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EVALUATION OF THE JOHNS HOPKINS  
PROGRAM FOR INTERNATIONAL EDUCATION  
IN GYNECOLOGY AND OBSTETRICS  
(JHPIEGO)

by

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TABLE OF CONTENTS

GLOSSARY . . . . .	v
EXECUTIVE SUMMARY . . . . .	vii
I. INTRODUCTION AND BACKGROUND . . . . .	1
I.1 Project Background . . . . .	1
I.2 Purpose of Report . . . . .	1
I.3 The Evaluation Team . . . . .	2
I.4 Methodology . . . . .	2
I.5 Constraints . . . . .	3
I.6 Assessment of JHPIEGO Accomplishments . . . . .	3
I.6.1 Quantitative Accomplishments . . . . .	3
I.6.2 JHPIEGO's Special Attributes . . . . .	3
I.6.2.1 Widespread Acceptability of JHPIEGO's Program . . . . .	3
I.6.2.2 JHPIEGO as a Goodwill Ambassador. . . . .	4
I.6.3 Need for New Directions . . . . .	4
II. PROGRESS SINCE THE 1980 EVALUATION . . . . .	6
II.1 The 1980 Evaluation . . . . .	6
II.2 Curriculum-Related Changes . . . . .	6
II.2.1 Reproductive Health . . . . .	6
II.2.2 Demographic Information and Contraceptive Technology . . . . .	7
II.2.3 Clinical Training in IUD Insertion, Minilapa- rotomy and Vasectomy . . . . .	7
II.2.4 Selected Issues Including Infertility . . . . .	7
II.3 Target Groups . . . . .	7
II.3.1 Training for Nurses . . . . .	8
II.3.2 Private Sector Training . . . . .	8
II.4 Approaches to Training . . . . .	8
II.4.1 Interchange Among Regional Training Centers . . . . .	8
II.4.2 JHPIEGO as a Resource Center . . . . .	8
II.4.3 Demonstration Service Projects . . . . .	9
II.4.4 New Directions . . . . .	9

III.	TRAINING . . . . .	10
III.1	In-country, Regional, and U.S. Training: An Assessment . . . . .	10
III.1.1	Overview . . . . .	10
III.1.2	In-Country Training . . . . .	10
III.1.3	Regional Training . . . . .	11
III.1.4	Stateside Training . . . . .	11
III.1.5	Recommendations . . . . .	12
	III.1.5.1 Follow-up . . . . .	12
	III.1.5.2 Materials . . . . .	12
	III.1.5.3 Regional Training . . . . .	12
	III.1.5.4 Baltimore-Based Training . . . . .	13
III.2	Curriculum . . . . .	13
III.2.1	Progress Since 1980 . . . . .	13
III.2.2	Voluntary Sterilization and Abortion: AID's Concerns . . . . .	14
III.2.3	Recommendations . . . . .	14
	III.2.3.1 General . . . . .	14
	III.2.3.2 Curriculum-Related Improvements . . . . .	15
	III.2.3.3 Teaching Methods . . . . .	15
	III.2.3.4 Use of Consultants . . . . .	15
	III.2.3.5 Expansion of Curriculum Reforms to Regional Training Programs . . . . .	15
III.3	Training Targets . . . . .	16
III.3.1	Overview . . . . .	16
III.3.2	Nurse-Midwives . . . . .	16
	III.3.2.1 General . . . . .	16
	III.3.2.2 Selection Criteria . . . . .	16
	III.3.2.3 Course Design . . . . .	16
	III.3.2.4 Materials . . . . .	17
	III.3.2.5 Follow-Up Activities . . . . .	17
	III.3.2.6 Overlap with Other AID and Donor Training . . . . .	18
III.3.3	Non-Physician Professionals . . . . .	18
III.3.4	Private Physicians . . . . .	18
III.3.5	Recommendations . . . . .	19
	III.3.5.1 General . . . . .	19
	III.3.5.2 Nursing Training . . . . .	19
	III.3.5.3 Non-Physician Training . . . . .	20
	III.3.5.4 Private Sector Training . . . . .	20

III.4	New Approaches to Training . . . . .	21
III.4.1	Overview . . . . .	21
III.4.2	Satellite-Based Program . . . . .	21
III.4.3	Correspondence Courses . . . . .	21
III.4.4	Team Approach . . . . .	22
III.4.5	Coordination with Other Donors . . . . .	22
III.4.6	Recommendations . . . . .	22
III.4.6.1	Correspondence Courses . . . . .	22
III.4.6.2	Donor Coordination . . . . .	23
III.4.6.3	Service Delivery Programs . . . . .	23
III.4.6.3	Coordination with Other Universities . . . . .	23
III.5	Institutionalization . . . . .	24
III.5.1	Achievements . . . . .	24
III.5.2	Recommendations . . . . .	25
IV.	EQUIPMENT . . . . .	26
IV.1	Observations . . . . .	26
IV.2	Recommendations . . . . .	26
V.	ADMINISTRATION, FUNDING, PLANNING AND PROGRAM MANAGEMENT . . . . .	28
V.1	Administration . . . . .	28
V.1.1	Organization . . . . .	28
V.1.2	Administrative Guidelines . . . . .	28
V.1.3	Relationships Between JHPIEGO and Johns Hopkins University . . . . .	29
V.2	Program Funding . . . . .	29
V.2.1	Fiscal Conservatism . . . . .	29
V.2.1.1	Background . . . . .	29
V.2.1.2	Reasons for JHPIEGO's Posture . . . . .	29
V.2.1.3	Examples of JHPIEGO's Fiscal Conservatism . . . . .	30
V.2.2	Budgeting . . . . .	30
V.2.3	Procedures for Fund Transfer . . . . .	31
V.3	Long-Term Planning . . . . .	31
V.4	Programming . . . . .	32

V.4.1	Overview . . . . .	32
V.4.2	Subgrantee Selection . . . . .	32
V.4.3	Country Selection . . . . .	33
V.5	Monitoring and Evaluation . . . . .	33
V.5.1	Monitoring and Follow-up . . . . .	33
V.5.2	Evaluation . . . . .	33
V.6	Recommendations . . . . .	34
V.6.1	Introductory Remarks . . . . .	34
V.6.2	Creating a Balance Between Programming and Financial Concerns . . . . .	34
V.6.3	Fiscal Management . . . . .	34
V.6.4	Staffing . . . . .	35
V.6.5	Planning . . . . .	36
V.6.6	Programming . . . . .	36
V.6.7	Monitoring and Evaluation . . . . .	37

APPENDICES:

- Appendix A: THAILAND: COUNTRY REPORT
- Appendix B: NIGERIA: COUNTRY REPORT
- Appendix C: EGYPT: COUNTRY REPORT
- Appendix D: TUNISIA: COUNTRY REPORT
- Appendix E: MEXICO: COUNTRY REPORT
- Appendix F: PERU: COUNTRY REPORT
- Appendix G: KENYA: COUNTRY REPORT
- Appendix H: LAPAROSCOPY PROGRAMS: NIGERIA, MEXICO, AND TUNISIA
- Appendix I: SCOPE OF WORK

GLOSSARY

AVS	Association for Voluntary Sterilization
FEMAP	Federacion Mexicana de Asociaciones Privades de Planificacion Familiar
FHI	Family Health International
FPAK	Family Planning Association of Kenya
FPIA	Family Planning International Assistance
IAC	International Advisory Council
ICD	International Cooperation Division
IEC	Information, education and communication
IMSS	Mexican Social Security Institute
INTRAH	International Training in Health
IPAVS	International Project of the Association for Voluntary Sterilization
IUD	Intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
LDC	Less developed country
MEXFAM	Mexican Family Planning Association
MOH	Ministry of Health
MCH	Maternal and child health
MOPH	Ministry of Public Health
OB/GYN	Obstetrics/gynecology
ONFP	Office National de la Famille et de la Population (Tunisia)
ORT	Oral rehydration therapy
PPFA	Planned Parenthood Federation of America

RAP            Resource Allocation Plan  
RDO            Regional Development Officer  
UNFPA          United Nations Fund for Population Activities  
UNICEF        United Nations Children's Fund

## EXECUTIVE SUMMARY

### The Project

Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) was formed in 1974 with a grant from AID. To date, \$63 million in U.S. government funds have been authorized. Current funding through an AID cooperative agreement is scheduled to terminate September 30, 1986. AID funds represent 95 percent of JHPIEGO's budget.

JHPIEGO's mandate is to train less developed country (LDC) medical professionals in up-to-date reproductive health concepts and techniques. Training is now done primarily in LDC institutions, though some courses are still conducted at JHPIEGO's Baltimore headquarters. Physicians and medical school faculty were the original target groups, recently augmented by the addition of nurses and para-professionals.

### The Assignment

This evaluation was requested to assist AID to design a follow-on project. At AID's request, the team was asked to look at several issues not in the original scope of work, namely: JHPIEGO's ability to program creatively and its stance vis-a-vis AID's Resource Allocation Plan, sterilization and abortion, and the private sector. The team decided against reviewing JHPIEGO's repair and maintenance (RAM) centers, because a comprehensive evaluation had very recently been conducted.

Team members visited JHPIEGO headquarters for 2 1/2 days and then dispersed for field trips in seven countries on three continents. The team felt the amount of time provided for the visit to headquarters was inadequate and therefore urges that recommendations on administrative matters (number 28-38 in the Executive Summary) be reviewed in concert with recommendations in the most recent management review. There were also problems in coordinating team members' availability which presented some difficulties vis-a-vis consolidation of findings.

### General Assessment

Quantitatively JHPIEGO has far exceeded its training goals over the past five years. At the same time, it has strengthened its image as an AID program that, perhaps better than any other, represents in a positive way U.S. interests abroad.

Indeed JHPIEGO, apart from its impact in training, has become a potent good will ambassador. More LDC physicians holding positions of influence have studied at Johns Hopkins University than any other foreign institution, and this linkage has been a potent catalyst in permitting the evolution of reproductive health programs in many politically sensitive areas of the world. Thus, there is little question about the importance of continuing JHPIEGO activities. To curtail or significantly reduce JHPIEGO funds would be counterproductive to AID's broader mandate.

#### Progress Since 1980

JHPIEGO has succeeded in implementing most of the programmatic changes recommended in the 1980 evaluation. In the area of curriculum development, JHPIEGO has initiated and expanded training in academic skills, microsurgery and sexually transmitted diseases. It has continued to train in reproductive health and administration. Each of these areas is appropriate in many parts of the world and fills an unmet training void. The training modules that have been developed by JHPIEGO are, for the most part, superior. The ability to provide high quality training under the Johns Hopkins umbrella is the unique feature of JHPIEGO.

In terms of trainee targets, JHPIEGO has moved rapidly into the area of nurse midwife training as recommended, although its involvement with the private sector physician remains minimal. It has also continued to provide training to health administrators and government officials. In its approach to training, it has seized opportunities to move from the strictly academic model into imaginative satellite and correspondence graduate courses for otherwise hard-to-reach target groups. It has also had some success in cooperative programs with other donor agencies. In general, JHPIEGO has shown that it has been able to respond imaginatively to recommendations designed to broaden the scope of its training and to encompass new types of trainees.

JHPIEGO has made progress on a number of fronts in institutionalizing its training initiatives. Although funding will also be a consideration in institutionalization, the fact remains that JHPIEGO has instilled among personnel in centers where it has had training programs a commitment to reproductive health training; it has convinced political leaders in many countries of the validity of its training in reproductive health; it has fostered a good understanding of the roles of endoscopic and laparoscopic sterilization procedures; and, although perhaps to a lesser degree, it has succeeded in beginning to institutionalize curriculum changes in universities where it has been involved, particularly through deans' conferences.

### In-Country Regional and Baltimore-based Training

In-country, regional and Baltimore-based training are all important, if for slightly different reasons. As a rule, new courses are offered in Baltimore and then modified for LDC in-country use. This model works well and should not be changed.

Baltimore training has also permitted influential administrators, physicians, and government officials to plan for program implementation in a supportive environment. There are numerous examples of this process leading to JHPIEGO successes at the field level. Of equal importance is the powerful influence JHPIEGO exerts in establishing positive Western ties with community and frequently with national leaders.

In-country and regional training programs are more cost effective than Baltimore-based ones. They help strengthen national health and family planning infrastructures, and they provide to trainees a more realistic view of the problems they may encounter after training.

Regional programs may have met more political and administrative problems than have in-country ones, but both types certainly should remain the principal vehicles for JHPIEGO training.

### Management and Programming

A number of management and financial problems tend to inhabit the programming process. Fiscally, JHPIEGO remains very conservative, with programming and long-term planning concerns often taking second place to budget issues. Furthermore, the programming process is based on a rigid philosophy. Programs are rarely drafted by LDC professionals, but rather by JHPIEGO staff after returning to Baltimore. This approach provides little flexibility to respond to particular local areas of concern. Monitoring and evaluation, which should be sources of critical input for new program ventures, also remain less than satisfactory. Despite these constraints, there is little change in the perception that JHPIEGO has selected appropriate subgrantees. Many have made significant contributions by administering regional and local training, and by virtue of their position and influence, have worked for changes in medical school curricula.

## Recommendations

### Training

#### General

1. In-country project directors, regional project directors and senior staff should spend more time in trainee follow-up, both to provide additional training and to encourage use of the techniques learned in training. This might require additional resources.
2. More resources should be devoted to acquiring texts and other materials for training.
3. Baltimore-based training should be expanded with flexibility for JHPIEGO to generate ad hoc courses where they may have impact on a national level.

#### Curriculum

4. The core of JHPIEGO training should remain the provision of short-term clinical training in family planning techniques.
5. Additional emphasis might be given to vasectomy training and courses in adolescent gynecology.
6. Linkages to the provision of family planning services need to be emphasized in all courses that fall within the scope of reproductive health. Where appropriate, demonstration service projects might be instituted.
7. Consultants should be involved in implementing changes in curriculum, particularly in regard to development of expanded use of lesson plans and contemporary teaching aids. Their site visits should be built into regional training.
8. All training courses covering the field of reproductive health should be incorporated into regional training.

#### Targets

9. JHPIEGO should continue to train nurses and health administrators.
10. Nurse training needs to be upgraded. Consultants should be provided to assess local needs, assist in development of curriculum/lesson plans and teaching aids, and provide coordination with personnel involved in service delivery.
11. A Baltimore-based conference for nursing leaders might be considered.

12. The merit of establishing an International Council of Nursing under JHPIEGO auspices with a goal of standardizing curricula should be assessed.

13. Better trainee selection methods might be instituted.

14. The nurses' follow-up questionnaires might be revised to assess more accurately their specific functions in the field.

15. Greater efforts should be made to involve the private sector in all JHPIEGO training. Funds should be provided for program development, including an assessment of local equipment needs, inter-agency cooperation, and training and follow-up. Appropriate program initiatives might include refresher training, post-graduate materials, and leasing of equipment.

#### New Approaches to Training

16. JHPIEGO should continue its satellite and correspondence post-graduate education.

17. To enhance donor cooperation, initiatives could take place both in the U.S. between Baltimore staff and headquarters of other stateside donor organizations and in the field, perhaps through AID-sponsored donor meetings.

18. JHPIEGO should consider developing a technical resource capacity to assist both donors and host country programs.

19. Additional efforts to link specific universities with JHPIEGO should be fostered.

#### Institutionalization

20. Institutionalization should be the theme of the next International Advisory Council (IAC) meeting.

21. Consultants should be hired to work with university deans to help augment curriculum change in specific universities.

22. A regional deans' meeting might be appropriate to permit countries that have made major teaching changes to share the impact of these changes with their neighbors.

#### Equipment Repair

23. Numbers of repairs and spare parts and cooperation among donor agencies in utilizing repair and maintenance centers (RAM) should be documented.

24. Ministries of Health should agree to assume eventual administrative and financial responsibility for all new RAM centers.

25. If equipment is not being used, consideration should be given to redeployment. Retraining of physicians, however, does not appear cost effective. Any decision should involve other agencies.

26. Where a RAM center does not exist, operating room nurses could be motivated to assume responsibility for equipment maintenance.

27. JHPIEGO should arrange a field visit to assess the various RAM centers at least every other year.

#### Administration, Funding, Planning, and Programming

28. Program development and planning activities need to be given the same priority as fiscal management.

29. AID and JHPIEGO should devise a plan to improve financial procedures. A future cooperative agreement might contain a plan for end-of-project activities.

30. Flexible additional funds should be provided for program development, technical assistance and evaluation. These costs should not be included in the cost of training cycles.

31. Additional authority should be given to the Deputy Director, particularly on program issues.

32. All Regional Development Office slots should be filled.

33. Additional in-country technical support is needed, either local hire, regional consultants, or JHPIEGO short-term consultants.

34. JHPIEGO should continue to respond to AID's priorities as set out in the Resource Allocation plan.

35. New ways to involve the IAC in strategic planning should be developed, and planning for these meetings should be improved.

36. The Baltimore-based program review process should be modified. Less frequent reviews with perhaps fewer participants might improve the situation. Financial, administrative and regional program staff should be involved in all program reviews.

37. In-country participation in programming should be increased; proposals should be written in the field with specifically designated inputs from the LDC program coordinator and the Baltimore programmer.

38. The new chief of evaluation should work out new evaluation procedures. These should require specific indices to measure program impact and be based on new procedures for trainee follow-up.

## I. INTRODUCTION AND BACKGROUND

### I.1 Project Background

Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) has been providing training in reproductive health to medical professionals for more than 11 years. To date, \$63 million in U.S. government funds has been authorized, first through an Agency for International Development (AID) grant and more recently by an AID cooperative agreement (AID/Pha-CA-0083). These funds represent over 95 percent of JHPIEGO's budget.

The purpose of JHPIEGO is to train less developed country (LDC) medical professionals in reproductive health and to help these professionals put up-to-date reproductive health concepts and techniques into everyday practice, thus increasing the availability of these needed services in developing countries.

Initially, most training activities took place at JHPIEGO's headquarters in Baltimore, Maryland. As training needs have increased and more LDC university training centers have been identified, the vast majority of training has been shifted to these LCD institutions. JHPIEGO's original emphasis was on the training of physicians and medical school faculty. More recent programs have included nurse and para-professional training.

### I.2 Purpose of Report

A four-person team was asked to evaluate JHPIEGO's operations during May and June of 1985 to assist AID in designing a follow-on project. The current project was reauthorized in June 1983 for the years 1984-86, with funding to terminate September 30, 1986.

The evaluation was to examine the overall effectiveness of JHPIEGO operations, including the process by which subagreements are developed, approved and monitored; the degree to which JHPIEGO in-country training is becoming institutionalized; the appropriateness of the training being provided; the efficiency with which training materials and equipment are provided and equipment repaired; and an assessment of what new activities/directions, if any, JHPIEGO should plan to pursue. The scope of work is provided as Appendix G. The only topic omitted was that of equipment provision and repair, because a recent evaluation had already covered these issues adequately.

During the briefing sessions in Washington, the team was requested to examine five additional areas:

- o To what degree JHPIEGO's geographic program mix and funding levels are in line with AID's Resource Allocation Plan (RAP);
- o How well JHPIEGO monitors compliance with AID's Policy Guidelines in Voluntary Sterilization;
- o Whether JHPIEGO dollars are in any way being utilized in training for or provision of abortion services;
- o To what degree JHPIEGO is prepared to focus on the needs of the private sector; and
- o Whether JHPIEGO has been creative in its approach to programming within the confines of its mandate and its financial constraints.

The discussion of these issues is integrated into the report as follows: adherence to the RAP is covered as part of the discussion of JHPIEGO's process of subagreement development; voluntary sterilization and abortion issues are discussed in the context of the curriculum; the private sector is incorporated into a section on training targets; and JHPIEGO's creative initiatives are highlighted both in the review of progress since the 1980 evaluation (Chapter II) and throughout the chapter on training (Chapter III).

### I.3 The Evaluation Team

The evaluation team consisted of four professionals with more than 50 years of collective experience in international health and development. Two gynecologists, one who ran a major AID-funded donor agency and the other who chaired a department of Obstetrics and Gynecology in Asia, were selected. The other two team members included a PhD demographer with extensive experience in program administration, and a director of nurse practitioner training with particular skill in program design, curricula development and evaluation.

The team was fortunate in that one of its members participated in the prior JHPIEGO evaluation five years ago and thus provided continuity in the assessment process.

### I.4 Methodology

During April and May, 1985, team members spent 2 1/2 days at JHPIEGO headquarters reviewing JHPIEGO's overall operation.

Discussions were also held with AID/W officials during that period. Subsequently, team visits took place in Nigeria, Kenya, Tunisia, Egypt, Peru, Mexico, and Thailand, all countries in which JHPIEGO has major national or regional training programs.

The Asian visits were limited because this area received comprehensive coverage in the last evaluation and JHPIEGO's efforts in Asia are phasing down.

