3. Job Description revision	Typist/stencils/paper	July/August
4. Task Analysis development	Typist/paper/xeroxing	June/July/August
6. Task Analysis revision	Typist/stencils/paper	November/December
7. Educational Objectives development	Typist/paper/xeroxing	September/October/ November
9. Educational Objectives revision	Typist/stencils/paper	January/February

It is assumed that the development team will be working on this in as much time they have and can spare from their other duties.

ASSUMPTIONS, REMARKS

1. Planning for visits to other countries should start in July/August and arrangements be made through WHO/SHDS.

2. The development of materials for the next step should start without waiting for the review results. Otherwise it will take too long. Adjustments in the materials can always be made later.

3. Based on the materials which is already available, the development team has to extract the specific tasks, objectives, etc. which apply to management and supervision, and write new ones when none are available. They also have to delineate the responsibilities between assistants, officers and doctors when these are working together.

4. If Dr. ElNeil agrees, Dr. Imade and Mrs. Adegoroye will be available for consultation and assistance.

5. Translation to French will be arranged via Lomé or Abidjan and details worked out with Mme. Sagbo who translated the VHW materials.

6. SHDS-Abidjan will investigate if it is possible to duplicate the French copy in Lomé, or in Abidjan if Lomé cannot do it.

INSTRUCTIONS GIVEN TO THE TEAM DEVELOPING THE VHW MATERIALS

1. Job Description

Job descriptions should be developed for the following categories of workers:

(a) assistants at the health center
(b) assistants at the primary health center (PHC)
(c) assistants at the comprehensive health center (CHC)
(d) officers at the PHC
(e) officers at the CHC
(f) medical officers/doctors at the CHC

Concentrate on the tasks which involve management and supervision.

Write it in terms of what they are supposed to do - their tasks; that is, do not write: responsible for maintaining drug supply, but (for the assistant):

- keeps on-going record on what drugs are available at the center
- notifies the community health officer weekly which drugs need to be ordered
- receives drugs and adds them to the stock, etc.....

(for the officer):

- orders drugs when necessary
- checks the record kept by the assistant on a regular basis (once a month)
- reminds assistant about need for report on drug status if not received when planned, etc.....

Do not worry too much about duplication or how specific the behaviours you put down are. Try to be clear about what the person has to do, given your experience and the tasks assigned to the different job categories.

Look at the categories and the training program to be sure that you have included most of the necessary tasks. Try to order them in groups - maybe the categories given in the educational objectives. Also, if you are unsure that all has been included, check with a community health assistant and/or officer to find out what they actually are doing.

The job description should, if possible, be finished before Dr. Kolawole goes to the U.S. so that he can take it there and we can discuss it. In any case, he should bring whatever is finished so that it can be discussed.

2. Task Analysis

When the job description is finished - and it is not necessary to wait until it has been approved and reviewed by other people - you should do a task analysis. Take each task which you have in the job description and try to break it down into behaviours, knowledge and attitudes. (Develop learning units). One way of doing this is to envision a situation in which the task is accomplished and set down the situation and which knowledge and attitudes are necessary.

Example: remind community health assistant that the drug status report is due.

BEHAVIOUR	KNOWLEDGE	ATTITUDE
• Note down when drug report should be on my desk	- knows when it should be - knows how to keep a reminder system - knows advantage of planning with check-points	- wants to keep a reminder system - wants to monitor the drug supply
• Check on a set date to see if the report is there		
• Wait a day to see if it is received		- accepts that delays may occur - is willing to excuse one day's delay
• Ask CHA what happened to the report	- knows reasons the CHA may have had for not turning in report - knows ways of preventing a re-occurrence	- wants to listen to CHA's point of vie - wants to resolve issue with minimum conflict - talks to CHA about non-performance in a non-threatening manner.

3. Educational Objectives

When you have the task analysis, ask yourself: which of these behaviours, knowledge and attitudes do we have to teach because they do not know them? Write objectives for these specifying (if possible):

(a) in which situation the trainee will demonstrate that he has acquired these behaviours
(b) which behaviours he should present in these situations
(c) what is the "content" of the behaviour
(d) what criteria - standards - you would use to know that he has achieved the objective.

For example: when given a case history in which a community health assistant has failed to turn in a report on drug supplies (and another student) (a), the student will:

- discuss (b) with the other student why the report was not turned in (c)
- decide (b) with the other student how to make sure it is turned in as planned (c) using the communication methods he has been taught in the course (d).

You can also write an objective which tests only the knowledge without testing the student's actual skills in communication:

When given questions (a), the student will:
- describe (b) what he will do when a CHA fails to turn in a drug status report on time (c), listing at least five of the seven required behaviours (d).

Which way you select will depend on the constraints you have in the course and which objectives you want to measure. Note that in general, the closer you teach and evaluate the actual behaviour you want the person to perform in his job, the more likely you are to be sure that he will perform as you wish on the job. Thus, it may be better to simulate the actual behaviour at least in some of the objectives, at the same time as for others you are testing only knowledge. You have to decide in which situations and for which behaviours it is more important to demonstrate the actual performance and write your objectives accordingly.

You will probably find that different tasks may be combined and result in only one objective, for instance: whatever report the CHA has failed to turn in (drug status, available equipment, maintenance performed, work schedule, etc.), the CHO will have to do the same thing.

4. Teaching Modules

When the job description is done, I will help you develop models for how the teaching units can be done and how job aides can be developed to fit the project.

NOTE: This looks like plenty of work. However, the main task for you is to extract from the materials you have available, the supervisory, management and administrative tasks and put them together in a job description for the categories of workers mentioned above. The other main task is to differentiate between the different posts and, for the PHC and CHC, to decide which task is done by which category of worker.

Only when the task, learning unit and educational objective is not available in the materials you have, do you need to construct new ones. You may also in some cases have to rewrite objectives, but that should not be difficult either. Use already working CHAs and CHOs, other health personnel, EHSS people and others to help you when needed in your work.

SE/il.

MANAGEMENT AREAS AS DEFINED IN THE OBJECTIVES FOR COMMUNITY HEALTH PERSONNEL

Areas of Management for Community Health Aides

1. Management of time, scheduling of activities
2. Management and control of assigned drugs, materials and equipment
3. Report to supervisor including record-keeping
4. Community work in village, school, and clinic
5. Communication skills
6. Health education
7. Self-evaluation of achievement of job objectives.

Areas of Management for Community Health Assistants and Officers

NOTE: They are both responsible for this but on different levels at different types of health centers. One of the tasks is to differentiate between the responsibilities to assign to the assistant and that to be assigned to the officer at the different types of health centers.

