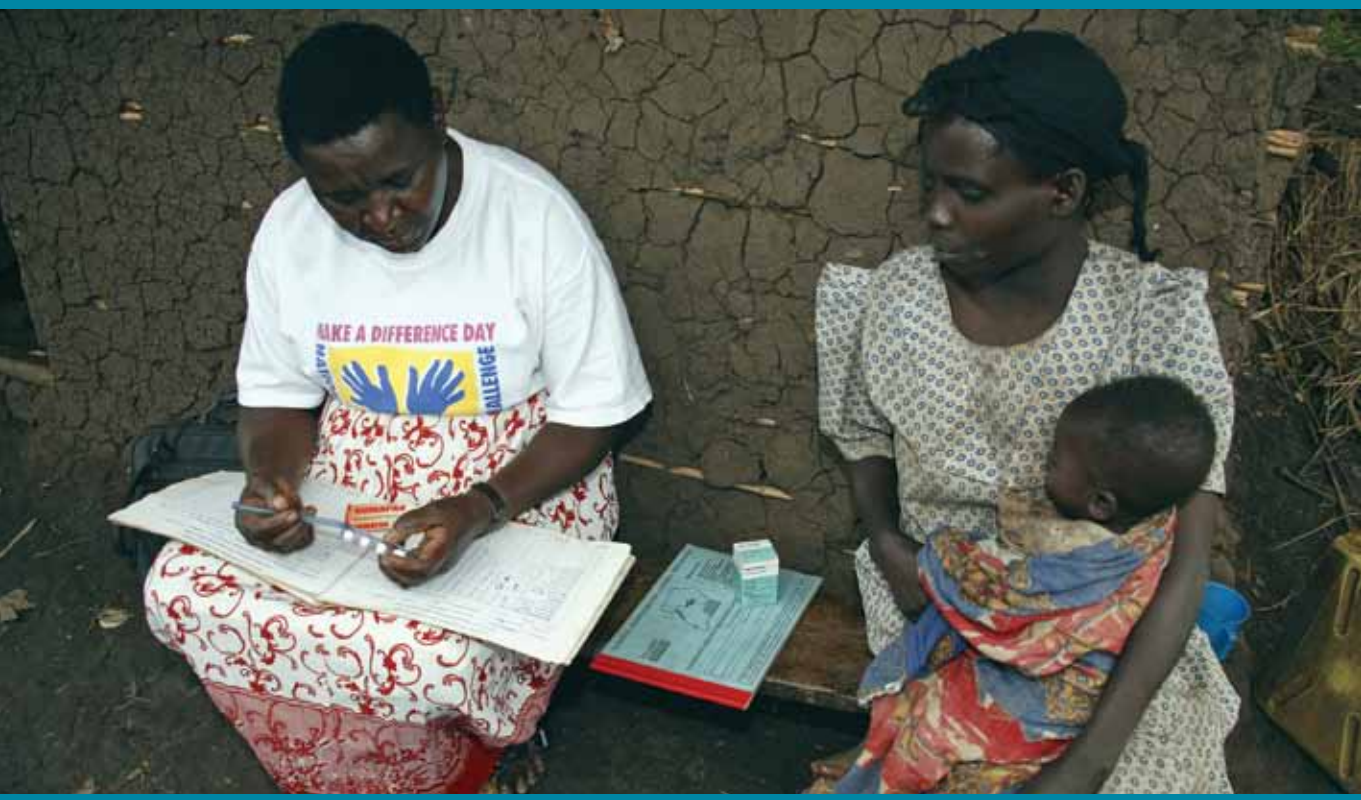
AFRICAN PROGRAMME FOR
ONCHOCERCIASIS CONTROL

CURRICULUM AND TRAINING MODULE ON THE COMMUNITY-DIRECTED INTERVENTION (CDI) STRATEGY FOR FACULTIES OF MEDICINE AND HEALTH SCIENCES

(2nd edition)



World Health Organization

WHO/APOC/MG/12.1

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**African Programme for Onchocerciasis Control,
World Health Organization (APOC/WHO)**

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INTRODUCTION

Preface

The communities, in partnership with health professionals, can manage the prevention and treatment of selected diseases that are prevalent in their environment. This has been confirmed by a multi-country study on community directed treatment with Ivermectin (CDTI) to control Onchocerciasis (river blindness). This strategy can be effectively and efficiently applied as a means of bringing multiple health interventions to the poorest communities, especially in remote areas. Such an approach is known under the generic name of Community Directed Intervention (CDI).