### I.5 Constraints

The timing of the evaluation presented problems for several of the team members. AID, however, was eager to undertake the work sooner rather than later. Postponing the evaluation by a month or two would have permitted better coordination and coverage and more opportunity to consolidate findings. The team also found that the time provided for the review of headquarters was too short to allow an in-depth study of all aspects of administrative and financial management.

### I.6 Assessment of JHPIEGO Accomplishments

#### I.6.1 Quantitative Accomplishments

JHPIEGO's goals from 1980-85 included the following: training 5,000 LDC professionals in 30 countries, training faculty from 75 percent of eligible medical schools, and training 6,000-12,000 medical students and other health professionals.

In fact, JHPIEGO exceeded these goals. Some 33,306 health professionals from 121 countries representing 50 programs have received training. Faculty from 80 percent of eligible medical schools have been trained. Only 3.6 percent of this training took place in Baltimore with the rest at in-country or regional training programs. The breakdown in the composition of trainees was 5,867 physicians; 3,172 paramedicals (nurses); and 22,366 medical students. Medical student training consisted of a very short series of lectures (12-20 hours) within the medical school curriculum while physicians and nurses have courses of several weeks. In almost all cases, the quality of the training is commendable.

#### I.6.2 JHPIEGO's Special Attributes

I.6.2.1 Widespread Acceptability of JHPIEGO's Program. Johns Hopkins' reputation has in large measure permitted programming in those countries where family planning has long been suspect. Since the last evaluation, JHPIEGO has strengthened its position in Turkey, Brazil, and Peru, has had significant impact in Moslem North Africa, and has played a leading role in Nigeria,

Kenya, and parts of West Africa by employing the reproductive risk concept that worked so well in Latin America. This approach permits an assessment of high risk women and stresses the importance of family planning services. In this process, however, there is also room for provision of other preventive and curative services to those who may be at greatest need.

I.6.2.2 JHPIEGO as a Goodwill Ambassador. Perhaps no AID-funded program better represents U.S. interests abroad than JHPIEGO. Indeed, JHPIEGO, apart from its impact in training, has become a potent good will ambassador. More LDC physicians holding positions of influence have studied at Johns Hopkins University than at any other foreign institution, and this linkage has been a potent catalyst in permitting the evolution of reproductive health programs in many politically sensitive areas of the world. To curtail or significantly reduce JHPIEGO funds would be counterproductive to AID's broader mandate.

### I.6.3 Need for New Directions

Part of the dilemma facing JHPIEGO at present is the result of the very success of the program. In Asia, for example, few opportunities remain to provide training in advanced techniques of female sterilization. In part, this is because the JHPIEGO program has been so successful. To take one well-documented case, the number of women sterilized has multiplied dramatically in Korea as a result of government support to private hospitals and physicians providing sterilization services. Many of these physicians were initially trained through the JHPIEGO program, which helped introduce laparoscopic procedures into medical practice in Korea and provided support for senior Korean obstetricians to tour the country's medical schools introducing laparoscopic procedures to faculty and students.

In most of sub-Saharan Africa, there are few opportunities for large-scale female sterilization programs, but the reasons for this are very different from those in Asia. Most African governments are still lukewarm at best about providing support for health and family planning. There is a shortage of trained personnel able to take advantage of JHPIEGO training in advanced surgical techniques and a lack of facilities for using these techniques on a widespread basis. Moreover, most of the available evidence suggests that the women of Africa are primarily concerned with fertility and that the concept of sterilization may be less acceptable than in other areas.

For the past several years, JHPIEGO has developed a variety of different programs to respond to the changing circumstances of the developing world (see Chapter II). The recommendations offered throughout the report are designed to suggest to JHPIEGO further changes in curriculum, training techniques and target

groups that would ensure that its work remains as highly relevant as it has been in the past.

## II. PROGRESS SINCE THE 1980 EVALUATION

### II.1 The 1980 Evaluation

The prior evaluation team designated 10 areas that it felt JHPIEGO should emphasize in the future. These included changes related to the content of the curriculum, to groups to be trained, and to approaches to training as well as to the mechanism for instituting change. This evaluation team found that JHPIEGO had made good-to-excellent progress in all areas related to the curriculum, that nurse education had increased considerably, and that some progress had been made in finding new ways of purveying information on reproductive health. As recommended, JHPIEGO has used meetings of its International Advisory Council (IAC) to discuss new directions.

The 1980 evaluation recommendations are paraphrased below, followed by the findings of the current evaluation team.

### II.2 Curriculum-Related Changes

The 1980 evaluation urged that additional emphasis be given to the following substantive areas: reproductive health; demographic information and contraceptive technology; clinical training in IUD insertion minilaparotomy and vasectomy; and infertility. The specific recommendations and steps taken are listed below:

#### II.2.1 Reproductive Health

(1) JHPIEGO should work with university personnel to expand university curriculum to incorporate all aspects of reproductive health. (1)\*

Deans' conferences in Thailand, Mexico, and Egypt have all led to adoption/standardization of family planning/reproductive health in medical school curricula. Similar conferences are scheduled for Turkey and Nigeria during the latter half of 1985. These conferences represent a good beginning, but obviously the process of changing host country institution curriculum is a difficult one, and no doubt progress will continue to be slow.

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\* The numbers enclosed in parenthesis reflect the number used to identify each recommendation in the 1980 evaluation.

## II.2.2 Demographic Information and Contraceptive Technology

(2) All JHPIEGO-funded courses should be expanded to include demographic information and contraceptive technology. Some would also benefit from addition of materials on human sexuality. (2)\*

Virtually all JHPIEGO courses now included information on demography and contraceptive technology.

## II.2.3 Clinical Training in IUD Insertion, Minilaparotomy and Vasectomy

In-country training (both regional and national) should be continued and expanded to include both didactic and practical training. Clinical sessions must not be limited solely to endoscopy. They should include training in IUD [intrauterine device] insertion, minilaparotomy and vasectomy, and discussions of other aspects of reproductive health. (5)\*

JHPIEGO has done an excellent job in this area. Virtually all of JHPIEGO national and regional training now includes IUD insertion, minilap training and other aspects of reproductive health, but vasectomy training has barely been started.

## II.2.4 Selected Issues Including Infertility

JHPIEGO's programs in selected areas (e.g., academic skills, administration, microsurgery, and infertility) are important and should be continued. Advanced training in infertility might be expanded to include training in the diagnostic use of laparoscopes, especially in Africa. Infertility training might also incorporate training in the treatment of sexually transmitted diseases. (6)\*

Information about infertility and sexually transmitted diseases is now an important component of both U.S. and in-country training.

## II.3 Target Groups

The 1980 evaluation urged strongly that nurse education and training be emphasized. It made a more tentative recommendation in regard to involving private sector physicians in training.

### II.3.1 Training for Nurses

(1) Nurse education and training should be strongly emphasized. One way might be for JHPIEGO to establish a relationship between a national council of nursing schools. (3)\*

Nurse training by JHPIEGO has markedly increased in LDCs. Regional family planning courses for nurses are now being held in Tunisia, Morocco, Egypt and Kenya and in-country family planning training for nurses takes place in Nigeria, Sierra Leone, and Zimbabwe.

### II.3.2 Private Sector Training

(2) Private physicians perhaps should be involved in training in some countries. JHPIEGO should coordinate this activity with the medical societies in the various countries. (4)\*

In part because of JHPIEGO's budgeting process (see Section V.4.1) and the conservatism of medical societies in general, this recommendation has not yet been implemented, but beginnings have been made in Malaysia, Jamaica, Colombia, Brazil and Egypt.

## II.4 Approaches to Training

The 1980 evaluation team set forth three specific ways in which JHPIEGO might broaden its approach to training: (1) interchange among various regional training centers; (2) development of JHPIEGO as a resource center; and (3) demonstration service projects as training adjuncts.

### II.4.1 Interchange Among Regional Training Centers

(1) One approach might be "university-to-university immersion" in reproductive health training. The various regional training centers should be urged strongly to share information and techniques. (7)\*

"University-to-University immersion" has not really materialized except for the interaction that occurs at the meetings of JHPIEGO's IAC and within the deans' conferences. Perhaps this suggestion was not practical. It is difficult to make top level people available for extended periods of time.

### II.4.2 JHPIEGO as a Resource Center

(2) JHPIEGO should become a resource center. A library of inexpensive materials on reproductive health should be assembled for JHPIEGO graduates and funded programs. (8)\*

JHPIEGO has become a resource center. The portion of its budget spent on providing educational materials to LDC centers and graduates has increased very significantly in the past five years, but continued updating is required.

#### II.4.3 Demonstration Service Projects

(3) JHPIEGO should fund demonstration service projects, particularly in countries where other agencies cannot fully function. (9)\*

JHPIEGO has not carried out demonstration service projects, but it has made a concerted attempt in Africa to link its training institutions to service/demonstration projects carried out by the Association for Voluntary Sterilization (AVS), for example, in Nigeria, Uganda, Sierra Leone, Kenya, Zaire and Senegal.

#### II.4.4 New Directions

(4) At the International Advisory Council (IAC) meeting, a full day should be devoted to a discussion of new directions for JHPIEGO. (10)\*

New directions for JHPIEGO is a basic theme of each IAC meeting. JHPIEGO has increased the meeting schedule of the IAC from every two years to every 18 months. Participants at the most recent meeting in Turkey criticized its lack of direction and focus. On the other hand, an early Africa-hosted meeting was successful in addressing pertinent subjects and developing new strategies. These meetings have the potential to serve an increasingly important function and should remain of high priority.

### III. TRAINING

#### III.1 In-Country, Regional and U.S. Training: An Assessment

##### III.1.1 Overview

The in-country, regional and Baltimore-based training programs offered by JHPIEGO each has a role to play in assisting JHPIEGO to achieve its overall goals. New courses are usually offered in Baltimore, then modified for presentation by LDC institutions. This approach works well and should remain in use. In-country training and regional training represent a significant reduction in costs. In-country training also encourages local institutions to work together and, independent of the training itself, helps to strengthen health programs and to advance health and family planning policies. Participants in both in-country and regional training programs are able to get a more realistic view and a good deal more practical patient contact in the provision of health and family planning services than those trained only in the United States. In some circumstances, regional training programs are often the most cost-effective and politically appropriate approach.

##### III.1.2 In-Country Training

The training modules that have been developed by JHPIEGO are, for the most part, superior. The ability to provide high quality training under the Johns Hopkins umbrella continues to be the unique feature of JHPIEGO. Particularly impressive is the adaptability of some of its training models. For instance, the medical student training under way in Mexico is a good example of an approach that appears to have wide applicability, not only for family planning but also for numerous other personal health, nutrition, and hygiene topics. It is unlikely that such an approach would have developed in the United States.

In many in-country training programs, however, trainee follow-up is needed to encourage greater use of the procedures that have been learned. In several locales, Thailand for instance, the techniques taught during JHPIEGO training sessions are not being used as frequently as they should be. In part the problem is due to candidate selection and the heavy pressures faced by doctors throughout the rural areas. However, additional follow-up visits would provide both motivation to trainees who need it and additional clinical support and training to enable them to feel more comfortable performing sterilizations.

Another problem noted in many of the country visits was a shortage of written materials, including scientific articles,

books, reports and the like. An important element in the continuing success of JHPIEGO's training is the provision of these materials to trainees, and their lack may reduce the effectiveness of the training initiatives.

Shortages in materials for information, education and communication (IEC) materials were also noted. JHPIEGO has made some progress in this area since the last evaluation, both as regards countries served and in total allocation of dollars. Two areas of weakness, however, were noted: slide lecture materials are somewhat dated (The International Federation of Gynaecology and Obstetrics [FIGO] is currently updating these materials), and teaching aids for nurses that address local needs are non-existent.

### III.1.3 Regional Training

Although problems of training follow-up and materials shortage also plague regional training, this approach has two advantages over country-specific models. It is often a cost-effective way to provide needed technical skills to LDC physicians from a number of countries; ideal examples are the regional training programs of the type carried out in Thailand, Brazil, and Egypt. Regional training programs also provide a means to penetrate areas where local sensitivities might preclude establishment of a center in a specific country. JHPIEGO's regional training program in Morocco, which permitted training of physicians from other Moslem countries in North and Francophone Africa, is a good example of this approach.

In some areas, JHPIEGO has had difficulty in implementing regional training programs. One concern has been the avoidance of creating a bureaucratic presence. Providing regional training grants to various other organizations is one approach that has been tested. Area-specific problems have plagued some of the programs. Indonesia and Tunisia, for example, have, for political reasons, not continued to exert their potential within the region. Administratively, the sole medical school in Kenya will have difficulties maintaining an expanded load, and Mexican activities are so fragmented with continually changing priorities that no single grantee can expect to provide a model that might gain widespread acceptance.

### III.1.4 Stateside Training

The prior evaluation team was emphatic in urging JHPIEGO activities away from stateside training and towards a regional and national approach. The resulting low percentage of trainees who were trained in Baltimore--less than four percent (see

Section I.6.1)--suggests that this recommendation was implemented in too rigid a manner. Despite the value and usefulness of the in-country and regional training programs, there will continue to be a need for Baltimore-based training. A crucial element in the success of the JHPIEGO program is the identification of those trained with Johns Hopkins and the respect Johns Hopkins' programs have. This gives JHPIEGO a tremendous opportunity to help shape health and family planning policies and programs.

There is little doubt that accepting an invitation to Baltimore has permitted influential administrators, physicians and government officials to plan for program implementation in a supportive environment. There are numerous examples of this process leading to JHPIEGO successes at the field level as well as to fostering positive Western ties with community and frequently with national leaders.

### III.1.5 Recommendations

III.1.5.1 Follow-up. Continued success of local training programs will require additional support. Further attention must be given to follow-up, in particular site visits by JHPIEGO-supported project directors and trainers. It is particularly important that in-country project directors and their senior staff be permitted to take advantage of the feeling of identity that develops among them and the trainees. This is best accomplished by field follow-up visits, which not only provide additional training but also encourage use of the techniques that have been learned.

In particular, more resources for follow-up visits to regional trainees should be provided to enable the trainer to continue to interact with the trainees and to provide an opportunity for further development of clinical skills. Trip reports describing these visits could be utilized as part of the extended evaluative process.

III.1.5.2 Materials. More resources should be devoted to acquiring current books and other materials. In addition, efforts should be made to provide updated slide/lecture materials. JHPIEGO may even wish to consider providing video cassette recorders to trainees to enable them to take advantage of the large and growing supply of films on family planning topics. It should also make an effort to procure the updated FIGO slide lecture materials.

III.1.5.3 Regional Training. Nigeria and Peru represent countries where JHPIEGO's presence and program impact should

soon allow regional activities, and Tunisia may re-emerge as an opportune locale for reproductive health training acceptable to the Moslem professional community.

Careful program development and follow-up are even more important at regional training programs than for other types of training.

III.1.5.4 Baltimore-Based Training. Baltimore-based training should be expanded, with flexibility for JHPIEGO to generate ad hoc courses where such training promises to have impact on a national level.

Senior health policymakers and perhaps the most highly regarded and influential physicians should continue to come to Baltimore for special courses.

### III.2 Curriculum

#### III.2.1 Progress Since 1980

During prior evaluations, JHPIEGO had been criticized for its limited focus and heavy emphasis on voluntary sterilization through endoscopy. Now a more typical approach (particularly for in-country training programs) is that clinical training is incorporated as part of a course on comprehensive reproductive health education. Such courses include discussions on human sexuality, early diagnosis of pregnancy, and diagnosis and treatment of sexually transmitted diseases. Emphasis on methods of fertility control, focusing on area-specific issues, is usually included (see Section II.2).

This expansion of the curriculum has had far-reaching effects, namely:

- The availability of JHPIEGO-sponsored microsurgery training (for sterilization reversal and treatment of infertility) has tended to defuse the perception that the prime focus of U.S. policy is on voluntary sterilization rather than on broader social issues.

- Utilization of the reproductive risk concept in Latin America has resulted in the acceptance of voluntary sterilization as an important component of reproductive health.

### III.2.2 Voluntary Sterilization and Abortion: AID's Concerns

AID's major curriculum concerns, at this juncture, relate to JHPIEGO's compliance with AID's policies on voluntary sterilization and prohibition of training for abortion. In both areas, there was no evidence that JHPIEGO was in any way circumventing AID guidelines.

#### o Voluntary Sterilization

In those countries visited by the evaluation team where voluntary sterilization was being carried out, good documentation was noted on compliance with AID's requirements for appropriate signed informed consent. Since JHPIEGO programs are almost always developed within the broader concept of reproductive health, other contraceptive services are generally available as consumer options.

Perhaps more than other donor agencies, JHPIEGO is well positioned both to monitor and to adhere to AID's stated policy on voluntary sterilization. Three factors contribute to JHPIEGO's strong adherence to the guidelines: (i) the scope of service delivery funded as part of training is very limited; (ii) most training is held in academic centers with the greatest visibility; and (iii) established training centers have the least staff turnover and are thus cognizant of the established policies.

#### o Abortion

JHPIEGO has been scrupulous in avoiding training in abortion-related technology, and has minimized discussions of septic abortion, even though these continue to be urgent life-threatening conditions very common in LDC countries.

### III.2.3 Recommendations

III.2.3.1 General. Future directions should be built on JHPIEGO's established strengths as well as those of the academic institutions in which it operates. The core of the JHPIEGO program should remain within the province of short-term clinical training in family planning education and technology. Despite the appeal of other types of courses, there is an undeniable need for continued clinical training and Hopkins has proven itself especially skilled in this area.

### III.2.3.2 Curriculum-Related Improvements

#### o Vasectomy Training

Training in vasectomies was the one area that has not been satisfactorily integrated into in-country clinical training (Section II.2.3). Additional emphasis on male fertility issues is needed. One way in which vasectomy may be given higher priority could be through a program for urologists.

#### o Adolescent Gynecology

While information on infertility and sexually transmitted disease has been incorporated widely into didactic training, given the large percentage of people under 21 in LDCs, a course in adolescent gynecology with an emphasis on fertility might also be appropriate and could be combined with sex education.

#### o Linkages to Service Provision

Linkages to the provision of service should be emphasized in all courses that fall within the scope of reproductive health. These links might best be illustrated, where the climate is ripe, if demonstration service models were built in as a training component. This would involve added costs, and JHPIEGO would need to exercise caution that the expenses were appropriate. JHPIEGO's reluctance to be viewed as a service delivery donor organization is understandable. It would, however, be perfectly appropriate to develop model service programs within major universities. Evaluation of training should not be based solely on changing knowledge, but should also reflect changing practices at the field level.

III.2.3.3 Teaching Methods. Curricula development activities will require careful attention to the expanded use of lesson plans and contemporary teaching aids.

III.2.3.4 Use of Consultants. Consultants should be involved in implementing all curriculum changes. The process, already initiated by JHPIEGO, of building site visits into the original program document should be continued, with greater attempts being made to adhere to planned travel--particularly in cases where a new course is being offered.

III.2.3.5 Expansion of Curriculum Reforms to Regional Training Programs. Newer subject modules in reproductive health

are all appropriate for expansion to the regional training level. Each region in addition to its present training mandate should have at least one training center in microsurgery. Where possible training in male fertility and vasectomy should be encouraged and linked to service delivery programs. Field follow-up should be built into all regional training efforts.

### III.3 Training Targets

#### III.3.1 Overview

Over the past five years, the most significant expansion of JHPIEGO training targets has been to nurse-midwives. During this period, two other groups have also been provided training by JHPIEGO: nonphysician professionals and physicians in the private sector.

This section reviews initiatives to all three groups.

#### III.3.2 Nurse-Midwives

III.3.2.1 General. Although JHPIEGO has been involved to some degree with training programs for nurses since its inception, these programs are receiving increased attention. JHPIEGO has begun to refocus training for nurses away from Baltimore to in-country programs where curricula can be designed to meet the educational needs of nurses in those settings. Gaining new clinical skills in an environment similar to their own should enhance the trainees' confidence and likelihood that theory will be applied to practice.

In the countries visited, the types of training varied considerably. In Nigeria the program was quite comprehensive. It included the full scope of family planning and promised to produce graduates who would be able to operate effectively in their work settings.

III.3.2.2 Selection Criteria. JHPIEGO programs for nurses appear to apply two appropriate criteria in selection of trainees: the need for training and professional potential to utilize acquired skills. It is less clear whether a third criterion is taken into consideration: the nurses' individual abilities. It was also not apparent if systems exist to drop nurses who do not demonstrate attainment of course objectives or safe practice.

III.3.2.3 Course Design. Because detailed course outlines were unavailable except in Ibaden's program, it was difficult to

draw conclusions about the adequacy of course design. Programs appear to vary significantly in clinical and didactic training. In one setting, the didactic and clinical components are integrated, while in another, nurses receive the didactic portion and return to the institution in small groups for clinical training. While separating the didactic from the clinical allows the program to accommodate larger numbers of trainees, its disadvantage is that it does not allow immediate application of theory to practice.