1. Planning activities of the health center personnel:
   a) set objectives
   b) plan for resources
   c) budget.
2. Time management and scheduling.
3. Make sure plans are carried out:
   a) develop resources, find resources (including personnel)
   b) supervise personnel to make sure tasks are carried out
   c) evaluate achievements against objectives on an on-going basis.
4. Administrative functions:
   a) monitor use of equipment and personnel
   b) monitor supply of drugs, materials, equipment, etc.
   c) maintain equipment, drug supply, hygiene, etc. (ensure maintenance)
   d) cost control, monitor budget
   e) work flow at the clinic.
5. Develop and monitor patient register, family health register and follow-up care (reminder system).
6. Organise and plan community out-reach activities (mobile services) with other personnel at the center - village, school, etc.
7. Plan, organise and deliver health education activities with help of MCH personnel.
8. Develop and use a recording system for the clinic which can provide information about health conditions and health activities in the area.
9. Evaluate personnel according to their job descriptions and provide:
   a) feedback
   b) assistance with resolving practical problems
   c) additional on-the-job training as necessary.
10. Report on clinic activities to his supervisor.
11. Problem-solving: how to deal with non-achievement of objectives; communication problems; personnel problems; equipment failure; lack of drugs; epidemics; crisis situations.

MEETING - 1[illegible] APRIL, 1980

DR. KOLAWOLE, DR. SOLANKE, DR. ERICSSON

Points discussed during the meeting

1. Personnel available to work on the materials are in Nigeria: Dr. Kolawole, Dr. Solanke, Mrs. Gbadamosi, Mr. Doula. Hopefully Mrs. Adegoroye and Dr. Imade will also be available to assist them.

   Miss Tinubu will be too busy with the National Health Service Corps training to participate.

   Dr. Solanke has just graduated from the university and has had no experience with systematic course design. However, it will probably not be difficult for her to learn while working with the others.

   Mrs. Gbadamosi participated in the course given in October and has developed materials for community health aides based on her work in that course. She seems to understand the principles and be able to work with the approach.

   The team that Dr. Kolawole has assembled seems to me to be very capable and able to develop this material.

2. Dr. Kolawole indicated that he would prefer that I provide the technical input supposed to be given by an outside Consultant. This should be explored, since I think it may be difficult at this time to introduce a new person.

3. Dr. Kolawole suggested the cooperation with another project in his unit funded by the UN Fund for Population Activities. (See separate Memo).

4. Dr. Kolawole indicated that what they needed more than anything at this point was someone who could steer their thinking in the right direction. After much discussion, the following tentative assignments were agreed on:

   A. Dr. Ericsson should review the already available materials and draw up a work schedule based on the availability of personnel and time.

   B. When the schedule is developed, Dr. Kolawole will review it and provide estimated costs for the development of materials. He will send this budget to Saul Helfenbein in Abidjan.

   C. Dr. Ericsson will develop guidelines and discuss them with the development team on Monday, April 14, before she leaves for Lomé.

5. A tentative work schedule was worked out (see attached materials).

6. Dr. Kolawole will be in the U.S. from June 8 to 28 and probably also in July. He will be in Boston from June 28 to July 5 (because he has relatives there) and would be willing to discuss the progress of the project at that time with me.

SE/ll.

...Central and West Africa
Immeuble « Le Général »
Angle Avenue Général de Gaulle et Rue Botreau Roussel
04 B. P. 799 ABIDJAN 04, Ivory Coast
Tél 32-58-21 / 33-15-59 - Télex 2366

9 May 1980

MEMORANDUM

TO: Dr. M. Hacen, Director of Preventive Medicine
MOH/WS/L/Mauritania

Ms. Linda Neuhausen, Health Officer, USAID/Mauritania

Dr. B.S.F. Adjou-Moumouni, Coordinator of Studies
WHO Regional Training Center, Lome

WHO Coordinator, Mauritania

Dr. A. Franklin, DSM, WHO/AFRO

FROM: Saul Helfenbein, Asst. SHDS Project Director SH
Sif Ericsson, SHDS Project Educational Coordinator pp SH

SUBJECT: SHDS Project Assistance to Training Component of Rural Medical Assistance Project (Project Trarza)

1. The objective of the visit of Ericsson and Helfenbein was to review the possibilities for collaboration between the WHO Regional Training Center/Lome and the MOH in adapting the RTC VHW training materials to local conditions and establishing in-country training programs for trainers of VHWs. This visit was organized in collaboration with the Ministry of Health and USAID/Mauritania who are jointly developing a Primary Health Care program in the Trarza Region of Mauritania. This visit was the first step of a possible follow-up activity to the 3-month training of VHW trainers course at the RTC/Lome. I. Diouf and M. Moctar who have been assigned by the MOH to be in charge of the training component of this project participated in the first 3-month training of VHW trainers course in Lome (July-Oct. 1979).

2. This memo summarizes suggestions for follow-up collaboration with the MOH PHC program in the Trarza Region: that is, a viable training strategy for this project and the optimal approach for adapting the RTC training materials to local conditions. A more detailed report will [illegible] by Dr. [illegible].

3. During this visit Helfenbein and Ericsson reviewed the proposed Trarza Primary Health Care project, with MOH and AID officials, had lengthy discussions with I. Diouf and A. Moctar, met with other government project personnel involved in village level training programs, and briefly visited several villages and training sites in the Trarza Region to acquaint themselves with conditions.

4. The results of discussions and visits indicated:

1. The approach to training in the Trarza project still requires some definition and clarification. Three levels of training are involved:

   a) Continued on the job training of the training program directors

   b) The training of VHW trainers both as trainers and supervisors

   c) The training of VHWs.

2. Program constraints need to be clearly and exhaustively identified as these will affect the training component of the Trarza project. Several constraints can be identified in the "course outline" which accompanies the RTC training materials. Specific issues that we noted which have to be taken into account are:

   a) The skills knowledge, experience (both with respect to training and Primary Health Care) of the PMI nurses and midwives who will be responsible for training and supervision of the VHWs.

   b) The logistical problems of training 192 VHW and maintaining effective supervision.

   c) The need for adequate supervision of the training program for VHWs in order to control the quality of the training given by largely inexperienced trainers.

   d) The diversity of local conditions that have to be taken into account in adapting the VHW training materials and in preparing training courses.

3. The following table presents a suggested approach to the training component. The strategy takes into account the above mentioned training objectives, current status of the training component, and constraints. It identifies phases where we believe the RTC can provide effective input in working with former participants of the Lome Center Trainers' course.

It uses the same training approach of the Lome Center. Since the Trarza project training directors are familiar with it, it will allow them to begin to apply what they have been taught at Lome to developing a training component for the Trarza project. In addition, working with the collaboration of RTC staff members, the training directors will [illegible] at the same time as they develop training programs to be used to train the VHWs.