CDI empowers communities to get involved in decision-making for their own health. Therefore it has the potential to strengthen Primary Health Care, in particular where resources and infrastructure are insufficient. CDI is also a good approach for boosting community participation in health delivery systems. For these reasons, APOC initiated the development of a curriculum for medical and nursing schools as a means of disseminating CDI in Africa.

In 2007, APOC invited six experts, under the chairmanship of Professor Mamoun Homeida (University of Medical Sciences & Technology, Khartoum, Sudan), to develop a curriculum on CDI Strategy. The members of the team were: Mrs Georgette Abangla and Professor Abdoulaye Diallo (West African Health Organization, Bobo Dioulasso, Burkina Faso), Professor Oladele Akogun (Parasite and Tropical Health, Federal University of Technology, Yola, Nigeria), Professor Khaled Bessaoud (Institut Régional de la Santé Publique de Ouidah, Bénin) and Professor Grace Offorma (Department of Arts and Education, University of Nsukka, Nigeria).

Subsequently, the draft curriculum and training manual were presented at a meeting of experts from ECOWAS countries, held in Bobo Dioulasso and aimed at harmonizing the programmes of different institutions. Fourteen countries were represented at that meeting.

A review and repackaging of the curriculum was completed in 2008. Since then high level review meetings of vice chancellors, deans, senior academics and heads of schools of nursing have been convened in Abuja (June 2009) and in Nairobi (November 2010) during which the curriculum and training module were finalized and adopted. One of the main recommendations from these consultations was to develop and produce a trainers' handbook.

Under the Chairmanship of Dr Yankum Dadzie, former Director of the Onchocerciasis Control Programme in West Africa (OCP) and former Interim Director of APOC, a team of experts was convened at a workshop in Ouagadougou in August 2011 to develop the trainers' handbook. The team included Professors Oladele Kale (University of Ibadan, Nigeria), Joseph Okeibunor (Dean, University of Nsukka Nigeria), William R Brieger and Bright C Orji (The Johns Hopkins University), Oladele Akogun (Parasite and Tropical Health, Federal University of Technology, Yola, Nigeria,) and Dr Uche Amazigo (Former Director, APOC). On behalf of the African communities, APOC Partners and Donors, we thank all these contributors.

We are hopeful that this second edition which has taken in account inputs from numerous contributors will effectively contribute to the preparation and production of future generations of health personnel empowered to use the CDI strategy to scale up priority health interventions at community level.

Dr Paul-Samson Lusamba-Dikassa
Director, African Programme for Onchocerciasis Control

BACKGROUND

Africa's insufficient health workforce is a major constraint to attaining the Millennium Development Goals (MDGs) for reducing poverty and disease. While Africa's burden of the World's disease is 25%, its share of the world's health workforce is only 1.3%.

As a result many out-of-reach populations are deprived of any kind of health services and the few established health programmes are not sustained, bringing disillusion to the population and loss of confidence in the health systems.

Communities are often not consulted or involved in determining the health needs or priorities of health systems.

In many previous health-intervention programmes, experts defined the problem, determined the solution and the strategy by which the interventions would be applied to the community. Such health systems are generally top-down in nature, and communities and partners did not collaborate in undertaking those health programmes.

INTRODUCTION

In Africa, weak health systems continue to be a major constraint to the attainment of the MDGs due to the dearth of human resources in the health sector, limited financial resources, poor health infra-structure, and application of inappropriate strategies applied. This has resulted in the inability of the Health systems to meet the health care needs of communities and loss of confidence by the populations, resulting in failure of health interventions.

Even when communities were involved in health-intervention programmes, their role was that of beneficiaries.

Furthermore, key factors, such as cost-effectiveness, accessibility, and fairness in health services, were not respected and the geographic coverage of these health interventions was too low.

There is disparity among the people, both within regions and between sexes. Although psychologically, people were dependent on the health services, for numerous reasons, lack of use of health facilities by people needing health care led to attrition of the health staff.

Moreover, health staff are often unmotivated and ill equipped to address the health care needs of the people. This is due to several factors including