Most of the didactic course content appears to have been patterned after medical programs that offer a schedule of lectures in one-hour blocks of often unrelated topics. While availability and schedules of lecturers must be accommodated, the quality of the curriculum would be improved if more attention were given to sequencing of topics and highlighting of key subject areas. For example, more time might be spent on the classroom and laboratory practice in physical assessment, especially for nurses whose basic preparation did not include assessment skills. A useful technique is the utilization of paid professional patients.

Project directors in both Nigerian programs visited supported the need for expanded didactic and clinical practice. The physician director of the Egyptian IUD insertion program asserted that two weeks was adequate and claimed that his trainees attained competence after 15 IUD insertions. While this is probably more than most U.S. programs are able to provide for their trainees, U.S.-based programs have demonstrated that accurate pelvic assessment, including determination of uterine size and position, requires well over 50 examinations. Wherever possible, it would seem worthwhile to broaden the nurse preparation as well as to ensure more comprehensive skills in physical assessment, patient education counseling and problem management.

III.3.2.4 Materials. JHPIEGO is providing a variety of films and texts for all programs. This was, however, the area most frequently mentioned when project directors were asked what more they would like from JHPIEGO. It was not clear whether trainees were sent material to review prior to attending courses or whether readings were assigned during courses. For follow-up after graduation, the newsletter produced by the Ibadan program with support from The Pathfinder Fund is an outstanding example of a means to ensure that nurses maintain self-confidence and remain up-to-date.

III.3.2.5 Follow-up Activities. In Nigeria, all programs appear to be conducting careful follow-up of graduates through the use of questionnaires.

III.3.2.6 Overlap with Other AID and Donor Training. Although other donor agencies have been involved in education for family planning nurses, there does not currently appear to be duplication of effort. In Nigeria, the Pathfinder and JHPIEGO programs were providing training of significantly different duration to midwives.

### III.3.3 Non-physician Professionals

Two other categories of non-physician professional professionals have been trained by JHPIEGO: senior policymakers and administrators. Courses for senior policymakers, especially in Baltimore, are particularly useful. Even though this category of professional may not be visible in the day-to-day provision of family planning services, they nevertheless provide important leadership to national health and family planning programs. Courses for administrators are valuable, but only if these individuals are at a level where they can, subsequent to their training, effectively influence the provision of health and family planning services in their countries.

### III.3.4. Private Physicians

Increased training to private sector physicians, an activity recommended in the 1980 evaluation, is moving quite slowly, though it may become more important as government-subsidized positions dwindle and the number of physicians in the private sector increases. In Egypt and Thailand, for example, the overwhelming majority of physicians serving in the public sector also have active private practices. Thus, the training of a public sector physician is to all intents and purposes the equivalent of training a private sector physician. Furthermore, in Egypt and Thailand as well as elsewhere, the pattern of private sector medical practice is changing. In Thailand, for example, almost enough physicians have been trained to fill all the government-funded public health positions. Moreover, physicians are recognizing the financial and lifestyle attractiveness of fee-for-service private practice, and more private clinics and hospitals are opening throughout the country.

This environment may be particularly suitable for JHPIEGO input. Since JHPIEGO already maintains training programs within well-respected academic institutions, holding post-graduate courses for private physicians would be greeted with enthusiasm. JHPIEGO could provide an important linkage between academia, the private practice of medicine and donor organizations which can support service delivery and commodity distribution. Training in endoscopy could also be offered as well as the development of a leasing program to gynecologists (perhaps through the RAM

centers). Such an approach could increase competition, lower costs and make voluntary sterilization on an outpatient basis more acceptable. Despite JHPIEGO's present level of comfort with its linkage to academia, it should keep in mind that in almost all developing countries, private physicians are the innovators in the provision of contraceptive service and frequently serve as the mainstay for the large and influential segment of the urban population.

### III.3.5 Recommendations

III.3.5.1 General. JHPIEGO should be funded to continue its training efforts for physicians and other health professionals. Nurses and administrators should continue as important target groups, and high priority should be given to the development of new training models.

#### III.3.5.2 Nursing Training

o Nursing training needs to be upgraded. Specific steps might include:

- Use of consultants (either host country or U.S. skilled nurse trainers) to give in-country assistance in the areas of (i) local needs assessment, (ii) curriculum development and lesson plans, (iii) development of appropriate IEC materials that address local needs, (which may need to be produced locally), and (iv) coordination with personnel involved in service delivery.

- A Baltimore-based conference for nursing leaders from target LDCs might be considered.

- The formation of an International Council of Nursing under JHPIEGO auspices could do much to standardize curriculum and to strengthen both the profession as well as the status of women on a global basis.

#### o Selection

JHPIEGO might wish to assist project staff in establishing passing scores for tests and standards to demonstrate clinical competence.

o Follow-up

Follow-up questionnaires might be revised to assess more accurately the specific functions of nurses. A simple experience log could help the program assess the extent to which the nurses are practicing their skills.

o Overlap

In Nigeria, consideration should be given to standardizing the two programs that exist in the same institution so as to avoid sending nurses back to similar work settings with different levels of knowledge and skills. The Mexican program should assess the success of the Ministry of Health's encouragement to schools to adopt standard curricula in family planning.

III.3.5.3 Non-physician Training. Training of non-physician professionals should also be a priority. Care must be taken to ensure that all those trained are actually involved in family planning education or in the provision of family planning services.

III.3.5.4 Private Sector Training. Greater effort should be made to involve the private sector in all JHPIEGO programs.

o Initiatives should be taken at universities and training centers where JHPIEGO has well-established relationships. The program should be planned, reviewed and modified by JHPIEGO's Board of Directors, AID and appropriate international and in-country personnel. This activity should be implemented as soon as possible.

o The very nature of JHPIEGO's present budgeting process imposed by AID will not permit JHPIEGO to play a major role in private sector initiatives. Flexible dollars, however, will be needed for program development, including an assessment of local equipment needs. Such budget planning will require inter-agency cooperation, and should provide for both training and follow-up. Funds for program development would permit JHPIEGO to survey its present sub-grantees and determine what role they might play in reaching the private sector on a country-by-country basis. Appropriate program initiatives might include refresher training for private physicians, development of post-graduate education materials (similar to the correspondence course already developed in one country), leasing to private physicians of endoscopy equipment through RAM centers for

in knowledge or numbers of procedures performed, the former qualitative in nature and the latter limited in perspective. In fact, however, JHPIEGO's efforts have produced results well beyond those reported, most particularly in the area of program impact. With the addition of...

use in private hospitals and clinics, and perhaps the availability of small pilot grants.

### III.4 New Approaches to Training

#### III.4.1 Overview

JHPIEGO has been particularly creative in the area of training techniques and has introduced a wide variety of new approaches including use of satellite-relayed education programs; implementation of correspondence courses for hard-to-reach areas; and collaboration with other universities and with other international programs. If JHPIEGO maintains the flexibility to expand some of these techniques of training throughout the developing world, it could significantly enhance the provision of family planning and maternal and child health education.

#### III.4.2 Satellite-based program

The satellite-based program under way in the Caribbean is a dramatic illustration of how JHPIEGO might exercise a leadership role in medical education, one that will have an impact far beyond family planning. This program is perhaps the best example of JHPIEGO's willingness to adopt new technology in training. The need for family planning training in many of the Caribbean islands has long been recognized; distances between islands and the shortage of personnel, however, have not allowed for the frequent gathering of health personnel at a central location. With a satellite system already in place and underutilized, JHPIEGO responded by promoting and funding a series of courses in reproductive health for personnel in Barbados, St. Lucia, Dominica, Trinidad, Jamaica, and Antigua. During the initial pilot project, practicing physicians, medical students and nurses were reached through the satellite system and in almost every case, the Ministry of Health was involved as an active partner.

This model has potential in Indonesia where medical and nursing personnel are scattered in thousands of islands. The Indonesian government has recently provided satellite linkages among the major islands, and JHPIEGO's plan to utilize this network for a pilot project in reproductive health represents an excellent use of available technology. The Indonesian Family Planning Board is likely to integrate this activity. JHPIEGO, for its part, having accrued diverse experience in satellite communications and training, could transfer the model to other countries where the technology is available.

### III.4.3 Correspondence Courses

Correspondence courses for general practitioners in Malaysia have also served to reach physicians who otherwise would not have been able to receive JHPIEGO training. The program was run by the National Family Planning Board and offered, for the first time in Malaysia, a diploma in family planning. This creative approach included the mailing of weekly course materials. The courses were coordinated, with tutorial support provided in different regions. Practical clinical experience was also offered, including counseling, IUD insertion and minilaparotomy for those physicians with surgical backgrounds.

### III.4.4 Team Approach

JHPIEGO has used the team approach to training whereby an entire team of service providers is brought together in a collegial learning experience. This is a genuinely innovative idea with applicability for a variety of other AID-supported training programs.

### III.4.5 Coordination with Other Donors

JHPIEGO's has not had extensive involvement in cooperative programming ventures with other donors, particularly those involved in service delivery. Nigeria represents one good example of such coordination; here JHPIEGO has worked closely with the World Health Organization, The United Nations Children's Fund (UNICEF), the United Nations Fund for Population Activity (UNFPA), and USAID to add an important family planning component to activities in oral rehydration and immunization. Failure to pursue joint programming more vigorously elsewhere, however, may be depriving JHPIEGO of opportunities to experiment with new training models. Joint programming may work best in those countries where bilateral programs exist.

Selection of future opportunities and successful implementation of new directions will depend to some extent on JHPIEGO's links with other organizations. While overseas project directors and Baltimore staff enjoy cordial links with other agencies, collaborative efforts of other AID-supported agencies are often less than ideal and must be strengthened.

### III.4.6 Recommendations

III.4.6.1 Correspondence Courses. JHPIEGO should be encouraged to continue its efforts in satellite and correspondence post-graduate education. Models already developed

should have applicability for many LDCs. The concept of a series of JHPIEGO post-graduate correspondence courses in reproductive health would be welcomed worldwide. Perhaps a standard monthly format could be developed for local translation and integration within Africa and Latin America. This approach would enable JHPIEGO to update on a continuing basis the presentation of new technology. It would also provide an opportunity for local academic and governmental organizations to add both their support as well as their service delivery arms for the tutorial section of clinical training.

III.4.6.2 Donor Coordination. It is likely that there will be opportunities for jointly implemented training programs supported by several agencies receiving AID funds for training. The Project Director and Deputy Director should establish closer relationships with the senior staff at other AID-supported agencies to facilitate coordination of planned activities.

AID would be well advised to sponsor a series of (priority) country-specific meetings to be attended by interested donors. This approach could increase the efficiency of expenditures and prevent duplication of effort.

III.4.6.3 Service Delivery Programs. JHPIEGO should consider developing a new technical resource capacity that would be available to assist service delivery programs run by other donor agencies or host countries. JHPIEGO-supported technical teams (most probably an educator and a surgical expert) could provide considerable technical knowledge to such donor agencies as Family Planning International Assistance (FPIA) or The Pathfinder Fund that are involved in service delivery but do not have the medical expertise of JHPIEGO. Because of its established credentials in the international health arena, JHPIEGO teams would meet little resistance among LDC health and population officials. Perhaps in concert with other academic medical groups such as FIGO, JHPIEGO could provide both manpower and updated teaching materials. Developing and coordinating these teams might require the addition of a new staff member (coordinator of technical assistance) at headquarters. The expense would be justified, however, given the widespread need for the skills and expertise that JHPIEGO could provide through this new approach.

III.4.6.4 Coordination with Other Universities. Although attempts to link LDC universities and JHPIEGO in an immersion program have failed in the past (see Section II.4.1), JHPIEGO should be encouraged in its efforts to develop stronger formal ties with these international academic institutions. The quality

of faculty and excellent resources in the John Hopkins School of Tropical Medicine and Hygiene should make closer relationships very desirable to other institutions.

### III.5 Institutionalization

#### III.5.1 Achievements

What are the prospects that JHPIEGO's training initiatives will continue in the long run, even without JHPIEGO involvement? There is no gainsaying, of course, that financial resources will always play in part in whether a program is mounted, and the JHPIEGO program is no exception. It is fair to say, however, that JHPIEGO has done a good job in sensitizing LDC medical and political communities to the need for continued teaching about reproductive health in medical schools. Four different steps towards institutionalization are described below:

##### o Impact on individual training centers

There is no doubt that within each individual center where JHPIEGO has mounted a training program, a commitment exists to ongoing training activities in reproductive health.

##### o Political support

Support at the government level is quite high, because JHPIEGO, particularly in Africa and Latin America, has succeeded in focusing the program on the politically important area of maternal mortality (see Sections I.6.2 and III.2.1 regarding JHPIEGO's increasing emphasis on the reproductive risk concept). An example of the importance of government support is a recent Peruvian ministers conference. This has already led to an in-country meeting, with Peruvian suggestions for changes in curricula likely to be implemented by almost all the country's medical schools.

##### o Incorporation of technology

A good understanding has developed of the proper roles for endoscopic vs. laparoscopic sterilization and the part they should play in a broader reproductive health program. Specifically, endoscopic sterilization has been accepted, particularly within the public sector, as an important component of family health, while in 1985, laparoscopic sterilization had taken its appropriate place as one method among many, a method particularly suited to urban, academic models, not necessarily at primary care facilities. The use of endoscopy has played a major role in

enhancing the credibility of physicians who provided these services, particularly by permitting them to address such broader areas as infertility, ectopic pregnancy, and detection of other pelvic pathology.

o Curriculum development

JHPIEGO has attempted to involve host country personnel in developing curriculum at two levels: it has invited representatives from the medical community in specific countries to participate in developing curriculum models, and it has held Deans' Conferences in a few countries designed to involve university leadership in making recommendations for permanent incorporation of reproductive health training in university curricula (see Section II.2). While these efforts represent a good start, curriculum change is perhaps the one aspect of JHPIEGO's efforts that will require the greatest amount of effort to ensure future institutionalization.

III.5.2 Recommendations

o Institutionalization should be the theme of the next IAC meeting, with each representative given the responsibility for preparing a paper on the subject. The proceedings of this meeting might be evaluated and reproduced.

o Consultants should be hired to work for an extended period with Deans in helping to augment change. Follow-up visits must occur at least semi-annually, and JHPIEGO should maintain copies of all new curricula.

o A regional Deans' meeting might be appropriate to permit countries that have made major teaching changes to share these with their often more conservative neighbors.

## IV. EQUIPMENT

### IV.1 Observations

Because a comprehensive evaluation of RAM centers had been completed recently, this report includes only cursory observations regarding their operations, plus a short discussion of the appropriateness of various types of sterilization equipment.

Specifically, RAM centers continue to be an appropriate method of maintaining and supporting equipment. There were no major problems with the availability of ancillary medications, gasses, suture materials or analgesics. This reflects JHPIEGO's presence in the larger, better-funded health centers. Such shortages, however, probably do exist at the provincial level.

The issue of the appropriate levels of voluntary sterilization equipment (endoscopes, laparoscopes, and laparocators) did not seem to present insurmountable problems. There is little doubt that laparoscopes and (more recently) laparocators have served an important role in the acceptability of sterilization as an important option in reproductive health.

Clearly the bulk of procedures in countries with established programs are provided with the simplest of techniques. Endoscopy however, permits secondary and tertiary health centers to provide essential ancillary services in diagnostic gynecology and thus permits voluntary sterilization to take its rightful place as an accepted method.

Some laparoscopes lie idle, although RAMs and retraining opportunities exist, but on the whole the equipment seems to be in use.

### IV.2 Recommendations

o In each country information should be gathered, not only on numbers of repairs and spare parts, but also on the cooperation among donor agencies in utilizing the facility.

o Before a new RAM center is approved, it would seem prudent to receive a prior commitment from the Ministry of Health that it will assume administrative and financial responsibility for the center within a given time.

o As greater emphasis is being placed on reaching the private sector, RAM centers might be utilized as part of a loan

or lease program where private clinicians pay a fee for maintenance and repair (Section III.3.5.4).

o Where equipment is lying idle despite availability of RAM centers and retraining opportunities, evaluations need to address the problem within the context of an inter-agency approach. Redeployment of equipment may be necessary: retraining, however, does not appear cost effective. The time and effort necessary to effect these changes must be weighed against continued opportunities where heavy provisions of equipment by JHPIEGO plays a minor role and reliance on other agencies and particularly on national ministries of health are given priority.

o Operating room nurses seem well motivated to assume responsibility for equipment maintenance; using them to perform this function may provide a viable option in those countries where a RAM center does not exist.

o JHPIEGO's recent field visit to assess the various RAM centers was appropriate and should occur at least every other year.

## V. ADMINISTRATION, FUNDING, PLANNING AND PROGRAM MANAGEMENT

### V.1 Administration

#### V.1.1 Organization

On paper, JHPIEGO appears to have developed an appropriate hierarchy, with a Corporation President and a Project Director. In reality, the Corporation President, though committed to JHPIEGO activities, spends minimal time on its work because of his responsibilities as Vice President of the Johns Hopkins Hospital. The Project Director has been an effective force for JHPIEGO but has recently reduced his input and now divides his time between work associated with JHPIEGO and his research and clinical commitment to the university. Because of the limited time these two individuals have to spend on the program, a major portion of day-to-day management is vested in the Assistant to the President, including not only all financial and administrative matters but also a large part of program planning and management. Placing such a large part of program management responsibility in the hands of the Assistant to the President, despite her proven ability, creates confusion to the staff, to people overseas, and to AID. There is in addition a full-time Deputy Director, but at present he seems to lack day-to-day responsibility for important aspects of the program.

Three Regional Development Offices (RDO) and associate slots have been established in Baltimore to provide better supervision and management of overseas program activities. While the filling of these positions addresses a critical gap in the organizational structure, the level of field intervention can still be no more than one of superficial monitoring. At the time of the evaluation, only one of the RDO posts had been filled. When staffing is complete, despite the limitations mentioned above, JHPIEGO will be in a far stronger position than previously to implement successfully its program activities.

Another move with positive implications for programming is the recent addition of a senior staff person with responsibility for developing and monitoring new models of evaluation. Over time, his input should be of great value in the programming process.

#### V.1.2 Administrative Guidelines

JHPIEGO has prepared a considerable number of written guidelines to assist staff in carrying out their administrative and program responsibilities. Further use could be made of such material at the LDC level to save time and enhance sub-grantee

staff effectiveness. The "Project Director Guide," for example, is a useful collection of often hard-to-obtain material.

### V.1.3 Relationship Between JHPIEGO and Johns Hopkins University

Although the question of the relation between JHPIEGO and the medical school hospital was not included in the scope of work, it has an important bearing on the project's fiscal conservatism (see Section V.2.1 below) and is therefore discussed briefly here. Cordial relations between JHPIEGO and the medical school and hospital are important, and the present part-time involvement of the senior staff helps in that respect. There is an underlying perception, however, that JHPIEGO is not viewed as a priority program by the medical school and university staff. It is common for American universities to be far less interested in the international component of their training programs and educational activities than the domestic. Nevertheless, the perception of their status may affect JHPIEGO staff morale and their willingness to take risks to improve the program. A fund-raising effort on the part of JHU earmarked for JHPIEGO would go a long way in reaffirming continued commitment.

## V.2 Program Funding

### V.2.1 Fiscal Conservatism

V.2.1.1 Background. Funding problems are a troublesome characteristic of the JHPIEGO contract, with AID voicing considerable concern over JHPIEGO's "overcautious" approach to expenditures of project funds and JHPIEGO expressing the view that AID does not understand its problems.

V.2.1.2 Reasons for JHPIEGO's Posture. Both positions have merit. It is true that JHPIEGO has felt the need to spend its annual allocations carefully. Like any of AID's cooperating agencies, the level of its annual appropriation is never certain. Unlike some other cooperating agencies, however, JHPIEGO has virtually no other source of external funding. In addition, it feels it cannot look to the University to cover any cost overruns.

Another reason for JHPIEGO's fiscal conservatism arises from its management structure; specifically, those in the top management positions tend to identify with Johns Hopkins, and to keep very much in view the financial aspect of the relationship between the university and JHPIEGO. Those with prime programming

responsibility are lower on the organizational hierarchy and their interests may not always receive adequate consideration.

JHPIEGO explains its fiscal concerns in part by complaining that AID has encouraged it to take on new projects without increasing the ceiling on its congressional appropriation. Not having anticipated that total funding might not increase, JHPIEGO claims it spent money thinking that AID would provide resources above and beyond the appropriation it initially received, which AID has not done.