Model of a Training Program

For Tutors*, VHW Trainers and VHWs

* Tutors are training program directors - i.e. Lome RTC participants and others of similar background and experience assigned to the program

Phase	Time	Objectives	Responsibilities
1. Preparation of PHI nurses/ midwives for role as VHW Trainers This will serve as a first phase refresher course for the tutors as well	5 days	1. To give VHW trainers an understanding of PHC, goals of the Tarza Project, the role of trainers in training and supervision.	MOH tutors
		2. To give VHW trainers an understanding of how training programs for VHW are developed with special emphasis on the village diagnostique and identification of VHW tasks.	MOH tutors. RTC staff will deal specifically with method of village diagnostique
2. Village Diagnostique This is the key phase in the adaptation of the RTC training materials	1-2 months	1. To expose VHW trainers in a systematic way to village conditions, so as to identify health problems and decide what VHWs can do about them.	Under direction and guidance of MOH tutors
		2. To work with animators in training village health committees, and selecting VHWs so as to begin to develop a working relationship with the villages and VHWs whom they will teach and supervise.	

Phase	Time	Objectives	Responsibilities
3. **Adaptation of RTC Training Materials** The adaption of the program should be undertaken following the village diagnosis. This will constitute the second phase of training of the Lome RTC participants i.e. on the job training in adapting the materials to conditions of PHC program locality. The training of VHW trainers will be carried out concurrently Emphasis will be placed on giving VHW trainers (PMI nurses and midwives) teaching practice with the materials as they are adapted.	25 days	1. To select tasks, course objectives, session plans and modify them according to conditions and realities of village life, referral system, logistic support and other constraints. 2. To organize session plans in a training program on basis of allocated training time, training logistics and facilities, possibilities of supervision, refresher courses. 3. To give VHW trainers opportunity to practice teaching with adapted session plans and visual aids.	MOH tutors working with input from VHW trainers. RTC staff will provide guidance and direction.
4. **Training program for VHWs** At least the first two cycles of training should be done primarily by the MOH tutors. The VHW trainers will work with the tutors and teach selected sessions as part of intensive teaching practice. They should be given as much supervised teaching practice in order to assure quality of teaching when they begin to teach on their own. The MOH tutors will find it easier to supervise them if they have first [illegible] with the course.	Recommended maximum 1 month	1. To give tutors opportunity to test and evaluate training programs so as to determine what further modifications are necessary. 2. To permit VHW trainers to observe training program for VHW. 3. To give VHW trainers increased opportunities for teaching practice under real training conditions so as to give them familiarity with materials and teaching methods before taking full responsibility for training VHWs.	MOH tutors. RTC staff will collaborate with MOH tutors in supervising teaching practice of VHW trainers and in evaluating trainers and course results

	Phase	Time	Objectives	Responsibilities
5..	Recyclage for VHW Trainers It is suggested that a regular recyclage program be instituted for VHW trainers to upgrade capabilities in training and supervision and to discuss program problems.	5 days	To review training and supervision methods.	RTC staff

ANNEX 5

04 04, Ivory Coast

June 16, 1980

M E M O R A N D U M

TO: Dr. B.S.F. Adjou-Moumouni
Coordinator of Studies
WHO Training Center, Lomé

FROM: S. Helfenbein
Assistant SHDS Project Director

SUBJECT: RTC Lagos Follow-up Visit to the Gambia

1. Please find enclosed a copy of the report Dr. El-Neil and I submitted to the MOH/Banjul on proposed plan of collaboration between the RTC Lagos and Gambian PHC program. There are some differences in approach from that proposed for Mauritania, but the overall pattern remains the same. You will be interested to know that the two Gambian graduates of the Lagos RTC who are developing their own session plans are using the VHW training materials as a guide for form, content and just generally for ideas whenever they run into a problem of formulating performance objectives or developing a session plan. We have had so far two approaches to follow-up and I imagine as this program develops, there will be many more to experiment with. I think there is probably not a single model to fit all needs and expectations.

2. I am also enclosing a copy of our latest memo to AID/W regarding the outstanding equipment. I hope we will obtain the waiver by the end of this month. If so, the equipment can be shipped by the end of July.

3. We had quite a history with the equipment for Lagos. On Dr. El-Neil's request, we shipped them via Lomé as he wanted to ensure a safe arrival. I appreciate everything that you and Mr. Lalo have done to expedite clearance from customs.

SH:ba

Enclosures: as stated

REPORT OF FOLLOW-UP MISSION TO THE GAMBIA OF THE WHO RTC TRAINING OF TRAINERS (TOT) OF VILLAGE HEALTH WORKERS (VHW) COURSE. 10 - 14 JUNE 1980.

Submitted by Dr. H. El Neil, Coordinator of Studies; WHO Regional Training Center (RTC), Yaba, Lagos

S. Helfenbein, Assistant SHDS Project Director for training , Abidjan, The Ivory Coast.

1. The objective of this mission was to determine and plan a programme of follow-up collaboration to Gambian participants in the above course in developing an in-country training programme for village health workers. Collaboration between the RTC and the Government of The Gambia was to be rendered in the context of SHDS Project objective II activities in the Regional Training Centers (RTC) Lome and Lagos towards the facilitation of the implementation of the Gambian Action Plan for Primary Health Care (PHC).

2. Consultations were held with Dr. E. M. Samba, Director of Medical Services, Dr. F. Oldfield, Deputy to Director of Medical Services, Dr. N. B. Akim, WPC, Banjul, Dr. P. Gowers, Medical Officer of Health, Dr. P. Parekh, Representative of Project Concern International, Mr. John Spring, UNICEF, Dakar, Mr. T. D. Smart, Mrs E. Mboge, Mr. M. Marenah, graduates of the Lagos RTC TOT Course, and Mrs A. Stafford, Trainer of traditional birth attendents (TBAs).

3. The training programme for VHW has been re-scheduled for January 1981. 18 villages in Lower River Division have been selected. Visits by the PHC training team have been made to several villages in a programme of "sensitization" to inform villages about the PHC programme request their participation and nomination of a village health worker trainee. The Primary Health Team has begun to develop a job description for village health workers. Tasks were identified in five areas. The RTC Lagos graduates have begun to do a task analysis, and prepare session plans for the training programme

4. The expressed needs for collaboration from the RTC through the SHDS project were in the following areas -

(i) collaboration in the development of the curricula of the VHW training programme

/....

(ii) provision of critical material resources in regard to the above;

(iii) provision of some collaboration in the development of a training programme for TBAs;

(iv) development of a programme to reorient the Gambian health workers to Primary Health Care.

5. The following recommendations were made with regard to the above expressed needs.

(i) Collaboration in the Development of a Curriculum for the VHW Training Programme.

Four possible areas of collaboration were identified to facilitate the development of a curriculum and its articulation for the first training programme of VHWs in The Gambia;

(a) Consultation by the RTC staff in the eleboration of a detailed operational plan for the training programme. Dr. U. O. Imade STC in Management will be available in July 1980 for this mission.

(b) Review of the task analysis and session plans prepared by RTC graduates and collaboration in any necessary revision. Mrs Anu Adegoroye, STC in curriculum development will be available in December 1980 for this mission.

(c) Collaboration in conducting, and administration of the training programme and preparation of the final field tested package for training VHWs in subsequent phases of the Gambian PHC programme. Dr. S. Ericson, SHDS educational Technologist will be available in January 1981 for this mission.

(d) Collaboration in evaluating the VHW training programme and in preparing an operational plan for further training and supervision. RTC and SHDS staff will be available for this mission.

(ii) Provision of resources to Develop the VHW Training Curriculum

(a) Funds would be available from the SHDS project through

/....

the WPC Banjul to defray directs costs associated with the development, production and adaption of VHW training materials.

(b) It was understood that either WHO/AFRO, UNICEF or other agencies, would furnish a vehicle to the Primary Health Care training team for the proposed extensive pre-training, sensitization of village communities, follow-up training and supervision.

(c) Consultants mentioned in point (i) would be financed completely by the SHDS project.

(iii) Provision of collaboration in Development of Curriculum for Training of TBAs.

Possibility of sending Sister Stafford to the Lagos RTC and the WHO collaborative programme for the training of TBAs in Sokoto, Nigeria preferably in August 1980, was suggested. Alternative funding possibilities including that of AFRO/SHDS funds would be explored.

(iv) Development of a programme to reorient Gambian Health Workers to PHC.

(a) It was suggested that such a programme could be linked to the already planned SHDS continuing education workshop for Nurses in The Gambia to reorient practising nurses to PHC. (This workshop is part of the Post basic Nursing education programme for The Gambia, Sierr-Leone and Liberia, approved under SHDS Project Objective II)

(b) Dr. V. O. Imade would be available during his proposed July visit to discuss the administration and management implications of The Gambian Primary Health Care programme for further workshops to reach the estimated 700 health workers in The Gambia.

6. We gratefully acknowledge the kind invitation of The Government of The Gambia to follow-up the products of the WHO Regional Training Center Course for the training of trainers of Village Health Workers, and we very much appreciated the collaboration of all who made available their time to meet with us and discuss the Gambian PHC programme and the possible modalities of continued collaboration.

Health Policy Institute
53 Bay State Road
Boston, Massachusetts 02215
617/353-4386

Center for Strengthening Health
Delivery Systems in Africa

Box 1
AID
Lome

May 27, 1980

Mr. Earl Yates
Office of Regional Affairs
Africa Bureau
Agency for International Development
Department of State
Washington, D.C. 20523

Dear Earl:

We are writing to you concerning our requests for waivers to purchase equipment for use in the WHO Regional Training Center in Lome, Togo. We have requested a waiver to purchase a Gestetner table model offset machine and also to purchase video equipment from TeleTape Video Company of London. We have searched thoroughly and found that this equipment cannot be purchased in the U.S. with the proper 220 voltage and wiring requirements needed for use in Lome. The video equipment is not available in Togo, and the cost of the offset machine is considerably higher if purchased in Togo rather than in London. Therefore we would like to purchase all of this equipment in London for export to Togo.

We have written to Mr. Kenyon in November 1979 and again in January 1980 to request approval for these waivers. We have recently received several urgent inquiries from the Lome RTC as to the status of this equipment. The teaching activities at the Center are being hampered by the lack of this equipment which we had hoped would be in place by early this year. Since there is a time lapse of several weeks between the time an order is placed and delivery of the equipment to Togo, it is most important that we receive approval for these waivers as quickly as possible.

If you need any further information about this equipment, please let me know. We look forward to hearing from you soon regarding this matter.

Sincerely,

Mary E. Grandfield
SHDS Project

cc: S. Helfenbein
S. Ericsson
J. Montague

ANNEX 6

EVALUATION DU MATERIEL PEDAGOGIQUE POUR LA FORMATION DES ASV (revisé Avril, 1980)

1. Quels problèmes ont été identifiés dans le village?

2. Quelles tâches ont été sélectionnées pour la formation de l'ASV?

Hygiène du Milieu:
Nutrition:
Santé de la Mère:
Soins aux Enfants:
Soins aux Adultes:
Soins d'Urgence:
Méthodes de Travail:

2.1 Avez-vous éprouvé des difficultés dans la sélection des tâches? (Si oui, décrivez les modifications vous avez faites).

2.2 Avez-vous eu besoin de modifier des tâches sélectionnées? (Si oui, décrivez les modifications que vous avez faites).

3. Quelles tâches ont été développées parce que vous n'avez pas trouvé quelques unes qui correspondent aux problèmes identifiés? (Si vous avez pu sélectionner toutes les tâches, continuez avec question 4).

3.1 Avez-vous éprouvé des difficultés dans la formulation des tâches? (Si oui, décrivez les difficultés que vous avez rencontrées).

4. Quels objectifs avez-vous sélectionnés? (Si vous avez formulez vous-même tous les objectifs sans sélectionner, continuez avec question 6).

Hygiène du Milieu:
Nutrition:
Santé de la Mère:
Soins aux Enfants:
Soins aux Adultes:
Soins d'Urgence:
Méthodes de Travail:

4.1 Avez-vous rencontré des difficultés en sélectionnant les objectifs? (Si non, continuez avec question 5).

4.1.1 La façon dont les objectifs ont été formulés les a rendus difficiles à comprendre. (Donnez des exemples qui le démontrent).

4.1.2 Les objectifs n'étaient pas suffisamment détaillés. (Donnez des exemples).

4.1.3 Les conditions employées n'ont pas été décrites suffisamment en détail (Donnez des exemples).

4.1.4 Les conditions décrites ne correspondaient pas au milieu dans lequel je travaillais. (Donnez des exemples).

4.1.5 Les comportements inclus n'étaient pas ceux que je désirais apprendre aux AIV. (Donnez des exemples).

4.1.6 Le contenu des objectifs n'était pas correct. (Donnez des exemples).

4.1.7 Autres difficultés (donnez des exemples de chacune d'elles).

5. Avez-vous eu besoin de modifier les objectifs sélectionnés? (Si non, continuez avec question 6).

5.1 Pourquoi avez-vous modifié les objectifs?

5.1.1 Les conditions décrites dans les objectifs n'étaient pas correctes. (Donnez des exemples).

5.1.2 Les comportements énoncé dans les objectifs n'étaient pas nécessaires ou il fallait ajouter de nouveaux comportements. (Donnez des exemples).