V.2.1.3 Examples of JHPIEGO's Fiscal Conservatism. JHPIEGO's fiscal prudence is exhibited in its practice of maintaining a balance of funds sufficient to support its staff for a year following the award of the last JHPIEGO grant overseas, a precautionary move should additional funding not be forthcoming.

Another example of caution is JHPIEGO's practice of paying consultants a maximum of \$125 a day, a fee considerably below that authorized by AID. JHPIEGO's position is that the low fee is maintained primarily because it is appropriate for LDC nationals, whom, it claims, do most of its consulting work. While it is true that LDC consultants are excellent for many assignments, some tasks would benefit from involvement of seasoned U.S. or European consultants. When new training modules are being developed for a specific site, for instance, an experienced training technology expert from the developed world should be made part of the process. A fee of \$125 a day is insufficient to attract such consultants; several people noted that they had refused invitations to provide consulting services to JHPIEGO because of the very low reimbursement. Other reasons JHPIEGO uses this low level of consultant pay are that it eliminates the need for consultant clearance from AID and that it rules out any risk of subsequent disallowances. Overall, however, the practice stands as a small but clear example of the problems inherent with putting concern above protecting Johns Hopkins financially ahead of concerns about JHPIEGO's overseas operations.

#### V.2.2 Budgeting

JHPIEGO's budgeting process seems to have improved since the last evaluation. The computer printouts of budgets by project and country are helpful. Projected budgets appear realistic, but certain assumptions, for example 10 percent inflation rates, need careful evaluation. Likewise, more project activities are specified in the program budget for countries that are listed elsewhere as being of low priority. Different

assumptions about inflation rates and projections of the total number of subgrantee awards in different countries could alter the budgets fairly significantly.

### V.2.3 Procedures for Fund Transfer

JHPIEGO has also significantly improved its procedures for transfer of funds to grantees. Few problems in this area were noted, except in relationship to new programs where JHPIEGO will often wait to assure the adequacy of further internal resources. On the whole, however, JHPIEGO's performance was commendable, representing a complete turnabout from the problems encountered during the previous evaluation.

### V.3 Long-Term Planning

Program planning needs to be improved. Too much time is currently spent by the regional staff on details and not enough on questions of future directions and program development. Until recently, planning appears to have been done in a very mechanical fashion without a clear linkage between the special strengths of JHPIEGO and the needs and resources of developing country institutions and programs.

Recent planning documents spell out more clearly the assumptions of the program and the special national and regional needs that JHPIEGO intends to serve. Even now, however, one senses that the planning process lacks focus and sufficient attention from the senior staff.

The rich resources available at Johns Hopkins in the School of Public Health as well as the medical faculty present the university with a special opportunity to make significant contributions to health and development activities overseas. Overseas project directors, however, must be involved in the planning process. Earlier evaluations criticized JHPIEGO's unilateral programming in which subgrantees were not able to play a role. Successful implementation depends on careful planning, and that requires the support, cooperation and insight of JHPIEGO's grantees.

Fiscal issues often intrude in the planning process. The concern of JHPIEGO management regarding funding levels often inhibits them from taking risks that may improve the program (see Section V.2).

## V.4 Programming

### V.4.1 Overview

In the absence of well-designed long-term plans, programming development assumes great significance in the shaping of program profiles, and here again, JHPIEGO's processes could be improved. Fiscal issues seem to dominate the process; AID tends to view JHPIEGO's activities by a formula of "trainees x training days" and then to divide grant dollars by this figure. Thus, JHPIEGO may find it easier and safer to expand an already existing series of courses than to develop new programs. The practice of programming at headquarters also has contributed to the mechanical quality of the programming process. Proposal writing is now done almost entirely by JHPIEGO staff in Baltimore through use of a standard format. This approach provides little flexibility to respond to particular local areas of concern. Furthermore, RDOs must spend so much time in the paperwork necessary to justify refunding of ongoing programs that they have little time left for technical assistance or development of new program ideas.

JHPIEGO has done too little programming in conjunction with other donor organizations, particularly those that are successfully implementing service delivery programs. In its relationships with Ministries of Health, too, it has stayed strictly within the confines of technical training matters, with little discussion of the service delivery by physicians. In Baltimore, program review sessions are often adversarial in tone, with the administrative staff taking what appears to the program staff to be little interest in the quality of the programs. That these sessions occur so often and are attended by so many people makes them an unwieldy part of JHPIEGO operations for all those involved.

Despite these constraints, JHPIEGO has been able to select acceptable subgrantees, to respond in large part to AID's Resource Allocation Plan (RAP), and to take some creative steps in program development.

### V.4.2 Subgrantee Selection

There is little doubt that over the years JHPIEGO has selected appropriate subgrantees. Many have made significant contributions by administering regional and local training, and, by virtue of their positions of influence, have worked for changes in medical school curricula.

#### V.4.3 Country Selection

JHPIEGO's apolitical approach to programming (Section I.6.1.2) has enabled it to respond rapidly to AID's priorities. The RAP for population programs gives precedence to countries that lack one or more of the following: (a) an organized infrastructure, (b) trained trainers and (c) a positive political climate.

JHPIEGO's program initiatives in such countries as Nigeria, Brazil, Mexico, Turkey, Peru, the Sudan, and various Moslem countries all represent its programming sensitivity and knowledge of global priorities. In short, JHPIEGO's total expenditures by region have followed AID's overall strategy for allocation of resources. The only exception has been regional training programs, some of which have been located in countries which, in light of their strong infrastructure, may rank lower among AID's priorities (e.g. Thailand and the Philippines), but which have proven themselves as exceptional training sites which should be retained.

#### V.5 Monitoring and Evaluation

##### V.5.1 Monitoring and Follow-up

Although monitoring of program progress has improved with the addition of the full complement of RDOs and their support staff, it is still less than ideal. Evaluation of individual trainees while they are enrolled in courses is usually undertaken, but because follow-up is limited primarily to mailed questionnaires of self-reported performance, long-term evaluation of individuals and programs cannot be effectively carried out (e.g. Nigeria). Examination of the impact of projects in terms of new acceptors of family planning is even more difficult and is rarely carried out. Peru is one exception where attempts are being made to go beyond the standard questionnaire in evaluating the effectiveness of specific programs. Certainly, however, further attempts to assess the impact of the program in a community setting, including analysis of what aspects of the program are most useful, would be valuable to JHPIEGO staff.

##### V.5.2 Evaluation

Partly as a result of paucity of feedback from the field, JHPIEGO has been unable to provide as comprehensive an evaluation database as is desirable.

Critics have faulted JHPIEGO for the limited scope of its evaluation reports: the information is focused either on changes

in knowledge or numbers of procedures performed, the former qualitative in nature and the latter limited in perspective. In fact, however, JHPIEGO's efforts have produced results well beyond those reported, most particularly in the area of program impact. With the addition of a senior staff person responsible for developing and monitoring new models of evaluation (see Section V.1.1), JHPIEGO is now well placed to develop better ways to measure program success.

## V.6 Recommendations

### V.6.1 Introductory Remarks

It should be noted that some of these recommendations are at variance with the most recent management review. Aware of its limited time at headquarters, the team suggest therefore that the following recommendations should be reviewed together with those in the management review.

### V.6.2 Creating a Balance Between Programming and Financial Concerns

JHPIEGO must be careful in designing its next five-year program. Specifically, program development and planning activities need to be given at least the same priority as fiscal management.

### V.6.3 Fiscal Management

#### o Improved end-of-project activities plan

AID staff and JHPIEGO personnel should work together to improve financial management procedures. Future cooperative agreements might contain a plan for the end-of-project activities that would satisfy both JHPIEGO's need to provide security for its staff and appropriate follow-up for ongoing activities. Such a plan could permit AID to have more resources available for current projects and a lower reserve or contingency for central staff support.

#### o Flexible funding for new initiatives

Flexible funds for JHPIEGO need to be provided. The cost per trainee formula is not an appropriate basis on which to prepare budgets for development of new training models. Instead, funding must allow not only for program development, but for technical assistance and evaluation as well. The costs for such

development activities should not be included in the actual cost of the projected training cycles.

#### V.6.4 Staffing

o Increasing ability of JHPIEGO Baltimore management to respond to program issues.

- If part-time involvement of the President and Director is to continue, then additional authority should be given to the Deputy Director for the overall management of the program.

- Financial and administrative matters currently handled by the Assistant to the President should continue to be handled by that office, but reports on program issues should be channeled through the deputy. This might increase the flow of information, strengthen the relationship between financial management and program planning, and save supervisory time and effort.

- Immediate attention should be given to filling the two RDO slots that were vacant at the time of the evaluation. The Deputy Director and the RDOs should devote increased attention to program development and field support.

o Increasing in-country technical assistance capabilities

- As JHPIEGO moves into new programming areas, more on-site technical support time will be required. The opening of regional offices may not be the answer, but, in their absence, each major program must be covered by trained support staff, either of local hire, regional consultants, or by JHPIEGO short-term consultants.

- Consideration should be given both to administrative and technical requirements; specifically, in some cases, the need may be for coordination of a wide range of program details which a skilled local administrator could be hired to address.

- In those cases where the issues are technical, local hire personnel might be represented by specialists who are well established within the local medical/political hierarchy. Regional consultants might be recruited from among the ranks of LDC university professors. Technical specialists, in any case, should have skills in curricula development and evaluation, and knowledge of the latest in educational teaching aids.

- For outside consultants, greater use should be made of the growing pool of family planning experts worldwide. AID, with input from JHPIEGO, should streamline the process required for

consultant approval. JHPIEGO should offer appropriate compensation consistent with the individual's professional status. If the assignment would benefit from use of an experienced consultant from a developed country, then such an individual should be hired. LDC professionals who already have a history of successful involvement with JHPIEGO should get additional compensation and time to develop programs and to provide the monitoring activities that should accompany them.

#### V.6.5 Planning

##### o RAP Priorities

- JHPIEGO should continue to respond to AID's priorities with the following proviso: AID should be judicious in suggesting that countries such as Thailand and the Philippines, which have proven themselves as exceptional training sites, should be phased out. On the contrary, it is in these countries where new training models can best be tested. Senior project staff from these programs are ideal candidates to serve as regional consultants and to provide post-training follow-up to colleagues from institutions within a given region.

##### o Involvement of the IAC

New ways to involve the IAC in strategic planning, aside from meeting every 18 months, should be explored.

Preparation for IAC meetings should also be improved. To assure that they are better focused, perhaps one individual at JHPIEGO could be assigned to review materials in advance of presentation and to assist in the production of appropriate graphics. This is standard format for most professional meetings. These meetings continue to serve an important function and should remain of high priority.

#### V.6.6 Programming

##### o Program Review Process

At JHPIEGO headquarters, a system of less frequent and more collegial reviews might enhance morale, improve management, and save money. A regional development staff person and a member of the financial and administrative staff working together to develop a project might represent one useful approach to sharing responsibility for program activities.

o In-country Participation in Programming

The program development process requires a fresh interactive approach which includes LDC personnel and addresses local needs. Efforts should be made to incorporate Ministry of Health needs as well as those of other donor agencies.

A three-stage programming process could be developed which would give new proposed grantees more involvement in the programming process. It is described below.

(i) A program development form would be sent to proposed grantees in advance of a JHPIEGO staff visit. It should be completed locally.

(ii) The JHPIEGO program person (probably the RDC) would be responsible for gathering the kind of background information required by Baltimore (e.g., the status of reproductive health training in the present physician and/or nursing curricula; the role of each level of health professional in the provision of related services; the current attitude of the respective government towards the provision of such services to the public and private sectors; and anticipated funding levels of USAID and other donor agencies).

(iii) The proposal would be written in the field, with both the local grantee and the JHPIEGO staff member involved. Each document would contain required information as noted in (ii) and in addition would state the reason for the selection of a particular grantee and specific training site.

This three-stage process should improve JHPIEGO's ability to modify course content in line with specific local needs, determine the type and duration of needed technical assistance, and state requirements for equipment and commodities including teaching materials. (Where endoscopy equipment is to be provided, the number of scopes already in country, the estimated percent of utilization, and the mechanisms for repair and maintenance should be noted.) Furthermore, this process might provide for evaluation indices that would better measure program impact, serve to pinpoint those opinion leaders who might require external training (perhaps at Hopkins), and ensure post-training follow-up activities which could have an appropriate and realistic linkage to service delivery.

V.6.7 Monitoring and Evaluation

o The chief of the evaluation division should be encouraged to meet with his counterparts among other donor agencies and to determine the relevance of their models to JHPIEGO needs.

- o New procedures should be devised for trainee follow-up.
  
- o New evaluative indices to measure program impact should be developed and weighted. A number of variables which relate to program impact are provided below. Obviously, the list could be longer, but funding limitations require selection among the many alternatives.
  - Changes in family planning policy.
  - Upward mobility of selected trainees and their potential to elicit change.
  - The role of JHPIEGO in bridging the gap between training and service delivery.
  - The establishment of new technology and its indirect role in providing essential services to consumers.
  - Specific changes in curricula for different classes of health professionals.
  
- o Additional technical expertise in the evaluation process should be provided by consultants.
  
- o In order to ensure the practical application of this approach, the chief of evaluation should be required to approve each project prior to approval and funding.
  
- o JHPIEGO should encourage AID to host an annual conference on evaluation where consensus on methodology, including indices and sampling techniques, could be agreed upon. Such meetings would ensure that the data collected could ultimately serve as a guide for programming and as a determinant in designating future funding levels.

## Appendix A

### THAILAND: COUNTRY REPORT

#### 1. Summary

Thailand's national family planning program, which officially began in 1970, is among the world's most highly regarded government efforts to improve health and encourage economic development by increasing contraceptive use and lowering fertility. Since 1970, fertility has declined by more than 60 percent, going from a total fertility rate of 6.3 to a TFR of 3.2. During the same period contraceptive prevalence among married women of reproductive age increased from roughly 16 percent to 64 percent. The pattern of contraceptive practice has also changed significantly. Initially, oral contraceptives were the most widely used method. Over the years, sterilization and injectables became increasingly popular. Today pills and sterilization are the most popular method.

The success of the Thai family planning program reflects strong demand among the population including those in rural agricultural areas, a well-developed public sector health care system that includes auxiliary nurse midwives who are able to provide oral contraceptives and insert IUDs, and strong support among policymakers and political leaders. The country has also benefited from steady economic development, which has led to improvements in transportation, communication, and education.

The Team visited Chulalongkorn University and Hospital, Siriraj Hospital and the Faculty of Medicine of Mahidol University and discussed JHPIEGO-supported activities with staff at a variety of levels. The Team also interviewed the Deputy Director-General of the Department of Health of the Ministry of Public Health as well as staff from USAID and several people active in family planning activities from Mahidol University, the Population and Development Association, and the Population Council. In addition, the Team reviewed a variety of project proposals, reports, and descriptions of activities.

Evaluating a specific program in Thailand is difficult. The Thai family planning program has been characterized by a long series of successes, thus making it hard to determine how individual components have played a role in helping fulfill national goals.

There is little doubt, however, that JHPIEGO has made a significant contribution and has filled an important training void. Clearly the prestige associated with the Johns Hopkins name has been important; the quality of the training itself,

51

however, is perhaps more important.

Since JHPIEGO initially emphasized laparoscopy training in Thailand, it is important to note that while endoscopy has not been a mainstay of the national program, it has permitted major academic institutes to contribute to the better acceptance of all surgical methods.

JHPIEGO-trained clinicians and administrators who have received U.S.-based training have returned to Thailand with a commitment to support and replicate such training for the Thai professionals as well as for others in Asia. Regional training should not be de-emphasized, as Thailand represents a unique milieu of professionalism, solid administrative support and a warm environment in which Asian professionals can and should continue to receive training.

## 2. JHPIEGO Activities

Current JHPIEGO activities in Thailand include:

### 2.1 Thailand National Endoscopy Educational Research Program. The National Family Planning Program.

In 1979, through JHPIEGO sponsorship, the Thailand National Endoscopy Education Research program was initiated under the auspices of the Ministry of Public Health. Training was conducted at Mahidol and Chulalongkorn Universities.

JHPIEGO support has increased the availability of service through training and provision of equipment. Most recently 20 physicians from provincial hospitals have been trained in female sterilization and diagnostic procedures using the laparocator. Thirty nurses working in outpatient operating rooms have also been trained to assist physicians to perform laparoscopy.

### 2.2 Regional Workshop in Gynecologic Microsurgery for Reversal of Sterilization.

This program supported a regional workshop in techniques of gynecologic microsurgery for surgeons from countries in Asia, Oceania, and the Middle East to increase the availability of sterilization reversal services in these countries. Training was provided in the theoretical and practical aspects of microsurgery as applied to sterilization reversal and treatment of infertility. Microsurgery equipment and educational materials were also provided.

Program. Based on the Team's visits to universities providing training and the discussions with senior officials at the Ministry of Public Health, it is apparent that this program

has been implemented as proposed, with the exception of training for one group that was cancelled as agreed jointly with JHPIEGO.

Training Curriculum. In general the curriculum appeared appropriate and well implemented. Experience with several courses has given the project directors a much clearer idea of how best to teach the use of the laparoscope for both diagnostic and therapeutic purposes. Future courses would undoubtedly take advantage of this.

This course was well designed. Because of the small size of the class and the strong support provided by Chulalongkorn Hospital and Faculty of Medicine, the training was almost custom-made to each participant's background and surgical dexterity. Careful supervision and tutoring was provided and extra sessions could easily be arranged. The training was enhanced by the fine collaboration within Chulalongkorn and between Chulalongkorn and local medical equipment companies that loan equipment for training and provide samples to students. The equipment given to each graduate by JHPIEGO adds to the value of the training.

Administration. Previous evaluations have commented on various administrative problems, most important of which was a series of difficulties related to the transfer of funds. The team found that these problems had been resolved. Administration of JHPIEGO seems smooth and characterized by easy communication between the senior staff at JHPIEGO and Thai grantees.

One area of weakness is the lack of a Regional Development Officer for Asia. In practice this means that both the USAID mission and the grantees are not kept well informed about new program opportunities and are not able to receive help with administrative or programmatic problems. This lack has also meant less JHPIEGO participation in activities in Thailand. Thailand is an attractive center for regional training and a source of valuable insights about training and the provision of health and family planning services. A greater participation by JHPIEGO staff in the designing and monitoring of projects in Thailand would improve the quality of the program and increase JHPIEGO's impact in Thailand and other countries.

Follow-up. Follow-up activities to JHPIEGO-funded training programs have been one of the weaker links of the overall effort. In the case of Thailand, good reporting is the rule rather than the exception. It is on the basis of monthly reports that underutilization of laparoscopes in the district hospitals was recognized and follow-up training instituted. The average caseload of 30 female voluntary sterilizations over an eight-month period, despite follow-up training, points up several factors:

- a. the utilization of minilap and postpartum tubal ligation as the main operations in the Thai voluntary sterilization program;
- b. the pressure on provincial hospital obstetricians and operating rooms to provide a variety of other health services; and
- c. the uneven selection of endoscopy candidates within the Thai national program.

New models may be needed in the future to improve realization of program goals.

Given the relatively high cost per trainee and the significant equipment costs inherent in microsurgery training, it is even more important that direct field follow-up by the training staff be built into each proposal. This is important both as an evaluative index of the training itself and as a way to provide necessary technical assistance when trainees return to the unique challenge of their own locale.

Evaluation. While the endoscopy program has been evaluated by pre- and post-course tests given each trainee, the more important field follow-up is not being conducted by the trainers. Ironically, in part this reflects the strength of the Thai family planning program. Close cooperation exists between the Ministry and the country's medical schools. Candidate selection and follow-up were carried out by the Ministry and training was provided by the University. In theory this means that those selected for training are part of the Ministry program and the program is being implemented in line with national policy. In fact, however, it frequently happens that trainees are not well selected because Ministry bureaucrats are not familiar with the technical and manual demands of laparoscopic surgery. Follow-up by the Ministry tends to be based on number of cases done (as reported to the Ministry), not on such issues as technical problems and patient comfort. While detailed evaluation of trainee performance is not well done (both trainers said they responded to requests from the field, not to an organized plan), Ministry service statistics and a series of national sample surveys of contraceptive practice provide valuable information on the number of and characteristics of sterilized couples. The Team's impression is that less evaluation is conducted of diagnostic use of the laparoscope than of its use in family planning. One hopes that the addition of the new evaluation officer at JHPIEGO may lead to more creative and better established variations.

### 3. New Training Activities

If JHPIEGO is to be responsive to the new Thai Five-Year plan aimed at reducing the population growth rate from the current annual rate of 1.6 percent to 1.1 percent, additional emphasis in involving all sectors in the family planning effort will be required. It is noteworthy that the Thai Ministry of Public Health recognizes the need for private sector involvement at a time when USAID has placed a priority on such activities. The evaluation team believes that JHPIEGO, at least in the case of Thailand, can play a role in this effort through the development of training for the increasing number of physicians who are not directly involved in the Ministry of Public Health Program. The Ministry of Public Health estimates that in two years there will be no vacancies available for physicians to enter government service and thus competition will be keen for all public sector medical positions.