5.1.3 Le contenu des objectifs a dû être changé. (Donnez des exemples).

5.1.4 Les objectifs n'étaient pas suffisamment détaillés. (Donnez des exemples).

5.1.5 Autres raisons. (Donnez des exemples).

6. Quels objectifs avez-vous dû formuler? (Si vous n'avez formuler aucun objectif, continuez avec question 7).

6.1 Avez-vous pu utiliser le format employé dans le livre? (Décrivez les difficultés que vous avez rencontrées).

6.2 Pourquoi avez-vous dû formuler vos propres objectifs?

6.2.1 Les conditions que je voulais ne se trouvaient pas dans les objectifs. (Donnez des exemples).

6.2.2 Les comportements que je voulais ne se trouvaient pas dans les objectifs. (Donnez des exemples).

6.2.3 Autres raisons. (Donnez des exemples).

PLANS DES UNITES DE COURS

7. Quels plans d'unité avez-vous employés? (Si vous avez formulé vous-même tous vos plans d'unité, continuez avec question 10).

Hygiène du Milieu:
Nutrition:
Santé de la Mère:
Soins aux Enfants:
Soins aux Adultes:
Soins d'Urgence:
Méthodes de Travail:

8. Avez-vous eu des difficultés en sélectionnant des plans d'unité? (Si non, continuez avec question 9).

8.1 Quelles difficultés avez-vous rencontrées en choisissant les plans d'unité appropriés pour les objectifs retenus?

8.1.1 L'objectif de performance donné dans les plans d'unité ne correspondait pas aux objectifs de cours (pour les modules: Hygiène du Milieu, Nutrition, Soins aux Enfants et Soins d'Urgence).

Je ne savais donc pas quel objectif devait être atteint à travers les différents plans d'unité.

8.1.2 Les plans d'unité n'ont pas été disposés dans le même ordre que les objectifs.

8.1.3 Autres raisons. (Donnez des exemples).

9. Avez-vous modifié vos plans d'unité? (Si non, continuez avec question 10).

9.1 Quelles difficultés avez-vous éprouvés en essayant de modifier les plans d'unité?

9.1.1 Je ne pouvais pas utiliser les activités parce que je ne savais pas comment les mener (donner des exemples).

9.1.2 Le niveau des stagiaires avait été sous estimé et je ne savais pas comment modifier les plans d'unité pour les adapter à des stagiaires lettrés. (Donnez des exemples).

9.1.3 J'ai du changer le contenu des leçons parce qu'il ne correspondait pas aux villages dans lesquels l'ASV devait aller travailler. (Donnez des exemples).

9.1.4 Je n'ai pas pu utiliser le matériel audio-visuel parce que je ne savais pas agrandir les images.

9.1.5 Je n'ai pas pu trouver le matériel à employer bien qu'il ait été indiqué dans le plan d'unité. (Donnez des exemples).

9.1.6 Je n'ai pas pu mettre les plans d'unité dans un ordre logique. (Donnez des exemples).

9.1.7 Autres difficultés. (Donnez des exemples).

10. Avez-vous formulé des plans d'unité vous-même? (Si non, continuez avec question 11).

10.1 Avez- vous pu utiliser les plans donnés comme un modèl pour vos propres plans? (Si non, décrivez les difficultés que vous avez rencontrées).

ACTIVITES PEDAGOGIQUES

11. J'ai trouvé que certaines activités planifiées que j'ai utilisées n'étaient pas appropriées. (Donnez des exemples).

12. Il n'y avait pas suffisamment d'activités de révision incluses pour permettre aux stagiaires d'apprendre les matières. (Donnez des exemples).

13. Il y avait trop d'activités de révision. (Donnez des exemples).

14. Le temps alloué aux activités n'était pas approprié. (Donnez des exemples).

15. Le matériel audio-visuel suivant que j'ai utilisé a été mal interprété par les stagiaires:

16. J'ai éprouvé les difficultés suivantes:

EVALUATION

17. Je n'ai pas pu développer des activités d'évaluation pour les objectifs, et l'évaluation prévue par le plan d'unité était insuffisante. (Donnez des exemples).

18. Je n'ai pas pu développer les instruments pour mesurer l'atteinte des objectifs. (Donnez des exemples d'objectifs).

19. Les activités d'évaluation et les instruments que j'ai utilisés n'étaient pas adéquats pour mesurer ce que les stagiaires avaient appris.

AUTRES ACTIVITES

20. Avez-vous pu inclure les activités au dispensaire dans le programme du cours des ASV? (Si non, donnez les raisons).

21. Avez-vous pu inclure les activités au village dans le programme du cours des ASV? (Si non, donnez les raisons).

APPENDICES

Appendix 1. Background Related to the Assignment

Appendix 2. Trip Itinerary

Appendix 3. AFRO Memorandum

Appendix 4. Course Methodology

Appendix 5. Course Objectives

Appendix 6. Course Schedule

Appendix 7. WHO/SHDS Guidelines for Applied Research on Health Service Delivery and Primary Health Care

APPENDIX 1

Background Related to the Assignment

The SHDS Project focuses its program on four inter-related objectives which include strengthening of health systems in West and Central Africa through programs in the areas of 1) health planning and management; 2) health manpower training; 3) disease surveillance and immunization; and 4) low cost health delivery.

The program in the fourth area of "low cost health delivery" has been the slowest in getting underway. Originally activities in this part of the Project were to be focused, to a large extent, on "strengthening the capabilities of two African educational institutions to serve as regional centers which would assist the countries of West and Central Africa, through training, applied research, and evaluation activities in developing and improving systems of low cost (affordable) health delivery". The CUSS (University Health Sciences Center) in Yaounde, Cameroon, had been identified as the institution in which the first center would be developed. Unfortunately, at about the time the program was scheduled to get underway, the Director of CUSS who had been very active in promotion on the new regional centers was unexpectedly replaced. Due to this sudden change and a desire to study the proposal in more detail, the Project Coordinating Committee voted in November, 1978 to table consideration on this aspect of the program. In early 1979, following the PCC meeting's decision, both USAID and WHO/AFRO requested that SHDS concentrate its efforts under Objective IV on applied research related to low cost health delivery, without attaching the program to specified centers. WHO/AFRO had identified applied research as an important aspect of its mid-term, five year plan for activities in the area of primary health care. As WHO/AFRO's funding and manpower for development of this aspect of its program was limited, it asked that SHDS consider developing a collaborative program in applied research, which would provide research training and also funding for applied research activities within the region. As a first step in this process, WHO/AFRO requested that the SHDS-sponsored primary health care workshop scheduled for June of 1979 develop the first draft of "guidelines for applied research" that could be used both within WHO/SHDS program and in other WHO/AFRO programs.