The model of private sector training is not new. AVS successfully trained MDs in vasectomy and immediately thereafter there was a rise in acceptors and a change in the ratio of male to female surgical sterilization acceptors from 1:6 to an estimated 1:4-5. In Thailand, JHPIEGO has long been associated with endoscopy training rather than minilap. It remains for JHPIEGO, the training institutions, and the MOPH to determine whether use of the laparocator by carefully selected trainees within the private sector would be cost-effective. New models would be required either to permit a private sector trainee to lease or acquire a scope at low cost, or to involve the private hospital where surgery is performed in scope procurement.

Although it originally did not function smoothly, the RAM center has been working well since it was taken over by the MOPH. Additional training in equipment maintenance was recently completed by two operating room nurses from Chulalongkorn. The Team believes that with the addition of perhaps one person by the MOPH, the RAM center could extend its maintenance activities to the private sector.

Careful selection of criteria would need to be employed prior to training. A minimum of two years of post-graduate training in either surgery or gynecology should be required and an age cut-off of perhaps 40 years is also realistic. In the case of private hospitals, initial training should be carried out within a research framework, with evaluation and follow-up representing major components of the first year's activities. Should the model prove successful, it could be expanded.

Additional JHPIEGO opportunities within Thailand must be approached based upon JHPIEGO funding capacity and its priorities within a given region. It is clear that the present training staff is more than adequate to expand its activities into the

academic skills course (already scheduled) and to include the administrators' program in reproductive health. The Team wishes to emphasize the potential of Thailand to continue to serve regional training needs in Asia. By not fully utilizing this time-proven approach, JHPIEGO would be losing a major opportunity to train selected health professionals from such countries as Burma, India and Nepal.

Concern about sexually transmitted diseases within the reproductive health community in Thailand is great, and a JHPIEGO-based course in this area would be greeted with enthusiasm. While the training center staff also indicated an interest in providing sex education to medical students, the Team believes that such activities, while important, could best be handled by an expansion of the nursing student curricula and the provision of mandatory courses at the university level. The adolescent programs recently supported by UNFPA appear to be a step in the right direction. The academic skills course for physicians could be modified to include sex education components. JHPIEGO field follow-up activities and questionnaires might also raise the issues of the nature and extent of the need for such activities. Continuation of the present microsurgery course for non-Thai Asian physicians would appear to be an important priority. Appropriate field follow-up must be included. With a remarkable success rate of over 60 percent of sterilization reversal procedures experienced by previous Thai microsurgical trainees, there is little doubt of the value of sterilization reversal training within any national program which emphasizes voluntary sterilization. After a JHPIEGO Asian Coordinator is recruited, field visits to priority countries within Asia should be scheduled to determine the nature and extent of future JHPIEGO programs.

#### 4. Recommendations

1. High priority should be given to a field visit by the JHPIEGO Asia Regional Officer to the Thai regional family planning center. This visit, combined with a visit to other Asian centers, should permit a better appreciation of Asian training needs and the capacity of the Thai centers to fulfill their requirements. It would also permit meeting among USAID personnel and staff members involved in training and service delivery for other agencies: International Training and Health (INTRAH), FPIA, AVS and UNFPA. Better coordination would allow a more careful allocation of JHPIEGO resources within the region. JHPIEGO may wish to consider the training of African doctors in Thailand and elsewhere in Asia where there are well-established national family planning programs of which sterilization is an integral part.

2. JHPIEGO should consider expanding training to private sector physicians in the near future. It may be appropriate to consider the development of new training procedures and equipment provision guidelines for this activity, including modification of maintenance in the present RAM center.

3. JHPIEGO should encourage improved field evaluation procedures for both in-country and regional training courses. Especially important is the support of field visits that enable evaluation of the training to be based on more than just a mailed questionnaire of self-reported performance.

4. JHPIEGO should obtain technical assistance for the development of criteria for the institutionalization of its program in Thailand and elsewhere. These should be based on country health services needs and should indicate how much change in medical school curriculum is needed to meet those goals.

5. Even in the mature and well-established family planning programs of Asia, the need continues for training in reproductive health and academic skills. Given the success of JHPIEGO's laparoscopic training, the Team believes consideration should be given to introducing new courses on STDs, reproductive health, and academic skills to countries in the Asian region. Special consideration should be given to conducting these courses at the regional training center at Chulalongkorn University.

6. JHPIEGO should investigate both in Thailand and in the United States the opportunities for training nurses in reproductive health.

**Appendix B**  
**NIGERIA: COUNTRY REPORT**

## Appendix B

### NIGERIA: COUNTRY REPORT

#### I. Objectives and Programming Strategy

Improving health and family planning in Nigeria is a high priority for AID and JHPIEGO. Nigeria's new military government has taken a position supportive of family planning. Moreover, a downturn in economic circumstances has caused people to rethink the appropriateness of high fertility and rapid population growth. Several AID-supported organizations have significantly increased their support to Nigerian institutions. Population, health and family planning activities appear to have taken off recently and there is widespread interest in beginning new projects. At this stage, however, there are few signs of dramatic increases in contraceptive prevalence in the rural areas. More trained personnel are needed, as are increases in the availability of contraceptive services. JHPIEGO has taken advantage of this greater interest in family planning and has built on its history of training Nigerian physicians at Johns Hopkins in Baltimore. JHPIEGO has built upon Nigeria's high regard for education by concentrating its initial institutionalization efforts at the country's most prestigious medical universities.

The need for improved health and family planning programs is clear. One out of five Africans is a Nigerian. The country's total population is estimated to be 91 million and is increasing at an annual rate of about 3 percent. Maternal and infant mortality are high. One of every 10 children dies before reaching his or her first birthday. Deaths due to complications of pregnancy and childbirth in some Nigerian communities are more than 50 times the level of the United States and Western Europe.

JHPIEGO's objective in Nigeria is to increase the number of professional health workers able to provide family planning, ORT, and other health services. Also recognized as important by JHPIEGO are the spin-offs of its support: increased status and credibility for those trained (particularly for doctors trained at Johns Hopkins itself), greater awareness of family planning role in health in the medical community, and increased availability of quality reproductive health services. JHPIEGO's objectives fit well with expressed AID goals and with the goals of other AID-supported agencies. JHPIEGO projects are reasonably coordinated with the work of such groups as The Pathfinder Fund and the Association for Voluntary Sterilization. For example, JHPIEGO's laparoscopic training has been supplemented by AVS

support for expanded facilities for laparoscopic procedures. JHPIEGO-supported training in Ibadan is likewise coordinated with work supported by The Pathfinder Fund.

JHPIEGO activities are also coordinated with government programs. The emphasis on training nurses, midwives, and community health workers is appropriate for Nigeria and fits with government and AID policy. Two of the projects visited were being carried out by the government health ministries and other activities appear to be implemented to meet needs expressed by government officials. The links between JHPIEGO projects in Nigeria and the work of other national and international groups seems to be maintained without burdensome formal communication requirements.

## II. JHPIEGO Activities

JHPIEGO supports thirteen projects in Nigeria, of which the team visited six. The team also discussed future activities that current grantees wish to undertake. According to the AID Mission in Lagos, the Nigeria Maintenance Center was recently visited by JHPIEGO's equipment technician who reported no serious problems. The team decided not to visit the FEMOPE marketing company responsible for equipment maintenance. Descriptions of each of the projects visited, taken from the Johns Hopkins population information program, are given below:

1. Reproductive Health Training, Benin Teaching Hospitals  
This program will establish a reproductive health care training center within the Department of OB/GYN at the University of Benin Teaching Hospital in Benin City. By the end of the first year, two educational programs in reproductive health/primary health care, with emphasis on the care of women and children, will be conducted for a total of 48 medical officers assigned to government hospitals in Bendel State and the neighboring states of Ondo, Ogun, Anambra, Kwara, Benure and Rivers, with the goal of improving the reproductive health care of women and the health care of children in these states. Educational materials and consultant support will be provided to supplement the training program.
2. Reproductive Health Training for Nurses and Midwives, Bendel State.

The training program for nurses and midwives is designated to broaden their knowledge in family planning and child spacing techniques, increase their knowledge as to how to teach other health workers, and improve administrative aspects of client service. A limited number of students in

health-related fields will be invited to attend the didactic sessions in Benin.

The course will be organized and coordinated by the State MOH and University of Benin Teaching Hospital (UBTH). Six sessions will be conducted during the year. Each session will consist of one week didactic and two weeks of clinical practicum. These sessions will be attended by up to a total of 150 student nurses and midwives, plus 26 graduate nurse/midwives who will continue in the clinical practicum subsequent to completing the didactic. The students in training who will attend the didactic sessions will be rotating through MCH or community health sections of their curriculum.

3. University of Ibadan Endoscopy Training Project, Ibadan.

The purpose of this agreement is to train physicians and operating room nurses in endoscopic techniques and advances in reproductive health to help reduce the high rates of maternal and infant mortality and morbidity and to improve the diagnosis and treatment of infertile women. It is expected that at the conclusion of the program all medical schools in Nigeria will have physicians trained in endoscopic techniques and that this training will be provided to medical students and residents at each of these institutions.

The specific objectives for the program are:

- a. To provide didactic and clinical training in endoscopy to 20 physicians from government hospitals with emphasis on management of fertility and infertility and the use of the laproscator and the mini-laprocator for diagnostic and therapeutic laparoscopy procedures.
- b. To provide didactic and clinical training in skills necessary to assist physicians in their performance of laparoscopic procedures to 20 operating room nurses from the same institutions as the physicians trained under this agreement.
- c. To provide medical equipment, educational materials and consultant support to supplement the training program.

4. Reproductive Health Training for Medical Officers, Lagos.

This project aims:

- a. To provide training in reproductive health including didactic lectures and clinical demonstrations on immunization, family planning and oral rehydration to

an estimated 60 primary health care medical officers, community health officers and nurses/midwives from Lagos and Ogun States.

- b. To initiate a pilot, follow-up project whereby trainees will be expected to conduct seminars for personnel in their home institutions to disseminate information they have acquired during the reproductive health training courses.
  - c. To provide consultant support and educational materials to supplement the training program.
5. Reproductive Health Training for Tutors of Nurses, Midwives and Community Health Workers, Ibadan.

This project supports the development within Nigeria of a training program in reproductive health/family planning for tutors of schools of nursing, midwifery and health technology, identified by the Ministry of Health, to improve the quality of services in reproductive health for the women and children in Nigeria. The integration of family planning into the approved curricula of these schools is a component of this program.

Objectives include:

- a. To provide didactic and clinical training in reproductive health and family planning to an estimated 73 tutors of schools of nursing, midwifery and health technology within the five accelerated states of the National Health Plan and as estimated 17 tutors from non-accelerated states identified by the Ministry of Health.
  - b. To integrate family planning into the approved curricula of the schools of nursing, midwifery and health technology.
  - c. To provide consultant support and educational materials to supplement the training program.
6. Integration of Family Planning into the Curricula of Nurses, Midwives, and Community Health Workers, Ibadan.

The purpose of this agreement is to support the development within Nigeria of an educational program to plan for the integration of reproductive health and family planning into the approved curricula of nurses, midwives and community health workers to improve the quality of MCH/FP services available to the women and children in the urban and rural health centers. The development of further projects to advance teaching of MCH/FP in teaching institutions throughout Nigeria is a component of this program.

Objectives include:

- a. To establish a core committee of an estimated seven representatives from federal, state and professional organizations in the five accelerated states identified in the National Health Plan (Lagos, Ogun, Ondo, Niger, Plateau) which will function in an advisory, coordination capacity throughout the duration of this program.
- b. To conduct a four-day workshop for an estimated 41 tutors of the schools of nursing, midwifery and health technology in the five accelerated states, an estimated five state Chief Nursing Officers, the seven core committee members and an estimated 15 selected tutors from the host state, Oyo, to develop a reproductive health and family planning curriculum to be integrated into the approved curricula of the schools.
- c. To conduct a one-day follow-up meeting for the core committee and an estimated five state representatives to assess the progress of the program on a state by state basis and determine further program strategies.
- d. To provide consultant support and educational materials to supplement the training program.

III. Effectiveness

Interviews with project directors and staff reveal that in general project objectives are being met both in terms of participant numbers and training outcomes.

Administration. Local staff were knowledgeable about the details of the projects. JHPIEGO's administrative requirements were understood and were not perceived as excessively burdensome. Staff in two places mentioned that the accounting requirements taught useful financial management skills. Some people complained about the slowness of fund transfers, but the complaints were not frequent and although the transfer of money doubtless causes problems from time to time, no more than continued attention to the problem is needed. Various JHPIEGO forms, however, could be improved. For example, participant follow-up forms were designed for and seemed best suited to physicians not nurses training, which is currently most important in Nigeria. Coordination with other programs and academic activities was being appropriately handled.

Program. The programs as implemented followed the objectives expressed in JHPIEGO project documents. Programs represented a sound approach to the problems identified by local personnel and JHPIEGO staff. Course plans, as well as trainee and teacher selection, were appropriately carried out. Training courses were conducted in accordance with the JHPIEGO proposal.

Follow-up. Follow-up was an area of weakness. Follow-up measures are described in detail in the various project documents, but not well carried out in practice. Participants are slow to return questionnaires. More thought needs to be given to increasing return rates. The problems of routine communication by either phone or mail in Nigeria are a significant part of the problem. Project personnel complained travel was difficult and expensive, further limiting follow-up. Nevertheless, staff has no new ideas about how to cope with this situation. Moreover, the best staff are burdened with a variety of obligations and are not skilled in making use of support staff. Record keeping systems are not adequate, and tickler systems or PERT charts for project activities do not appear to have been widely employed.

Evaluation. Evaluation is another area where improvements would yield substantial gains in program quality. Project staff are aware of the importance of evaluation. However, the use of pre- and post-test forms involves the mechanical application of what appeared to the team to be not very well designed tests. However, the clinical evaluation appears thorough and well documented. Because follow-up is limited, longer-term evaluation is not effectively carried out. Examination of the impact of the project in terms of new acceptors of family planning is more difficult and less frequently conducted. While it would be a mistake to exaggerate the importance of evaluation, attention to the impact of program, especially trainees' awareness of the advantages and disadvantages of various methods coupled with an assessment of what aspects of the training are most useful in a community setting, could be useful.

Service Delivery. Because of the still limited availability of family planning services and supplies and the modest demand for contraception, particularly sterilization, the program's impact on services has not as yet been dramatic. However, JHPIEGO-supported projects are contributing to expanding and strengthening the pool of professionals able to provide quality family planning and reproductive health services which will be crucial in future program implementation. JHPIEGO's strategy of training the trainers and teams of service providers seems particularly well suited to meeting this goal. The projects also contribute to an increased demand for contraceptives and government support for family planning from health personnel at all levels.

Course Content and Implementation. The team reviewed class schedules and topic outlines. No detailed syllabi or information on teaching or learning activities were available. The team understands the demand for comprehensive coverage of the range of topics of interests to the participants. Nevertheless, the subjects covered were frequently too numerous and, as a result, impossible to cover adequately in the allotted time. Natural

family planning, including instruction in the Billings Method, was covered in one hour, the same amount given to eclampsia, a topic of questionable significance for the trainee.

Institutionalization. The team found that JHPIEGO-supported activities have been diffused to the student bodies in Ibadan and Benin and that family planning and reproductive health topics have been incorporated into the education of doctors, nurses and midwives. Students participate in family planning clinics and counseling sessions. The curriculum development project has the potential to improve significantly the coverage of family planning and reproductive health in midwifery education throughout the country. There have been important research by-products of JHPIEGO's support as well. Physicians at several sites are using the equipment and trained staff to conduct policy-oriented health research, sometimes in collaboration with AID groups.

Private-Public Sector. Only limited private sector involvement in laparoscopic sterilization was found. However, it is worth noting that those private physicians the team heard about who were performing laparoscopic procedures had been trained by JHPIEGO. The difficulty of freeing private practice doctors for training represents a serious barrier to greater expansion of private sector activities following the JHPIEGO model. The staff of projects currently funded by JHPIEGO emphasized public sector programs.

#### IV. Unmet Needs and Future Opportunities

The team was impressed with quality and relevance of the ongoing JHPIEGO program. The local (as opposed to Baltimore) training was widely regarded as appropriate and the team agrees. The Baltimore site is still attractive for training of senior administrators, however. In a country like Nigeria unmet needs abound. The team believes that JHPIEGO's decision to take a more federal outlook is sound, although it should be cautiously implemented so as not to fracture the already developed programs. JHPIEGO also has an important opportunity to coordinate its training activities with emerging service delivery activities supported by national and international groups. A similar opportunity exists to upgrade educational material dealing with reproductive health topics. Provision of general health education courses and material, although frequently requested, do not seem an appropriate activity for JHPIEGO. Once the current curriculum is institutionalized, probably five and perhaps ten years away, JHPIEGO should develop appropriate refresher training. Even now information on service delivery could be more aggressively provided.

53

## V. Summary and Conclusions

During its stay, the team visited JHPIEGO-supported programs in Lagos, Ibadan and Benin. Interviews were conducted with project directors (or their delegates), project staff, trainees, hospital and university personnel, and staff from AID and AID-supported programs in Nigeria. The team also reviewed a variety of documents related to each of the new projects visited. Included were project proposals, evaluation reports, curricula, and progress reports. The team observed several midwives who were participating in JHPIEGO-supported clinical training sessions. Unfortunately, no classes were underway and several key project staff to Nigeria were not available during the team's visit.

The team found enthusiastic staff implementing carefully designed training programs that appear to be making an important contribution to strengthening Nigeria's effort to improve maternal and child health and to increase the use of family planning. In addition to the practical skills transferred, JHPIEGO-supported activities have helped increase awareness of reproductive health problems and the potential contributions of a range of health interventions. One physician interviewed said JHPIEGO's program "has changed doctors' minds, not just stopped babies." The level and type of training appear to be appropriate, as does the selection of candidates. Facilities for the courses are adequate. The officials in charge of the departments of institutions where the training is or has taken place are supportive of JHPIEGO-supported programs and eager to see them expand. Discussions with graduates of JHPIEGO-supported programs indicate that they have mastered a great deal of information on the provision of family planning, ORT and other reproductive health services. Administrative aspects of the programs seem to be in order and not particularly burdensome. JHPIEGO's staff were well regarded by their Nigerian colleagues. The balance of in-country and U.S.-based training is regarded as appropriate. Equipment provided by JHPIEGO appears to be in good repair and well used. Designated facilities are adequate for the provision of laparoscopic procedures.

Problems were, however, noted. Several people complained of a lack of flexibility in candidate recruitment, which meant it was difficult for local personnel to respond to local needs, in particular for accomodating additional students. Based on its observations, the team believes more flexibility could be allowed. Several people said a longer period of training for nurse-midwives was necessary. The team agrees that additional training would be valuable. It is difficult, perhaps impossible, to master the wide range of material presented in the time allowed. Particular note should be made of the problems of gaining adequate clinical experience in the time allowed. The

54

team believes more generous provision of course-related material may have a substantial impact. The provision of a small supply of contraceptives for each nurse-midwife would be especially useful to reinforce their newly acquired skills. Few of those visited had adequate mid- to long-range plans. Thus, future directions and needs are not as well specified as they could be. With a little extra effort, plans could be outlined to identify the most important areas for JHPIEGO support.

## VI. Recommendations

The team recommends that:

1. JHPIEGO should continue to offer high-level training for family planning administrators and health policy-makers.
2. JHPIEGO should consider offering continuing education conferences and other updates for graduates of training programs.
3. JHPIEGO should produce a newsletter for professional midwives, physicians, and program managers that would contain a combination of technical-medical updates, program management information and national population issues. News of program accomplishments could be shared, as well as features on projects, individuals, etc.
4. Educational packages given to participants should be distributed to all program faculty and lecturers.
5. Students nurses attending workshops should get inexpensive pamphlets, e.g., "Basics of Birth Control" (Planned Parenthood Federation of America [PPFA] fact sheet could be modified). A simple brochure on the role of the nurse in family planning could be commissioned if one is not available that is culturally appropriate.
6. The Benin midwife training program could benefit from the Omni Film on Pelvic Examination to supplement its pelvic models.
7. Consideration should be given to standardizing the length of training for midwives. Didactic content should also be reviewed in the Benin program, e.g., strengthen topics around birth control method management.
8. JHPIEGO should consider expanding the educational materials it furnishes to include available patient education materials, teaching posters, etc.