SHDS agreed to concentrate on development of a collaborative program in applied research. In June of 1979 the participants at the workshop gave recommendations concerning acceptable guidelines for applied research. The SHDS staff then worked to prepare a comprehensive document, based both on these recommendations and others suggested by the WHO/AFRO Advisory Committee for Medical Research in Africa. This was presented to WHO/AFRO in September, 1979. In addition, WHO/AFRO and SHDS worked jointly to outline program activities for 1980. These activities were to include finalization of the research program, planning and implementation of a regional course for development of research protocols, and

selection and support of applied research activities within the region. In November, 1979 the Project Coordinating Committee approved the 1980 plan.

In early 1980 further planning was completed on the applied research program. SHDS and WHO/AFRO tentatively scheduled the research course for late July, 1980 and Upper Volta and Senegal were chosen by the Regional Director as two possible sites for the activity. WHO/AFRO selected Dr. Thomas Nchinda (Cameroon) and Dr. Papa Soulye Ndiaye (Senegal) as the two AFRO consultants to participate in the planning and implementation of the course. SHDS identified Dr. Yolande Mousseau-Gershman (Canada), and Dr. Ann Brownlee (SHDS Boston) as two additional trainers. Dr. Mousseau-Gershman and Dr. Brownlee were also given the assignment of working with SHDS Abidjan and WHO/AFRO staff to develop final plans for the research program as a whole. A trip was planned for completion of this assignment in March-April of 1980.

APPENDIX 2

TRIP ITINERARY

WHO/AFRO arranged for meetings between Drs. Brownlee and Mousseau-Gershman and Drs. Nchinda and Ndiaye. As the latter two consultants were apparently unable to travel due to scheduling constraints, it was suggested that they be visited in turn in Senegal and Cameroon. Thus the itinerary followed by Drs. Mousseau-Gershman and Brownlee was as follows:

March 30, 31, 1980	Dr. Mousseau-Gershman met with Dr. Ndiaye in Dakar, Senegal to work on preliminary planning for the July research course.
March 31 - April 5, 1980	Dr. Brownlee joined Dr. Mousseau-Gershman in Abidjan where the week was devoted to joint planning with the Abidjan staff concerning the research program and course. In addition, Dr. Brownlee worked on other SHDS activities.
April 6-9, 1980	Dr. Brownlee and Dr. Mousseau-Gershman worked in Brazzaville with the WHO/AFRO staff, Dr. French and Mrs. Harvey on final planning for the research program and course. Dr. Brownlee concentrated on planning for the research program, Dr. Mousseau-Gershman on the design of the research course.
April 10, 1980	Dr. Mousseau-Gershman and Dr. Brownlee, along with Mrs. Harvey, met with Dr. Nchinda in Yaounde, working further on plans for the research course. (Dr. Mousseau-Gershman departed after this work was completed.)
April 14-16, 1980	Dr. Brownlee met with the directors of the Lome and Lagos Training Centers on other Project business.
April 17-20, 1980	Dr. Brownlee worked with the SHDS staff in Abidjan on drafting of final documents concerning the research course and program.
April 22, 1980	Dr. Brownlee met with Dr. Ndiaye in Dakar to discuss final plans for the research course.
May 7-8, 1980	Drs. Brownlee and Mousseau-Gershman met in Boston for two days of additional work on the research course.

WHO/SHDS GUIDELINES FOR APPLIED RESEARCH ON HEALTH SERVICE DELIVERY AND PRIMARY HEALTH CARE* **

1. Purpose of the guidelines

To encourage the development, application, and testing of strategies and techniques which will improve the capacity to plan, implement, and manage appropriate health delivery systems in West and Central Africa.

2. Objectives of the WHO/SHDS program for applied research on health service delivery and primary health care

2.1. To train and assist appropriate personnel in the region in 1) design of protocols and proposals for applied research on health service and primary health care; 2) research methodology; and 3) development of funding support for applied research.

2.2. To encourage the development and submission for funding of proposals for applied research on health care likely simultaneously to be of benefit in improving the health of the population and the applied research capabilities within the region.

2.3. To select proposals for WHO/SHDS sponsorship and participate in their support through offering WHO SHDS program funding and/or assisting in locating other funding sources.

2.4. To offer needed technical assistance to these applied research projects.

2.5. To obtain support for publication, dissemination, and application of useful findings of applied health services research undertaken in Africa.

3. The program's research priorities

3.1. Emphasis on national and regional health priorities and needs

Priority will be given to research proposals that:

--Focus on development of solutions to health problems that have relatively high priority in the country(ies) in which the research will be undertaken;

--Focus on solving problems that are critical to the successful implementation of primary health care programs;

---

*The first draft of these guidelines was prepared, at the request of WHO/AFRO, by a group of African health professionals and SHDS staff at the last WHO/AFRO-SHDS sponsored workshop on primary health care held at CUSS/UHSC (University Health Sciences Center) in Yaounde, Cameroon, June 12-16, 1979. This final draft was prepared by the SHDS staff, taking account of the workshop recommendations and other relevant documents from WHO/AFRO and elsewhere.

**Applied research on health services delivery and primary health care can be defined as the systematic study whereby basic knowledge and methodologies from one or more disciplines are brought to bear on the health needs of individuals and communities within a given set of existing conditions. (This definition closely follows that made by the WHO/AFRO Medical Advisory Committee on Medical Research in Africa during its third session, November 1978, page 7 of the report.)

--Focus on development, application, and evaluation of techniques and strategies that will significantly improve the health of local populations in the region and especially that of groups that are underserved, high risk, or otherwise vulnerable; and

--Address health issues and problems of importance to the effective delivery of health services throughout all or a substantial portion of the region.

3.2. Emphasis on areas identified by the Alma-Ata Conference as essential to primary health care:

Research proposals should focus on one or more of the following areas which have been identified by the International Conference on Primary Health Care at Alma-Ata in 1978* as essential to primary health care:

--education concerning prevailing health problems and the methods of preventing and controlling them;

--promotion of food supply and proper nutrition;

--an adequate supply of safe water, and basic sanitation;

--maternal and child health care, including family planning;

--immunizations against the major infectious diseases;

--prevention and control of locally endemic diseases;

--appropriate treatment of common diseases and injuries; and

--provision of essential drugs.

3.3. Additional areas for emphasis

3.3.1. Health manpower training

Priority will be given to research proposals, among others, that seek solutions to important problems of health manpower training, especially as this training relates to primary health care workers and their supervisors.

3.3.2. Health planning and management

Priority will be given to research proposals, among others, that seek solutions to current problems of health planning and management that hinder the delivery of adequate care to local populations.

*Page 4, Item 3, of the "Declaration of Alma-Ata" in Alma-Ata, 1978, Primary Health Care, WHO Geneva, 1979.

3.3.3. The cost of health care

Priority will be given to research proposals, among others, that address important problems concerning the cost of health care and the cost effectiveness and efficiency of various health program strategies.

3.3.4. Appropriate health technology

Priority will be given to research proposals, among others, which involve the development and/or application of appropriate, acceptable, low-cost, and effective technologies (either new or traditional) that, when possible, make broad use of local resources. Appropriate technologies for primary health care may include, among others, methods for promoting community participation, for involving and integrating traditional healers and birth attendants in the health system, for making use of traditional medical and pharmaceutical knowledge, for creating village pharmacies, etc.

3.4. Aspects of health service delivery to be explored

Research proposals focusing on programs of health service delivery might examine one or more of the following aspects of existing or alternative programs:

—The inputs into health delivery programs (e.g., personnel, staff training, equipment and supplies, budget, etc.)

--The process of health care delivery (e.g., administration and delivery of care, the cost and quality of the care provided, methods of program monitoring, etc.)

--The outputs of health delivery programs, (e.g., services rendered, persons served, etc.)

—The impact of this care on the population (e.g., effects on health status, demographic, socio-economic and political effects, etc.)

3.5. An integrated approach to health care

When appropriate, the proposal should reflect an integrated approach to the problems of health and health care.

Consideration of the health situation in the context of wider issues of socio-economic development and the country(ies)' development plans and problems is encouraged.

In some cases research may focus on development oriented-programs other than those traditionally considered "programs of health service delivery", which, nonetheless, may have a significant impact on health.

Collaboration with experts from disciplines, research organizations, and/or government ministries that should articulate with the health sector, such as those concerned with development, planning economics, housing, education, nutrition, agriculture, communication, social welfare, etc., is encouraged in cases where this collaboration will provide the study with a broader and more realistic consideration of the problem explored.

3.6. The value of comparative research

Projects which aim to replicate studies already done in other areas or countries will be considered when the proposed study is likely to produce comparative data and results of practical benefit in solving health-related problems.

Projects which explore the same aspect of health or health care within several countries or areas of the West and Central African region within a comparative format are encouraged. (This, however, does not preclude selection of protocols focusing on only one area or country.)

3.7. Choice of research topic

The choice of research topic is the prerogative of the individuals and/or organizations proposing the research. The list of priorities given above is presented to give applicants some idea of the types of topics that have been identified by African experts as important health and health care problem areas toward whose solution applied research could make a useful contribution. This list by no means covers all possible topics, but simply gives some of the general guidelines concerning acceptable research topics that will be used when considering proposals for possible funding under the WHO/SHDS Program of Applied Research.

4. Acceptable research standards and methodology

4.1. Knowledge and advancement of the field of study

The proposal should demonstrate a thorough familiarity with the current state of knowledge and research in the field to be explored and should indicate how the proposed study would advance understanding on the topic selected for research. Projects which take account of and build upon or explore complementary aspects of other research on the same problem are encouraged.

4.2. Maintenance of scientific standards of research

The project should use research design(s) and methodologies of acceptable scientific quality. For example:

--The research hypothesis(es), if there are any, should be clearly and acceptably stated.

--Methods for testing the hypothesis(es) should be of acceptable scientific quality.

--When using the experimental method, inclusion of control group(s) should be considered when practical.

--Research variables should be clearly identified, and adequate methods for controlling appropriate variables devised.

--Samples, if used, should be selected so as to avoid systematic bias.

--Issues concerning the reliability and validity of measurements should be adequately addressed.

--Statistical methods, when employed, should be appropriate.

--Pilot testing of the research methodology and design, when appropriate, should be included as part of the project.

--Methods for analyzing research data gathered should be adequately and clearly planned before the research begins.

4.3. Use of acceptable research methodology

Acceptable methods of research of any type and from any recognized discipline appropriate to the solution of the applied health sciences research problem may be used.

Not all research projects, for example, would necessarily utilize the experimental scientific approach (isolating a problem, testing a hypothesis with rigorous controls, and obtaining clear cut results). Health services research should be practical and applied and may use other methods such as observations made in health institutions and the field, critical analyses of existing health practices, studies of interesting cases, etc. The results will not always be expected to yield definite answers but should make available important data that will facilitate decision-making by health authorities.

4.4. Compliance with ethical standards of research

The proposal should comply with acceptable ethical standards for research. These would include adherence, when applicable, to acceptable ethical standards on such important issues as:

--the rights of human subjects involved in medical research;

--the rights of persons studied to privacy, confidentiality, and respect for cultural and religious beliefs (including the question of special problems involved in guarding these rights when dealing with illiterate or semi-literate populations);

--consideration of the social and environmental costs and benefits of the research and of the necessity of assessing the impact of the research in social, environmental and other areas; and

--the right of the population studied to feedback concerning the results, whenever appropriate.

5. Organization, administration and staffing of the research project

5.1. In-country approval of the proposal

Approval for the proposed project should be obtained from whatever national, university or other research review body is appropriate within the country(ies) in which the research will be undertaken. (In some countries this might be a national health or medical research council which is part of a more general national research review body.) The appropriate review body should, among other things, ascertain or verify that the project will contribute towards solving a problem whose solution is of high priority because of its probable positive impact on the health of the country's population.

The proposal should comply with whatever grant conditions normally apply in the country(ies) in which the project will be located.

5.2. Participants in the research

5.2.1. Use of local personnel

The principle investigator(s) on the project should be from the country or region in which the proposed research will take place. The project should utilize local or regional personnel in other project positions whenever possible. The proposal should indicate the nature and extent of local and regional research capability available for the project and how local and regional expertise will be utilized.

5.2.2. Appropriate types of personnel

The types of personnel used within the project are not restricted to health researchers, but can include research, service, and planning workers from a variety of disciplines and levels, as well as students enrolled in academic or training institutions, depending on the needs of the project When appropriate, efforts should be made to collaborate with research, planning and/or service personnel in other areas that should articulate with that of health, such as rural development, planning, economics, education, agriculture, etc.

5.2.3. Involvement of health service personnel

Health service personnel of various levels working within the health program or area studied should be involved, as appropriate, by those responsible for the planning and implementation of the research projects. As necessary, arrangements should be made for integration of research activities into the normal pattern of work.

Efforts should be made to foster, through project design, close collaboration between research and service personnel. Health service personnel, involved during the planning

stages, may be able to identify important problems of health or health care toward which research might be addressed. In addition, they may be able to give valuable advice concerning implementation of the research in health care and community settings. Health personnel who understand the research objectives and are involved in appropriate roles in the study's execution are much more likely to have an investment in utilizing its results.