9. Consideration should be given to establishing an internship or preceptorship period for midwives who are returning to practice setting with simple reporting requirements, forms, envelopes, and postage furnished. Award certificates following "successful completion" to guarantee feedback. Documentation of practice should be considered.
10. IUDs with practice kits might be supplied to assure midwives practice their skills.
11. Participant follow-up forms should be redesigned to better capture experience of midwives and nonphysician trainees.
12. Some technical assistance should be provided to strengthen natural family planning as part of the midwives' curriculum.
13. Adequacy of funding for follow-up visits to midwife participants should be assessed.
14. JHPIEGO should continue to encourage the utilization of local experts and resources while monitoring the adequacy of teaching. Workshops on curriculum development testing techniques and teaching strategies should be continued.
15. Although the private medical sector should not be ignored, priority should continue to be given to developing the skills of the public health workers who care for the majority of women and infants in Nigeria.
16. Consideration should be given to initiating a limited approach to the private sector physician and midwife through sponsorship of local medical society meetings at which family planning subjects could be presented.
17. Teaching aids, including medical journals and textbooks for medical students and house officers, could be supplied.
18. Assistance might be given with the development of institution- or program-specific five-year plans for JHPIEGO and other national and international support.

Appendix C  
EGYPT: COUNTRY REPORT

## EGYPT: COUNTRY REPORT

## I. Overall Program Objectives

Although Egypt has had a Supreme Council for Family Planning (recently renamed the Population and Family Planning Board and, more recently still, the National Population Council) headed by a senior government official since 1965, the country and its leaders have not moved to implement a national family planning program as forcefully as many other developing countries. Egypt's crude birth rate has remained high (approximately 37) and the country's population is growing at an annual rate of 2.7 percent. What one group of international experts called "nearly 30 years of official disinterest by Egypt's political leadership about population issues" has been at least partially redressed by President Housni Mubarak who has issued a stream of supportive statements, prompted the reorganization of the country's family planning program, and received briefings from a number of foreign population experts visiting Egypt. The family planning program has recently been reorganized (organizational charts for the new program structure were being drawn up during the Team's visit) and there is widespread hope that new leadership will be able to substantially increase the prevalence of contraceptives from the current level estimated to be about 28 percent.

The pattern of contraceptive use in Egypt is heavily weighted toward the pill, which is by far the country's most popular method. According to one recent study, oral contraceptives accounted for 83 percent of all fertility control (including prolonged breast-

feeding and traditional methods) used in rural Egypt. IUDs and sterilization, on the other hand, represented 12.5 and 4 percent, respectively, of all contraceptives used by married women in rural areas.

JHPIEGO's objectives in Egypt have been to increase awareness of the importance of reproductive health and to provide training in the modern methods of fertility regulation to physicians who occupy positions as teachers and providers of reproductive health care. JHPIEGO has chosen to work with a small number of key medical schools to institutionalize training programs that cover all family planning methods but concentrate on endoscopy. JHPIEGO and its Egyptian grantees are trying to encourage physicians to use the risk approach to reproductive health, especially to the provision of family planning services. Promotion of voluntary sterilization, however, is not an important program element. The theory underlying JHPIEGO support is that once endoscopy and the risk approach are institutionalized at Egyptian medical schools, more sterilization services will follow in both the public and private sector. There is some evidence that this is happening. Physicians report that there has been a growth in female sterilization procedures as a proportion of all laparoscopic cases.

JHPIEGO-supported projects seem to fit well with the large and diversified population assistance program supported by AID in Egypt. The concentration on high technology and high quality medical education appears to be an appropriate balance to AID's support of community and nonphysician-based contraceptive distribution programs. The

centers the Team visited at Al Azhar and Alexandria universities are involved not only in medical education but also in a variety of other training, research and service activities that provide the directors of the JHPIEGO program with a network of national and international contacts active in Egypt's health and family planning programs. Staff of the two JHPIEGO-supported programs the Team visited appear to work well together, exchanging ideas and contacts.

Particularly noteworthy is the relationship with the Ministry of Health, which appears cordial and mutually supportive. In spite of the lack of official approval for contraceptive sterilization, JHPIEGO-supported centers train Ministry physicians who are helping disseminate both endoscopy and the concepts of high risk pregnancy management. One important result of this collaboration has been an increasing recognition that high parity constitutes an important risk factor, although Ministry physicians are more conservative in their application of high-risk approach than university-based providers of care. At Alexandria, a promising collaboration is underway between the medical school and the Higher Institute of Nursing, staff from which have regularly taught in JHPIEGO-supported programs to train nurses to insert IUDs.

JHPIEGO-supported activities have also been coordinated with the work of the AID-funded Association for Voluntary Sterilization (AVS) and its principle Egyptian grantee, the Egyptian Fertility Care Society. AVS-funded equipment maintenance facilities have been shared, for example. However, the different programmatic orientations are apparent. AVS-funded programs sought to increase the availability

and use of voluntary sterilization, whereas JHPIEGO's support was for training in endoscopy, one by-product of which would be greater use of sterilization by high risk patients.

## II. Ongoing Programs and Objectives

JHPIEGO currently supports three projects in Egypt at Al Azhar University in Cairo, Alexandria University and the University of Assuit. The objectives of these projects are as follows:

1. Endoscopy Training Program, Human Reproduction Training Center, Shatby University Hospital, Alexandria

This project teaches physicians and paramedical personnel current concepts in reproduction through four types of training: (a) physician laparoscopy training, (b) non-physician health personnel laparoscopy training, (c) local anesthesia training for physicians, and (d) nurses IUD training.

2. Endoscopy Training Program, Al Azhar University, Cairo

The goal of this project is to improve maternal health through the training of physicians and nursing personnel in modern aspects of reproductive health. Objectives for 1984-85 included training 40 physicians in endoscopy and 20 nurses in equipment maintenance. In addition, six physicians will receive training in tubal microsurgery.

3. The Standardization of Curriculum in Reproductive Health for Medical Schools in Egypt, The University of Assuit, Assuit.

The purpose of this project was to alleviate the shortage of trained personnel in family planning by developing a standard curriculum in reproductive health and encouraging its integration into Egypt's eight medical schools. Program activities included a three-day meeting of medical school administrators, Ministry of Health physicians, and family planning organizations to define competency levels and curriculum content. A follow-up meeting is planned to assess progress in implementation of recommendations.

### III. Effectiveness

Administration. The Team found JHPIEGO's programs to be well managed but not without administrative problems of a sort that may be inevitable, but one wishes were less troublesome. Almost everyone the Team spoke with complained about the excessive amount of paperwork required by JHPIEGO. Project directors also criticized the mechanical nature of JHPIEGO's trainee follow-up procedures and the lack of enthusiasm for the more personal dimension of follow-up.

JHPIEGO's staff were well thought of and their contribution to the program was appreciated. The lack of a Regional Development Officer for Asia, however, represents a potential problem, probably more in terms of keeping AID and the National Population Council informed about JHPIEGO activities and need for support than with JHPIEGO grantees. Special attention needs to be called to the January 1985 Presidential Decree that stipulates that all foreign-supported proposals and projects be reviewed by the National Population Council before AID review and approval. This arrangement seems likely to slow

decisions, especially if JHPIEGO is not adequately staffed to provide the support needed to deal effectively with the National Population Council.

Less significant administrative issues include occasional difficulty with the transfer of funds, auditing procedures, and the special needs of foreign trainees in Egypt. JHPIEGO grantees appear to be dealing with these problems with equal measures of common sense and good humor.

Program. The Team found that the programs proposed by Al Azhar and Alexandria universities supported by JHPIEGO had been implemented in a timely and responsible fashion. Both programs have met their trainee quotas (with the exception of one training program for nurses) and have covered appropriate geographical areas in recruiting trainees. By the end of its fourth year of support, the program in Alexandria, for example, trained people from 35 institutions in Alexandria as well as staff from 17 institutions in 10 other governorates. The two-week IUD insertion training for nurses has been well attended and has a long waiting list. Because of the questionable legal status of nurses performing this procedure, the program has admitted only nurses who are assured of being able to use their skills.

Follow-up. Follow-up is a matter of concern to both project directors. Those trained feel a sense of identity with the program (comparable to that which the Egyptian project directors feel toward Johns Hopkins), but project directors feel more could be done to promote effective follow-up. The questionnaire approach currently used is not well thought of because it minimizes the all-important

interpersonal relationship between the professor and the trainee. The group at Alexandria has instituted a second follow-up visit to trainees that serves to reinforce the training and provide a continuing link to the program. Both project directors mentioned the need for continuing educational material that could aid in follow-up and also encourage the continued use of the newly acquired skills.

Evaluation. Both projects the Team visited seemed to be conducting appropriate trainee evaluations. Pre- and post-tests are given, but more important the Team sensed that the project directors and program staff had a detailed and realistic view of almost every trainee's progress.

The current JHPIEGO-supported programs do not provide a significant amount of service to high risk women in need of a completely effective, long-lasting method of fertility control for health reasons. Because trainee follow-up is poor, accurate data on the nature of the procedures performed is hard to obtain. Estimates given to the team were that 5 percent or less of all procedures done by those trained at Al Azhar University were sterilizations. The comparable figure for those trained in Alexandria was 25 percent. Sterilizations, however, appear to be increasing as a proportion of all procedures.

Because of the recent visit of a JHPIEGO equipment specialist, the Team did not probe into the issues of repair and maintenance. But both project directors expressed concern about the issue. Dr. El Salwi of Alexandria, in particular, was worried that lack of adequate repair procedures would jeopardize the effectiveness of the program. During

its stay in Egypt, the Team learned that the nature and extent of Association for Voluntary Sterilization (AVS) support, including that for repair and maintenance of laparoscopes, was likely to change, adding to the uncertainty surrounding this issue.

#### IV. Curricula at Institutions

Outlines of course content and class schedules were reviewed for the endoscopy program at Al Azhar University in terms of a general content and balance between didactic and clinical hours. Syllabi or lesson plans are apparently not prepared to detail topic content or teaching/learning activities. Al Azhar's endoscopy project conducts a two-week didactic component followed by one week of clinical training. The Shatby project, on the other hand, has integrated the didactic and clinical components, an approach the Team regards as better suited to the training needs.

A review of the Al Azhar classroom schedule for endoscopy training shows that out of 40 hours of didactic, only 5 hours are devoted to nonsurgical contraception, family planning and population issues. Among the topics covered is research design, but no time is scheduled for a discussion of hormonal contraception.

Al Azhar University has made significant progress in the institutionalizing of a family planning curriculum. Dr. Hefnawi explained that different levels of instruction now exist for medical students, house officers, and specialists from the Ministry of Health. The Al Azhar curriculum was apparently used as a model in the curriculum standardization workshop held in Assuit in October 1984.

Because neither syllabi nor class outlines were made available to the Team for the Alexandria programs, it was not possible to fully assess the appropriateness or adequacy of their didactic content or clinical practice.

On the basis of the narrowly-focused program for nurses and limited time devoted to contraceptives and reproductive health for physicians, it is the Team's impression that all of the programs are missing an opportunity to significantly enhance the family planning skills of the professionals being trained.

It is uncertain whether the short period of clinical training for nurses is adequate for them to attain competence in assessment and management of IUD patients. Project staff described deficiencies in the preparation of both nurses and physicians in Egypt. It makes sense, therefore, to provide them with as much family planning education as feasible.

#### V. Unmet Needs and Future Opportunities

Half the women in Egypt who die in pregnancy, childbirth or from abortion are over age 30 and/or have four or more children. Voluntary surgical contraception for women for whom pregnancy represents a risk of serious illness or death is a recognized medical practice. There are signs that the newly appointed Secretary General of the National Population Council, Professor Maher Mahran, may be quietly supportive of greater provision of female sterilization services. He reportedly believes that the most pressing need at the moment is not for more research or additional training but for a more aggressive stance toward the provision of contraceptive services and that a need exists for sterilization, especially among high-risk women.

It will continue to be difficult for the National Population Council to provide leadership to a sterilization program, but quiet support should be forthcoming for a program aimed at giving physicians the technical skills needed to provide good services and an understanding of the health impact of high fertility and its treatment. The Ministry of Health may continue to make provision of sterilization services at government hospitals difficult. This raises the question of the need to train physicians active in the private sector. The Team recognizes the problems involved in such training, but believes more imaginative programs that capitalize on the unique role of private physicians but do not promote excessive medical entrepreneurship could be developed. The Team believes, contrary to the impression of some JHPIEGO senior staff, that substantial support would be provided by AID and the National Population Council for a person or program aimed at energizing the private sector provision of endoscopy training and services. The private sector is already active in the provision of other contraceptive services, and it seems likely it could play an important role in the provision of sterilization services. One estimate given the Team was that two-thirds of the births averted in Egypt were by contraceptives obtained from private sector sources.

Both project directors, but especially Dr. Serour from Al Azhar University, expressed an interest in in vitro fertilization. The Team does not believe this would be an appropriate activity for JHPIEGO support. Likewise, the Team feels that only limited additional resources should be devoted to microsurgery training. Its importance for Egypt's family planning program is largely symbolic. Local support would probably be available for microsurgery and the need for it and

its availability will remain limited for some time. A more important need is for an additional endoscopy training program in Upper Egypt and more support for incorporating reproductive health courses in the training of doctors, nurses and other health workers.

## VI. Recommendations

Consideration should be given to:

1. Providing more audiovisual and teaching aids to project directors and staff.
2. Providing opportunities for project directors to meet and discuss problems and issues in program implementation.
3. Expanding the endoscopy program to a suitable location in Upper Egypt.
4. Incorporating more in-depth coverage of contraception, including current issues related to safety and problem management.
5. Developing programs that better meet the needs and opportunities available among the private health care providers.
6. Careful evaluation and monitoring of the laparoscopic equipment repair and maintenance.
7. Sponsoring regular continuing education programs for trainees.
8. Publishing a newsletter for JHPIEGO graduates.
9. De-emphasizing highly specialized techniques and stressing a broader focus on the provision of family planning.
10. Developing syllabi for established courses that include behavioral outcomes, topic outlines teaching/learning activities and related readings.

## Egypt Key Contact List

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APPENDIX D  
TUNISIA: COUNTRY REPORT

## Appendix D

### TUNISIA: COUNTRY REPORT

#### Program Objectives

With a population of seven million, Tunisia is the smallest North African country. Tunisia has had a government-supported family planning program since 1965. A guide for tourists quotes President Bourgiba, "Birth control concerns not only the private lives of individuals but the nation as a whole." Tunisia has established a system that attempts to provide all citizens free access to birth control information and services. The Tunisian program has helped reduce the birth rate, but contraceptive services are still not universally available.

Tunisia's population program is conducted through the Office National de la Famille et de la Population (ONFP), with which JHPIEGO cooperates. JHPIEGO has supported the ONFP program by educating physicians through American- and Tunisian-based courses in laparoscopic sterilization, laparoscopic diagnosis, health administration, as well as by providing general physician and nurse training in reproductive health. A Repair and Maintenance Center is also an important part of the current program. To date, some 400 individuals, mostly physicians, have been trained. The JHPIEGO-supported program has become a regional training center for Francophone and North African countries.

The professional relationship between JHPIEGO and institutions in Tunisia is good. The special emphasis on laparoscopic sterilization has given credibility to those involved in the day-to-day delivery of services. Sterilization provides an attractive activity to physicians which the delivery of other outpatient family planning services does not. The development of Tunisia as an international training center for JHPIEGO has enhanced the status of Tunisia's hospitals and medical schools. The relatively low-key role JHPIEGO currently occupies is in accord with Tunisia's priority at AID and Johns Hopkins.

#### Linkage to Government and International Organizations

JHPIEGO's only relationship in Tunisia is with the Government of Tunisia through the ONFP which is a part of the newly created Ministry of the Family and the Promotion of Women. JHPIEGO enjoys cordial relations with physicians who have important places in the national health care system. These relationships are useful sources of support, advice, and information. The strength of JHPIEGO's links with the country's physicians are one concrete result of JHPIEGO's Baltimore-based training. Only minimal relationships exist, however, between JHPIEGO and Tunisia's three medical schools and the country's other training programs. Likewise, except for IPAVS, there appears to be little contact between JHPIEGO and other USAID-supported programs.

### Current Program

At present in Tunisia, JHPIEGO supports a RAM center (NMA 16), the Tunisian National Education Educational Program in Reproductive Health, Endoscopy, and Laparoscopy (NCA 6), and a Clinical Practice Center (NTA 33).

Comments by the administrator and physicians in two laparoscopy centers strongly support the conclusion of the recent RAM evaluator (Chapter V) that breakdown of equipment was not a problem. Use of laparoscopy in various Tunisian centers appears to range from around 1,000 per year to around 50 with available population apparently a more important factor than local initiative.

Both the National Training Program and the Clinical Practice Center are apparently in abeyance. At the Ariana Clinic, the most recent training occurred in the late fall of 1984. The personnel, equipment, and facilities needed for training all appear intact. Training should be able to start very quickly. There are enough patients requesting sterilization to provide clinical teaching. The facilities are in smooth working order, clean, and attractive, and seem to have appropriate staff. The training center where the didactic lectures are given is in a new location which is attractive but somewhat on the outskirts of the most populated area. The location might provide some transportation problems, especially if there were an attempt to establish clinic services at the site for teaching purposes.

The reason for the slowdown in JHPIEGO activity is not clear, but apparently centers around the change in bureaucratic structure at the upper level of ONFP, the reduction in the number of untrained Tunisian physicians (which makes it more difficult to schedule those who still need to be trained), and a reduced number of trainees coming from overseas.

JHPIEGO's objectives and those of its Tunisian grantees remain the same, and if demand and support increase, the number of persons trained at all levels can be increased. In the meantime, the centers continue to operate. It is easier to train at the centers than in hospital surgical units because of competition for time in the operating theaters.

### Program Effectiveness

The RAM Center, the training centers, and the educational program appear to be effective. The ability to perform outpatient sterilization in small units has helped spread the "Family Planning Center" idea over most of Tunisia. Although sterilization is only a small portion of the program, these services allow the ONFP to attract and provide interesting work for physicians in the program. Positions in the ONFP training center are apparently much sought after; they provide both young physicians and better established doctors a small but steady source of additional income.

Administration at JHPIEGO-supported centers seemed effective. Buildings were clean and had appropriate staffing patterns. There was adequate space for both the surgical and clinical programs. The recovery areas also had appropriate equipment and staff. Dirty and clean utility rooms were found. The sterilization facilities appeared reasonably modern.

No problems in the receiving of funds were discovered, but because of the recent low level of activity, this may be a false impression. There were no complaints about JHPIEGO's reporting requirements. There did seem to be a slight undercurrent that the need to send all documents to the senior administrators at institutions in Tunisia slowed things down a great deal. Junior staff hoped some formula could be found to reduce this.

The only curriculum seen was that used to train physicians in the laparoscopy course. It appeared adequate and probably provided an appropriate guide for the different teachers who were used in the training program.

The Family Planning Centers in Tunis are reportedly used for the training of "residents, medical students, nurses, and technical personnel." The exact process by which this takes place was not observed and, thus, is not clear. The amount of variation in the use of the centers by the different medical schools could not be established.

Essentially all of the physicians working in the clinics have private patients. Laparoscopy has moved into the private sector and appears to be well-supplied and reasonably popular. However, there is apparently a limit to the number of procedures being performed because of a shortage of equipment.

#### Future Opportunities

The ONFP seems very pleased with JHPIEGO's training programs and appears to have profited from them. Such programs probably need to continue a bit longer. More importantly, there needs to be a major emphasis on getting such training institutionalized in Tunisia's medical schools.

Medical schools in Tunisia are much more involved in training nurses and "technical personnel" than are schools in America. The ONFP expressed interest in being a conduit for such programs, but JHPIEGO probably should make direct contact with the schools. Although there is some family planning material in the academic institutions, curricula need improvement. Further institutionalization of family planning education could be aided by workshops, seminars, regional conferences, and small research grants to appropriate faculty to enable them to investigate local issues. Providing a small subsidy to increase the use of the local family planning centers for teaching purposes should also be considered. Subjects such as reproductive risk and sexually transmitted diseases should be incorporated into the curriculum.

Another unmet need is for more personnel in the country's more rural areas. ONFP needs help in developing training programs aimed at helping rural communities. Educational programs for the rural nurse and technician need attention. The time appears very advantageous for a short, two- to three-year program aimed at nurses and technicians working in rural areas and designed to help them improve their services.

To the extent possible, AID needs to continue to provide support to contraceptive services with particular emphasis on the IUD for the multiparous woman who are waiting to decide about sterilization, and on NORPLANT or its equivalent.

A method is needed whereby the private physician can more easily obtain the use of a laparoscope for use in his private clinic. JHPIEGO and ONFP should discuss how this might be done. Revolving loans, low interest loans, a subsidy to the RAM center to gradually move into a commercial operations are options to be reviewed. If there were more scopes in the private sector, more tubal ligations would be done. There would also be a general increase in the perception that sterilization was good since there would be more selling of the concept by the private sector.

A final unmet need is a better system by which personnel are recruited for training in the United States. National leaders do not feel sufficiently involved in the selection. This is a delicate issue but one that needs to be carefully reviewed.

Other concerns mentioned by the Tunisians were for more training in the United States in areas such as general reproductive health, STDs, nursing education, etc. They are also anxious for continued support of the RAM center.

Finally, JHPIEGO should establish more direct communication with the International Cooperation Division (ICD). Although it is appropriate to send all communication to the highest office, little, if any, filtered down to the ICD. For example, ICD staff had apparently not seen the RAM center evaluation.

#### Recommendations

- o Continue the Regional Training Program.
- o Increase contact and program development with the medical schools.
- o Develop an extension training and support system for rural nurses and health technicians.
- o Emphasize the newer and longer-acting contraceptives to fill the gap between termination of childbearing and sterilization.

- o Investigate methods of getting laparoscopes into the private sector.
- o Use French-speaking personnel by JHPEIGO and AID as consultants and contact personnel.
- o Encourage training in microsurgical techniques, and help in developing the necessary support system for microsurgery in the private sector.
- o Support ONFP in its desire for further training of personnel in Baltimore in those areas necessary for a mature, on-going family planning program.
- o Develop methods to keep the Division of International Cooperation better informed on programs, reports, and contracts that involve JHPIEGO.

**Appendix E**  
**MEXICO: COUNTRY REPORT**

## Appendix E

### MEXICO: COUNTRY REPORT

#### Program Objectives

With a population of 77.7 million and a annual growth rate over 2 percent, Mexico is one of the world's fastest growing developing countries and a major source of Latin American population growth. The Mexican government has had an official family planning policy since 1976. Most observers credit the Mexican family planning program with significant gains. The annual population growth rate has been reduced from 3.2 percent in 1976 to about 2.3 percent in 1984 because of declines in marital fertility caused by increased contraceptive prevalence.

Currently, the public sector (social security, health ministry, service for government employees, and children's services) provides 60 percent of the country's family planning services. The remaining 40 percent is provided by private physicians, pharmacies, and nonprofit organizations such as the Mexican Family Planning Association (MEXFAM) and FEMAP (Federacion Mexicana de Asociaciones Privadas de Planificacion Familias).

Priorities identified by senior government officials center on motivation of Mexico's young population to delay childbearing and limit family size. Meeting this goal will require training of health and social service professionals, integration of the concept of reproductive risk with the concern about population and development, and increasing population education programs especially those that concentrate on adolescents.

The Mexican Social Security Institute (IMSS) believes laparoscopy has its place in the country's overall family planning program but is encouraging mini-laparotomy and vasectomy as more cost effective, particularly in Mexico's rural areas.

There is evidence that laparoscopic sterilization has become an acceptable procedure at least in urban areas and within major hospitals. According to Dr. Francisco Altano, Mexico's National Association of Endoscopists now has a membership of approximately 300, an indication of the extent of use of laparoscopic procedures. It should be noted that the laparoscopes were provided by the Association for Voluntary Sterilization (AVS), which also is responsible for their maintenance.

Significant progress has also been made toward the integration of family planning education in the country's major medical schools. Dr. Juan Vera reported that 21 medical schools have adopted his JHPIEGO-supported model course as part of their ongoing curricula.

JHPIEGO's overall objectives for Mexico have been (1) to provide training in endoscopy; (2) to provide training in selected center in laparoscopic procedures, especially female sterilization; (3) to provide training in microsurgery; and (4) to promote the institutionalization of family planning in the country's medical schools.

JHPIEGO's projects have complemented both public, private, and nonprofit efforts. The Ministry of Health and Social Security provides education and training but, unlike JHPIEGO's more comprehensive approach, its focus has been on training for specific clinical service delivery. JHPIEGO activities appear to be well coordinated, not only with the public sector but with other international donors such as ACS.

### Ongoing Programs

JHPIEGO currently supports two major and two lesser projects in Mexico. The main projects are a fertility management program for medical students and laparoscopic training for selected obstetricians and gynecologists.

#### (1) AMFEM Fertility Management Education Program, University Autonoma de Tamaulipas Tampico

The goal of this program is to institutionalize fertility management education for medical schools so that physicians will be better able to make family planning services available. Specific objectives are to

- o provide training for 53 medical school instructors;
- o provide fertility management training to 20,000 medical students through 885 courses in 37 Mexican medical schools;
- o work toward institutionalization of the curricula in medical schools;
- o develop instructor manuals and provide educational materials and teaching aids.

#### (2) Reproductive Health and Laparoscopy Training Program, Hospital Civil, Guadalajara

This project was funded to provide training in laparoscopy and reproductive health to teams of physicians, nurses, and anesthetists who are leaders in reproductive health to promote improved practice and institutional support. Specific objectives are to

- o train five teams of physicians, nurses, and anesthetists from institutions that lack trained personnel;
- o provide refresher training in laparoscopic techniques for 10 previously trained physicians;
- o conduct a conference on laparoscopy for public- and private-sector physicians;

- o conduct an update in gynecology and reproductive health for post-doctoral students and institutional leaders in western Mexico.
- o provide consultant support, educational materials, and medical equipment.

#### Effectiveness of JHPIEGO Programs

This report specifically addresses three projects currently being funded:

- 1) NCA 8, "AMFEM Fertility Management Education;"
- 2) NTA 8, "Clinical Practice Center Agreement" at Hospital Civil in Guadalupe; and
- 3) NCA 74, "Reproductive Health and Laparoscopy Training Program."

The team did not visit project NTA 40 in Veracruz.

Overall, the team found the three programs to be effective and well implemented, but specific points need to be made regarding each project since they differed in staff, orientation, and objectives.

1) The Fertility Management Education Program has been used in approximately 28 medical schools. AMFEM does not cover the "private" sector medical schools. The team observed a teaching session and was impressed with the relaxed atmosphere, the students' participation, and the presence of first-year medical students even though the course was directed toward second-year students. The team examined the records from the various medical schools where the course was offered. Attendance was uniformly good. The two video tapes reviewed provided a good introduction to human sexuality and to the problems of population growth. Both videos were professionally done.

The team visited the University of Noreste Medical School and met the dean and staff involved in conducting the course. As encouraged by the project director, Dr. Vela, the teachers are not ob/gyn specialists. Topics covered in the 15 sessions are well balanced and appear to supply medical students with practical information on how to prevent an unplanned pregnancy, as well as technical information that will be of use in later years when they are medical practitioners. The program has not been in widespread use long enough to measure its impact on career choice or children born. Informal reports from people at the University of Tamaulipas, where the program has been used for about six years, suggest the program has no effect on career choice, but Dr. Vela believes the number of children being raised by the medical students had been reduced. The course is also evaluated by the faculty teaching it. Pre- and post-tests are given to all students. Scores are kept as part of the attendance record.

The team did not investigate in detail the financial aspects of the program. At the time of the visit, the financial records were being audited, but the team was not clear to whom the report would go. According to Dr. Vela, JHPIEGO's reporting procedures took time but were not excessively burdensome.

In summary, the program appears well run and effective. The voluntary attendance appears to be an important element in the course's success. The long-range impact is unknown, but the course almost certainly contributes to reducing unwanted pregnancies and instilling interest in reproductive health among physicians in training.

2) Program NTA 8 at Guadalajara under the direction of Dr. Francisco Alfara Boiza is well run. Dr. Alfaro is extremely competent and has a high degree of interest, organizational skill, and teaching ability. The current staff of ob/gyn associates and anesthetists are supportive. Apparently even with the conclusion of an AVS salary grant, the staff has continued to help in the Hospital Civil's laparoscopy program.

The hospital's endoscopy unit operates every day beginning around 7:30 a.m. By 9:30, 9-11 cases can be completed. At present, there are about 7.5 cases per day with some 50 percent being post-partum, 40 percent interval, and 10 percent diagnostic. All are done under local anesthesia with Valium and Demerol I.V., except when Demerol is not available. Some 900 post-partum sterilizations are done annually, following about 5 percent of all deliveries at Hospital Civil.

There are two complete operating units in one large room. Dr. Alfaro's unit has a total of four scopes, two laproscopators, and two other devices. Teaching aids are present and used. The complication figures up to 1982 were excellent and since 1982, there have been no respiratory problems. Performing post-partum Falope ring procedures is apparently a special aspect of the program, but it is not formally taught as part of NTA 8.

It is difficult to measure the program's overall effectiveness because of the wide dispersion of those trained. Dr. Alfara suggests that subsequent use of the skills learned is not very high among Mexican physicians, unless they work in a reasonably large hospital, receive support from other staff, and the scope does not break down. (See subsequent comments about repair and maintenance of scopes.) Physicians associated with IMSS do not get much support, but those with a reasonable private practice apparently make use of the skills acquired through the program.

3) NCA 74 "Reproductive Health and Laparoscopy Training Program," also at Guadalajara, was just getting under way at the time of the team's visit. On the day of our site visit, we did receive informed consent forms signed by the surgeon/trainer. They appear to be in order although we did not have an official translator.

The facilities, equipment, and technical skill of the staff are more than adequate. The 34 or so procedures performed each week, of which half are post-partum, are more than enough for teaching purposes. Dr. Alfaro said he does not teach a particular technique as part of the course. One team, composed of a surgeon, anesthesiologist, and nurse, have completed the course. Dr. Alfaro reports some difficulty in recruiting and wishes to enlarge the recruitment area.

Five physicians have been recruited for refresher training. Dr. Alfaro, however, is having problems recruiting previously trained physicians, since most are reluctant to admit they have lost their surgical skill. Department chairman also resist authorizing time off. Since there is some cost to attending the course, this may also be a factor in slow recruitment.

One objective of the program in addition to sterilization training is to hold a series of 4 or 5 roundtable discussions about various aspects of laparoscopy, equipment maintenance, complications, anesthesia, etc. The team got the impression that a standards manual could come out of the discussions but plans are not yet firm. This would be a valuable outcome if it does happen. Not directly related but of interest were comments about the lack of interest by the National Association of Laparoscopists in such a manual. Board acceptance is thus questionable unless the manual is of obvious quality, readily obtained, and endorsed by appropriate professional organization.

Another objective is a planned meeting that was scheduled for shortly after the site visit. Recruitment was not a problem. In vitro fertilization and an endocrinology update are being emphasized. A copy of the program was not available. Dr. Alfaro appears to have used some leeway in arranging this course. The team was less impressed with the level of interest in family planning among some senior staff.

Family planning availability at the hospital may not be as great as desired. It is the team's impression that there are not many services are being delivered.

Of the JHPIEGO-supported programs in Mexico, the student education project is drawing to a close and has accomplished its objectives. The refresher training program has just gotten under way, but may have problems in reaching its objectives because of participant recruitment difficulties, limited case material--patients are available only in the morning thus leaving about one-half the time for didactic when two-fifths was planned. The redeeming factor is the obvious skill and expertise of the project director.

#### Curricula Development

The team had an opportunity to experience first-hand a segment of the AMFEM training program, and was impressed with the course content and teaching methodologies. Dr. Vela has prepared an instructor's manual and is emphatic that the course be presented as a package which he has dubbed "The Kentucky

Fried Chicken" of family planning education. The course's personalized approach appears to stimulate and hold student interest. Within its 15 hours, there is time for the students to integrate their professional knowledge through counseling and managing patient needs.

Dr. Vela has provided for extensive instructor training and support to help assure consistent quality and institutionalization. He reports that an esprit de corps has grown among the instructors. A major benefit of this program should be its impact on the delivery of family planning sources as graduates move into medical practice in both public and private sectors.

Dr. Vela expressed concern about the difficulty of measuring impact because of the long delay before the medical students enter practice. He pointed to the growth in popularity of the course and the reduction in pregnancies among students as a measure of the course's immediate effectiveness. Pre- and post-test scores indicate significant knowledge gains and Dr. Vela expressed interest in an instrument that could measure shifts in attitudes.

While the reviewers were unable to observe a course in session at the Hospital Civil at Guadalajara, the curriculum was discussed with Dr. Alfaro. He reported that the course does not include a review of basic demography or the reproductive risk concept as listed in the project course content. Teaching methodologies include slides and video cassettes which he has prepared. The trainees meet for 60 to 90 minutes each morning to cover the didactic content, then proceed with clinical practice. The first group completed the course in May. The high volume of procedures appears to be more than adequate to provide clinical experience for the trainees. Although a family planning clinic is described as being established, in fact the clinic does not exist. It will be available in two years when the hospital moves to a new facility.

No printed curriculum was available for the two-day didactic portion of the refresher program other than the content listed in the project. The conference schedules for November 1985 was described as planned in a workshop format consisting of small work groups whose task will be to develop sets of voluntary standards. Dr. Alfaro described the update conference topics as focusing on endocrinology, including in vitro fertilization.

Dr. Alfaro accepts physicians from both the public and private sector. He pointed out that some physicians employed in the ISS hospitals have encountered difficulty gaining permission to attend the refresher course.

#### Unmet Need and Future Opportunities

As Mexico becomes more and more successful in reaching women and families who have all the children they desire, it must turn to meeting the more difficult challenge of its younger generation. Widespread availability of contraceptives must be supplemented by educational and motivational efforts on the part of the professionals and community-based workers. The team was told

repeatedly that the publicly funded programs will concentrate on these efforts and that the private voluntary groups such as JHPIEGO, AVS, IPPF, and FHI can best serve family planning in Mexico by testing and demonstrating innovative approaches.

Over the next five years, JHPIEGO's strategy will shift to support of university-level education in family planning for Mexico's nursing students and to support of the dissemination of the reproductive risk concept among health professionals. A longer-range objective is to provide continuing education in contraceptive technology to physicians and nurses who have received basic JHPIEGO training. The team considers these objectives and strategies to be realistic and consistent with the needs of USAID and Mexican families, and with JHPIEGO's own resources and professional competence. More involvement with nursing education, however, may make it necessary for JHPIEGO to identify additional professional staff and consultants from this field.

#### Recommendations

Consideration should be given to:

- o Providing increased flexibility to project directors for accepting appropriate candidates for training and permitting a streamlining of the budget modification process.
- o Reviewing Dr. Altaro's book on laparoscopic techniques with the possibility of publication.
- o Assisting Dr. Vela in identifying, recruiting, and supporting influential nursing educators or maternal and child health nurses to support integration of the model curriculum into schools of nursing.
- o Expanding Dr. Vela's model curriculum to schools of social service and pharmacy.
- o Encouraging more general family planning content in the laparoscopic training project, e.g., risk factors for family planning, new approaches to reversible contraception, etc.
- o Assistance in assessing the impact of Dr. Vela's education model both on student attitudes toward and knowledge of family planning.
- o Coordinating with AVS and other donor agencies as well as the Ministry of Health to assure laparoscopic equipment is kept in working order.
- o Update utilization reports for laparoscopic equipment now in Mexico donated by AVS/JHPIEGO.
- o Increased financial support for conference attendees who are encountering problems because of Mexico's economic problems.

**APPENDIX F**  
**PERU: COUNTRY REPORT**

## Appendix F

### PERU: COUNTRY REPORT

#### Summary

Peru exemplifies perhaps better than any country the role that JHPIEGO can play in convincing both medical and political leadership that reproductive health and population issues can be integrated into politically acceptable family planning services. Peru's slow acceptance of family planning programs is typical of a number of Latin American countries, and JHPIEGO's emphasis on reproductive health rather than family planning has been consistent with the Peruvian approach. The evolution of the JHPIEGO program reflect this emphasis. Until 1983, the technology disseminated through JHPIEGO training was intended primarily to address reproductive health problems, not female sterilization. Training trips by key physicians and health leaders to other progressive Latin American programs and to JHPIEGO's Baltimore headquarters offered strong evidence that reproductive risk could be redefined to permit voluntary surgical contraception to younger women at risk, and that family planning should be considered a part of any effort to improve reproductive health. The importance of political support and the part JHPIEGO can play in eliciting that support is also exemplified by the Peru experience. Both the Minister of Health and the National Council on Population (whose president is the long-time JHPIEGO in-country coordinator) are in favor of increasing the number of physicians who should receive JHPIEGO training. Over the long run, this support should also go a long way in permitting trained physicians the opportunity to provide IUD and surgical contraceptive services to women at risk.

#### Country Background

Peru's population is almost 20 million, with an annual growth rate of 2.6, exceeded in Latin America only by Bolivia and Ecuador. Contraceptive prevalence is estimated at 40 percent; however, almost half of this number includes the use of traditional natural family planning methods. Surgical contraception, relatively rare except for those women at greatest health risk, has recently jumped to about 4 percent of acceptors and will undoubtedly increase. Vasectomy, however, is relatively unknown. Provision of these services is progressing through Ministry of Health (MOH) hospitals and clinics (70 percent) and much more slowly, through the social security health network (13 percent). Mission and private hospitals also provide a small portion of services. However, almost all physicians maintain a part-time practice, and this represents an important, though presently untapped, resource.

### Program Achievement

Until 1983, JHPIEGO's activities in Peru were primarily associated with selective training to key physicians in reproductive health, which often included endoscopy training and the provision of laparoscopes. It was clear from the outset that the endoscopes would be utilized primarily for infertility diagnosis and to a much lesser degree for female sterilization. Nonetheless, such training did permit the dissemination of technology to teaching hospitals and enabled medical opinion leaders the opportunity of viewing endoscopy as one component of reproductive health. The training also provided the important opportunity for visits to other progressive Latin American programs (Mexico, Colombia, Brazil). These site visits permitted trainees to see first-hand how health and population issues could be integrated into politically acceptable government and private sector models in the provision of family planning services.

Perhaps the single most important initiative of JHPIEGO was the hosting of a Peruvian training session in Baltimore for health care leaders. This activity, more than any other, helped pave the way, not only for future JHPIEGO training activities, but more important, for the development of a national effort. Specifically, after this Hopkins-based course, participants agreed to a Peruvian national education campaign in reproductive health, conceived by USAID and utilizing mass media.

Despite the absence of in-country personnel and the lack of follow-up visits, the Baltimore training set the wheels in motion for the establishment of training models to be employed within all major hospitals. Moreover, an ambitious JHPIEGO-funded program for the MOH, including the Social Security Administration, has already been established. The plans call for the training of almost 650 physicians, half of whom are Ob/Gyns who will receive training in surgical contraception; the curriculum for physicians includes all aspects of family planning with an emphasis on IUD insertion. The overall program has already begun with a curriculum development workshop, which also served as a vehicle for the training of trainers. This is to be followed by training for the chiefs of service from 72 major medical institutions. <sup>1/</sup> Training for 160 Ob/Gyns and 300 General Practitioners is also planned. What is perhaps most encouraging about these training initiatives is the tangible

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<sup>1/</sup> While the program got a somewhat late start, this was not due to JHPIEGO, and, no perceived problems on the grant administration level appear to exist except for a possible need to adjust in-country travel per diems as the rate of inflation in Peru.

support provided by the office of the Minister of Health and through Peru's National Council on Population. Unfortunately, the Social Security Administration has lagged far behind in implementation of programs that would provide priority patient care in reproductive health.

During this year, the concept of reproductive risk has been fully accepted and surgical contraception recognized as an important component. Furthermore, the most recent training cycle redefined reproductive risk in terms so that younger women, those with multiple abortions as well as those with consistently short pregnancy intervals, could be considered for elective sterilization services. At the same time, the National Council on Population has been pressuring the government to enact official reproductive health legislation.

It becomes increasingly clear to trainers that para-professional training which includes outreach work and direct patient counseling is an important component of all successful service delivery programs. The idea of including nurses, para professionals and community leaders is being accepted. A demonstration region for an expanded training model has been established in ICA and is expected to be expanded to other regions. Eventually, JHPIEGO will probably be asked to expand the proposed national training to incorporate these health workers; if so, JHPIEGO should respond favorably. JHPIEGO should study the success of this Peruvian model from its inception of ministerial-level Baltimore training through each of its well planned components to determine its applicability to other countries - particularly in Africa.

#### Coordination

USAID, by virtue of its strong and creative health and population staff, has played an important role in priority setting, thus enabling all donor agencies to fund complementary activities with a minimum of duplication.

#### Maintenance

After a series of meetings with the MOH, USAID, the new representative of The Pathfinder Fund, and university chairmen, it became clear that a full-time equipment supervisor for repair, maintenance was needed. One such person had already received training but necessary clearances were not received to offer him a position. The evaluation team urged ministry personnel to ask JHPIEGO for initial support in return for a commitment of office space and continued funding at the end of a two-year period.

#### Private Sector

USAID/Peru plans to move rapidly into programming geared

toward the private sector. The opportunities in Peru are particularly evident and JHPIEGO's established credibility in training should be incorporated in the training of private physicians. Hospitals such as Loyaza (where the sole micro-surgery unit exists) are particularly well suited for endoscopy and minilap training.