5.2.4. Involvement of community members

In some cases it may be possible to involve persons in the community studied in either the formulation of the research problem, planning of the research, its implementation, or evaluation. To the extent that community involvement and participation of any of these types is feasible, appropriate, and beneficial, it is encouraged.

5.2.5. Affiliation of participants with local or regional institutions

The group applying for the grant should be affiliated with a local or regional institution or organization. There are no specific restrictions on the types of institutions that may be involved. The institution may be, for example, an educational organization, a governmental, private, or community agency or group whose work relates to the planning or delivery of health care or applied health-related research, etc.

5.2.6. Use of outside personnel

In cases in which certain necessary technical expertise is not available within the country or the region, the project designers may wish to utilize expertise from outside the region. In cases such as this the project design, when practical, should include mechanisms for training local personnel in the skills initially provided by outside consultants.

5.2.7. Collaboration with outside institutions

In certain cases where particular types of technical expertise are not available locally, the organization(s) proposing the study may wish to collaborate with institutions from either within or outside the region in implementation of the study. If so, the local or regional organization(s) involved should have the major decision-making power on the project.

5.3. Length, scope, and budget of the project

5.3.1. Length of the project

The length of the project may vary, depending on the particular problem or issue addressed and the methods proposed to investigate it. Because research funds are limited and potential projects to be funded numerous, the projects pro-

posed should be as short and practical as possible, considering research requirements.

If the research is successfully completed and there are strong indications both that the results thus far have been of major practical benefit and that further study will yield additional positive results of sufficient value, an application may be made for funding of further "phases" of the project.

5.3.2. Scope and complexity of the project

The project should be of a scope and complexity that is reasonable, considering the past research experience and current research capabilities of the investigators, and the needs of the particular study.

5.3.3. Size of the project budget

The project budget should be reasonable considering 1) realistic funding needs of the research study proposed; 2) the capacity of the research group to use the funds effectively; and 3) the benefits the project is likely to bring in terms of improved health and/or health care, in comparison with the project's cost.

5.4. In-country coordination of the project

Research projects selected should be coordinated by whatever research body is most appropriate within a particular country. In some countries national health or medical research councils (at times part of a larger national research body) supervise and coordinate health-related research. In countries where these councils or similar bodies do not exist, authorities might be encouraged to explore the possibility of developing them. As much as possible, a balance should be maintained between the need for guiding research in accordance with nation policy directives and the need to preserve a climate that fosters beneficial creativity and innovation.

Whenever possible, authorities responsible for supervision of health research should coordinate with similar authorities in other areas or disciplines that should articulate with that of health.

5.5. Monitoring and evaluation of the project

The proposal should indicate what techniques and mechanisms will be utilized either internal to the project itself and/or an institutional or national level for monitoring and evaluating the project for quality of work, maintenance of the work schedule, adequacy of administrative and fiscal procedures, etc. Development of adequate monitoring and evaluation mechanisms for the project are essential. Periodic and final reports should be made.

5.6. Strengthening of local and regional institutions and their research capabilities

Whenever possible, proposals should include arrangements which serve

to strengthen institutions and their research capabilities within the country(ies) and/or region in which the project will be located. These arrangements could involve such things, among others, as 1) hiring of needed staff who may remain with the institution after the project ends; 2) planning for staff experience on the research project which will be of benefit to them in future work; 3) planning for on-the-job or more formal training of project staff in research techniques and other appropriate areas which will be of value to them and their institutions; 4) encouraging, through the research design, development of institutional mechanisms for project administration, monitoring, and/or evaluation that will be applicable in other program areas; and 5) encouraging, through the research design, establishment of collaborative relationships between institutions and individuals of long-term value.

Plans for dissemination and utilization of research results

6.1. Dissemination of results

Tentative plans for dissemination of research results should be outlined within the proposal. Major emphasis should be placed, in these plans, on distribution of results to potential users, both national and local, within the West and Central African region. Findings may be published in journals or other publications with principle circulation outside this region but, if so, should first be presented in publications with wide distribution within the region. (Note: Use of the publication and dissemination resources of WHO and other international organizations is encouraged.)

6.2. Utilization of findings

The proposal should include a statement concerning practical application of the results anticipated. It should describe any arrangements which have been or will be made within the country and/or region which will assure or make more likely utilization of the research results for improvement of health or health care.

7. Suggested format for research proposals

7.1. Title

7.2. Introduction

Brief summary of project, including at least 1) problem or need identified; 2) project goal, objectives, research design, and methodology; 3) investigators and institutions participating in project and their roles; and 4) rationale for proposed approach to problem.

7.3. Statement of problem or assessment of need

Brief description of 1) circumstances that have prompted proposal of the research 2) relation of the proposed research to other past or current studies (both by the investigators and others), and why the research

is needed; and 3) relevance of the study to national and regional health and health research priorities.

7.4. Goal and objectives

Description of 1) overall goal of the project; and 2) specific objectives, both short and long term.

7.5. Research design and methodology

Description of the overall research design and methodology, including 1) research hypothesis(es); 2) methodology for gathering data including, if applicable, sampling plans, variables, instruments and plans for determining their reliability and validity, compliance with ethical standards, and why methods chosen are most appropriate; 3) methods of data analysis; 4) anticipated results; 5) plans for dissemination of findings; and 6) project timetable or schedule, with target dates for completion of various stages of the project specified.

7.6 Project personnel and administration

A brief description of personnel that will be involved in the project, including staff involved in research, secretarial support, administration and evaluation. The discussion should include information on the positions planned, percentage of time on project, institution in which the positions will be located, brief job descriptions, identification of individuals who would fill the positions and their past experience. Brief discussions should also be included of plans for administration, monitoring, and evaluation of the project and of what institutions will be involved in the project and the roles they will play.

7.7 Significance

Significance of project, including 1) expected practical applications of results, plans for utilization of findings for improvement of health and/or health care, both nationally and within the region as a whole, etc.; 2) potential value of results for training purposes; and 3) extent to which the project is likely to strengthen the research capabilities of African researchers and institutions.

7.8 Budget and other support

Description of 1) budget for entire period of project with details of first year costs; 2) budget justification; and 3) other sources of support for project, either applied for or already assured.

7.9 Appendices

Appendices with more detailed data on various aspects of project than that given in the body of proposal, such as 1) list of personnel on project, their roles, percentage of time on project, summary of background and experience, curriculum vitae, etc.; 2) description of organizations involved in the research, roles they will play, their experience in related areas, facilities and equipment available; 3) bibliography of publications related to proposed research; and 4) other relevant material.