#### Monitoring and Technical Assistance

Monitoring and technical assistance visits by JHPIEGO staff and consultants have been relatively few in the recent past, but the present programming document calls for three consultant visits and four JHPIEGO staff visits. These technical assistance initiatives are particularly important given JHPIEGO's expanded role in Peru.

#### Evaluation

The evaluation component of the present JHPIEGO program in Peru is significant in that it seeks to evaluate all segments of the program well beyond the standard questionnaire format. The present program should enable the newly appointed JHPIEGO evaluation coordinator an opportunity to use new evaluation models which could have applicability in determining program impact in other JHPIEGO-funded countries.

#### Recommendations

1. Continue to view Peru as one of JHPIEGO's highest priority countries.
2. Make certain that technical visits by JHPIEGO staff and its consultants, as authorized by the present grant document, take place on schedule.
3. Add para-professional training to all training models.
4. Develop a special module for training of key Social Security personnel.
5. Train and support an MOH staff person to handle repair and maintenance of service equipment. This individual might also service equipment which may ultimately be provided as part of private sector initiatives.
6. Work with private sector contractee (to be determined) in the provision of training.
7. Involve the JHPIEGO director of evaluation in assessing each module of the present program in Peru. This program incorporates training, service demonstration, and curriculum development and has led to policy change. Therefore, the evaluation model could serve as an important beginning in JHPIEGO's measuring of program impact.

Persons Contacted

Dr. Carlos Muñoz - President, National Council on Population  
Dr. Carlos Bazan - Minister of Health  
Dr. Trelles - Vice-Minister of Health  
Dr. Franco Ponce - past Minister of Health  
Dr. Cardo - Minister of Education  
Dr. Daniel Alzamora - Director General, Department of Health Services  
Dr. Nazario Carrasco - Coordinator, Family Planning and Reproductive Health, Social Security Administration  
Dr. Luis Sobrevilla - Vice Chairman, National Council on Population  
Dr. Diaz - Professor, Ob-Gyn, Loyaza Hospital  
Dr. Daniel Gutierrez - Coordinator, National Program of Training in Reproductive Health  
Mr. John Sanbrailo - Director, USAID  
Mr. George Hill - Deputy Director, USAID  
Ms. Norma Parker - Chief, Health, Education and Population, USAID  
Mr. Art Danert - Chief of Population Section, USAID  
Ms. Brenda Doe - Ass't Population Officer, USAID

The team's having been provided with a series of top level interviews, particularly during a period of government transition, is a reflection of the prestige and continued commitment of Dr. Carlos Muñoz to the national effort. It also indicates a new willingness on the part of the ministerial personnel to discuss issues associated with reproductive health now that it has become an acceptable program on a national level.

APPENDIX G  
KENYA: COUNTRY REPORT

## Appendix G

### KENYA: COUNTRY REPORT

#### 1. Introductory Remarks

Despite the need for and acceptance of JHPIEGO activities in Kenya, reliance on the one existing medical school as a training locale may limit the extent to which JHPIEGO's efforts can expand and the impact which it can achieve within Kenyan national efforts. USAID has recognized this issue, and suggested a limitation of its scope to the public sector.

#### 2. Team Visit

The evaluation team's visit concentrated on university training model by meeting with personnel and by reviewing Ministry of Health program strategies. It also met with Gary Merritt, Head of the Office of Health and Population for USAID/Kenya and reviewed USAID's recently completed seven-year Kenya project paper on family planning. It also reviewed a recent comprehensive report by Joseph Dwyer, representative for Africa of the International Project of the Association for Voluntary Sterilization (IPAVS). Both reports dealt with training objectives of donor agencies. Dr. Mati, the chairman of the Department of Ob-Gyn at Nairobi University was in the U.S. on sabbatical leave but discussions were held with Dr. Andrei Makoha, director of the JHPIEGO-funded training effort there.

#### 3. Country Background

Kenya is reported to have the highest growth rate of any nation: 3.8 (reportedly down from 4.0), with the present population of almost 20 million expected to double by the turn of the century. This projection, coupled with a high rate of inflation and a 30-percent unemployment rate, has kindled new interest in family planning at all government levels. USAID and other donor agencies such as FPIA, AVS, JHPIEGO, Pathfinder, UNFPA, IPPF, and The World Bank have recently coordinated efforts toward providing training, equipment and services in an effort to expand the overall program and to recruit additional acceptors. Where possible, the broad umbrella of reproductive health in countries such as Kenya with high rates of infertility and inter-tribal rivalries needs to be retained. JHPIEGO has wisely functioned within that philosophy.

Nonetheless, surgical contraceptive services (primarily for women) have recently been given a high priority by top government leaders. Provision of surgical contraception is urgently required to meet demand, with training at all personnel levels for the provision of this service a prerequisite.

#### 4. JHPIEGO Achievements to Date

JHPIEGO has already performed an important role in this effort. To date it has utilized Kenyatta National Hospital to train 30 gynecologists in endoscopy and almost three times that number of medical officers in reproductive health, including minilaparotomy. JHPIEGO has also taken an important initiative in nurse training; 90 nurses have received updated training in reproductive health and 32 physician and nurse teams received training through equipment maintenance workshops.

#### 5. Future Role for JHPIEGO

It is difficult to determine the actual extent of surgical contraceptive services available in Kenya, as post-partum tubal ligation performed in association with cesarean section is not uncommon. It is estimated however that at least 30,000 endoscopy and minilap female sterilizations were performed through 1984-- a figure significant in that prior estimates were only in the hundreds. However impressive, the total is still quite low in light of consumer demand, which has been estimated at between 17 percent and 40 percent of fertile-aged women. Even if one accepts the lesser figure, (most of whom have four or more living children), the need for a half-million procedures would exist. A realistic goal, therefore, would be 250,000-300,000 procedures being performed within the ensuing seven years by utilizing all methods of surgical contraception, the figure adopted by USAID/Kenya in its project paper.

USAID/Kenya has tentatively earmarked JHPIEGO as assuming responsibility for 40 percent of Kenyan physician training needs over the next seven years. Under discussion is the training of 8,000 nursing personnel. Since USAID has reserved no bilateral funds for these purposes, it will request a JHPIEGO commitment of approximately \$660,000 towards this effort.

Clearly, this is not an unreasonable role for JHPIEGO if careful attention is paid to selection of candidates and to a closer definition of the role of endoscopy within the overall program. This latter point may be particularly important as many of the 30 ob-gyns originally trained are no longer at the provincial or district hospitals where the equipment is present. It appears that most laparoscopes are underutilized even when one includes their use in infertility patients. Given the high rate of pelvic inflammatory disease and consequent infertility in many parts of Africa including Kenya, it is appropriate for endoscopy training to remain an important mainstay of the program, particularly at referral hospitals. Whether the retraining of gynecologists located at the outlying 41 district hospitals is realistic should be left to further critical

analysis--despite University of Nairobi personnel promoting such efforts.

JHPIEGO must make certain that IPAAS's emphasis on minilap and JHPIEGO's province of endoscopy remain separate and that overlap in training specialties does not occur. The possibility of overlap may be increasing, since JHPIEGO is providing training in minilaparotomy to district health officers. Should JHPIEGO be given the primary responsibility for nurse training, careful attention must be paid to curriculum design and the projected role of nurses in Kenya's overall provision of services.

## 5. Constraints

### 5.1 Availability of Operating Rooms

It was only this past year that the term voluntary sterilization was used by ministry personnel during a most important national conference on reproductive health. Even vasectomy, while not having many advocates, is receiving attention in the media and should be included as a component of future training programs. It is clear that the MOH, with support from USAID's bilateral program as well as from centrally funded activities through JHPIEGO, AVS, FPIA, Pathfinder and The Family Planning Association of Kenya, is gearing up for a major national effort requiring training, equipment and financial support. Recent analyses have concluded that one of the greatest obstacles to providing surgical contraceptive services stems from the lack of availability of suitable operating rooms which can be employed for outpatient use. Most are fully utilized in providing curative services for hospitalized patients. Some capital investment will therefore be required to ensure adequate additional space for operations within the clinics and private health centers. The World Bank is prepared to designate funds specifically for this purpose. Whether ob-gyns and medical officers will consider offering such procedures as a priority can only be based on the strength of MOH directives. However, there is every reason to believe that the position of the Ministry will not change and that voluntary surgical contraception will evolve to become an important component of the overall reproductive health effort.

### 5.2 Reliance on Sole Medical School

Both USAID and University of Nairobi personnel view JHPIEGO training efforts favorably. The quality of training has apparently been excellent, and the material well received by the participants. JHPIEGO has handled smoothly the key administrative functions of obligation of funds and provision of equipment, although additional technical field support might be helpful. Overall, the cost/benefit ratio of the JHPIEGO training

has been positive.

One problem, however, is that JHPIEGO must work within the administrative confines of the sole medical school. While interest in training by the medical staff is high, there seem to be many other time-consuming priorities; even the training director (who maintains a sizeable private practice) appears overextended. Even though JHPIEGO built a follow-up component into the endoscopy training. The transfer of medical personnel, non-availability of operating room time and lack of administrative support have all combined to produce rather mixed results and rather sparse reporting. The importance of field follow-up after the completion of training is key to the transition from training to service delivery. Improvement of follow-up will require even closer cooperation with University of Nairobi staff to ensure adequate budgetary and program support post-training.

6. Limitation of JHPIEGO Role to Public Sector and Implications for Cooperation with Other Organizations

USAID/Kenya has recognized these present constraints, and while noting the importance of continued JHPIEGO training, has nonetheless suggested a limitation in scope of its future activities in the public sector. Meanwhile, IPAVS, FPIA, and Family Planning Association of Kenya (FPAK) have been slated to play an increasingly greater role in extension of surgical contraception through non-governmental facilities, mission hospitals and through the private sector. This division of responsibility leaves JHPIEGO responsible for training of those professionals who will respond most directly to MOH goals. Now that the present Kenyan government has redefined eligibility criteria (not always followed) for voluntary sterilization to only three births and age thirty or above, consumer demand will undoubtedly build and the need for public sector expertise in this area will grow accordingly.

While a regional office model is probably not suited to JHPIEGO, an IPAVS regional office probably with on-site availability of administrative and technical skills, is scheduled to open soon in Nairobi. This may represent an opportunity for increased cooperation between IPAVS and JHPIEGO. For instance, a jointly agreed upon set of training standards for Kenyan health professionals could be developed which would benefit both parties.

Another area for cooperation might be development and support of an equipment and maintenance center with the aim that the direct responsibility of staffing would be transferred to the MOH within a reasonable amount of time.

## 7. Regional Training

The addition of regional trainees to the next JHPIEGO training cycle is an encouraging development. Kenya represents an ideal host country for English-speaking African health professionals, particularly in light of the government's positive stance towards fertility regulation. University staff have had considerable training experience and appear to be looking forward to increased regional responsibilities. Unfortunately the approved program document does not contain a field follow-up component for regional trainees. Such an activity would provide additional inducement for senior training staff while allowing for important "African to African" post-training technical assistance.

## 8. Inclusion in Medical School Curricula

As the demand for family planning services increases, all graduating medical students will need to be capable of inserting IUDs and performing basic minilaparotomy and vasectomy procedures. These clinical skills are not currently contained within the medical school curriculum. There is reason to believe that meetings by senior JHPIEGO staff with the Minister of Family Health and the Minister of Education would bear fruit. A good first step might entail providing key ministry personnel an opportunity for additional Hopkins-based training in academic and administrative skills. Built-in field follow-up would then further ensure the likelihood of such programs becoming fully implemented.

## Recommendations

1. JHPIEGO's continued presence in University-based training for Kenyan health professionals, as elaborated in the USAID/Kenya position paper, seems appropriate.
2. Ongoing coordination with all agencies involved in physician and nurse training (e.g., IPAVS, INTRAH) should be strengthened.
3. Consideration should be given to utilizing the administrative and technical expertise at the (soon to be approved) IPAVS regional office in Nairobi.
4. One component of the above recommendation might be the establishment of a jointly sponsored equipment maintenance center with projected support from the MOH.
5. Additional administrative help on a full-time (not course-to-course) basis would aid greatly in project evaluation and provide for the timely submission of reports. It would also

provide the training staff additional time to work in curricula modification and field follow-up.

6. A consultant should be hired with experience in curriculum design and program evaluation, if JHPIEGO is given primary responsibility for nurses training under the new USAID project.
7. Field follow-up, ideally by African training staff members, should be built into regional training modules.
8. All training in reproductive health should include a vasectomy, minilaparotomy, and IUD insertion component. Inclusion in medical school curricula should be discussed by JHPIEGO with government officials.
9. As the provision of surgical contraception grows within Kenya, the importance of one or two university physicians receiving microsurgery training will become evident.
10. Priority should be given to the area of curricula development with the possibility of initially inviting ministry-level professionals to JHPIEGO/Baltimore to attend a modified administrator/academics course. During this time program development, particularly in terms of addressing curricula needs, could be initiated with appropriate field follow-up to ensure implementation.

APPENDIX H

LAPAROSCOPY PROGRAMS: NIGERIA, MEXICO, AND TUNISIA

## Appendix H

### LAPAROSCOPY PROGRAMS: NIGERIA, MEXICO AND TUNISIA

#### Nigeria

Conversations with physicians in Ibadan and Benin support conclusions that down time as a result of nonfunctioning equipment was within reasonable limits.

At the Ibadan University Hospital the laparoscopes were working. Three diagnostic procedures were performed in the morning of the team's visit. The operating area was spacious, but very hot because the air conditioner was broken. The prep area, recovery room, charts, and general flow seemed within the normal range. Discussions with staff suggested that the workload was not as high as it could be, recruitment apparently being the problem.

The team also visited the University of Benin Hospital. A new suite on the first floor is currently being built. It will be near the current outpatient units and the main offices of the department. No trouble with the instruments was reported. The major problem was obtaining space in the regular operating theaters. Space and facilities are apparently limited, so the number of cases being done is low. Economic problems were given as the reason for many of the services problems.

Two large theaters in the labor and delivery area were reserved exclusively for operative obstetrics even though the use rate was very low. At least one room in the area should be available for laparoscopy until the outpatient unit is finished. In addition to space, there was also a staff available in case of need, clean and dirty utility rooms, a recovery area, and direct access to the outside corridors.

#### Mexico

The following conclusions are based primarily on discussions with Dr. Alfaro, Dr. Fuentes of the Ministry of Health, and Ms. Cantu of AID:

- o There are approximately 250 laparoscopes in Mexico.
- o Approximately one-half are in working order.
- o Approximately 15% are in active use.
- o Ms. Cantu was not exactly sure who was responsible for the care and maintenance of the instruments and equipment. Dr. Alfaro implied that he made his own arrangements.

- o Dr. Fuentes described a Ministry of Health plan for centralized maintenance of laparoscopes. Some initiative comes from the need to save dollars.
- o Better maintenance will be needed, but there is little evidence that this factor plays a major role in the relatively low use of the scope for sterilization. Minilaparotomy is very popular with the IMSS and with the private sector, and this is a more important element in the pattern of use.
- o Dr. Alfaro's unit was impressive. He is one of the few advocates of postpartum sterilization using the scope and has a ready supply of postpartum patients. Postpartum sterilization constitutes about 40% of his total activity. Dr. Alfaro was careful to point out that he did not formally teach the candidates this technique, but that they did see it performed. The anesthesia team, teaching equipment, general spaciousness of the division, availability of patients, and presence of students and residents all made for an excellent teaching unit.

### Tunisia

NCA 6 - "Tunisian National Education Program in Reproductive Health, Endoscopy, and Laparoscopy," has been receiving support from JHPIEGO for about seven years. The program's status is being reviewed. According to information supplied, about 200 physicians have been trained in laparoscopy and/or anesthesia.

At the Ariana Family Planning Clinic, the facilities are attractive, clean, and appear to run smoothly. Two laparoscopic tubal ligations using the falope ring went smoothly; anesthesia was a combination of nitrous oxide, pentathol, and valium. There is a shortage of any real anesthesia record but some data are recorded. Following a brief betadine prep of the umbilicus and vaginal canal, the nurse inserted the tenaculum and dilator into the uterus. One liter of gas was insufflated while the rings were put on the scope. Insertion went smoothly and in time the rings were in place, the instruments out, the gas released, and the incision closed. A single, vertical mattress stitch was used. The surgeon directed the nurse to move the uterus while he had both hands on the scope. No attempt was made to inspect the upper abdomen in either case, and when asked, the surgeon said it was not routine but sounded interesting.

Between cases, the scope was wiped with a cleaning solution and placed back into the sterilizing solution along with the scaple, forceps, Touhy needle, and the needle and ethicon that was left over from the first case. After the last case, the nurse broke down the scope completely according to the standard method.

The Hammar Lif Family Planning Clinic's facilities are new and very impressive. Space is generous, the area is clean, the recovery room has wall oxygen, and the clean and dirty utility room are adequate. A mixture of Fentanyl, nitrous oxide, and Valium are used. I could not get any clear impression as to how much local along with Demerol and Valium is being used. In both clinics, a standard medical history form is used which is such as to allow a carbon copy to be sent to a data collection unit. The consent form is in both French and Arabic and seems to meet the requirements.

The training center where the didactic lectures occurred is housed in a very attractive building which had been a private home. The facilities are spacious and have the potential for providing some student quarters. The only possible problem is that it is situated in a rather high-class residential area. If any kind of clinical teaching were to be done, it would be difficult to attract patients.

At the RAM center, the technician in charge reported no problems with the repair and maintenance program, and said that there was no evidence of reduced use because of broken equipment.

#### Conclusion

This review of three countries indicates that the use of the scope varies greatly. It is at or near maximum in Tunisia; it has a few local proponents but no real acceptance in Mexico; in Nigeria, the low level of infrastructure limits its use. There was no visible abuse. There was interest, if not active use, on the part of the private sector, in all three countries.

APPENDIX I  
SCOPE OF WORK

Scope of Work for Evaluation of  
The JHPIEGO Corporation - AID/pha-CA-0083  
(Project 932-0604)

I. Background

JHPIEGO, a Corporation affiliated with the Johns Hopkins University, was formed in June 1974 with a grant from A.I.D. Since then, JHPIEGO has received approximately \$63 million in A.I.D. funds, first under its original grant and then under an A.I.D. Cooperative Agreement. These funds represent over 95% of JHPIEGO's budget.

The purpose of JHPIEGO is to train LDC medical professionals in reproductive health and to help these professionals put up-to-date reproductive health concepts and techniques into everyday practice, thus increasing the availability of these needed services in developing countries. Specific objectives include training 5,000 LDC professionals in programs in 25-30 LDCs, training faculty from 75% of eligible LDC Medical Schools, training 6,000-12,000 LDC medical and paramedical students and helping to staff and equip 10-15 LDC service sites each month.

This A.I.D. project was reauthorized in June 1983 for the years 1984-1986. Authorization beyond 1986, therefore, will soon be needed. The last A.I.D. audit of JHPIEGO was completed in 1979; the most recent comprehensive evaluation took place in the fall of 1980; an APHA review of JHPIEGO's management operations in Baltimore was conducted in May 1983.

General Plan for the JHPIEGO Evaluation

A four-member evaluation team will spend approximately four weeks in April/May 1985 evaluating JHPIEGO's overall operation by visiting AID/W, JHPIEGO's headquarters in Baltimore and five or six countries in which JHPIEGO has major national or regional training programs.

Following the visits to countries of Latin America, the Near East and Africa, the team will reassemble in Baltimore and/or Washington to prepare its evaluation report. Asia will not be visited because it was well reported on in the last evaluation and JHPIEGO's efforts in Asia are phasing down. The team will provide a debriefing for AID/W upon completion of its written report, late in May or early in June.

Purpose and Scope of the Evaluation

The evaluation will examine the overall effectiveness of JHPIEGO operations, including the process by which subagreements are developed, approved and monitored; the degree to which JHPIEGO in-country training is becoming institutionalized; the appropriateness of the training being provided and an assessment of what new activities/directions, if any, JHPIEGO should plan to pursue.

Items to be covered in the Evaluation:

A. Organizational Structure and Staff

Does the table of organization appear adequate for carrying out JHPIEGO's responsibilities? Do the lines of authority appear to be clear? Is there a logical and efficient delegation of authority during the 65% of time that the Director devotes to other duties? Do essential positions such as regional development officers (RDOs) and deputy RDOs appear to be appropriately filled?

Are the duties and responsibilities of each position adequately defined? Does the table of organization appear to promote a smooth and expeditious flow of work?

B. Subagreement Development and Monitoring

Are the steps and procedures efficient by which JHPIEGO plans, develops, refines, approves, implements, monitors and evaluates its in-country subagreements? Are procedures too cumbersome? Are delays a significant problem?

Are subagreements planned and implemented so as to direct resources efficiently at priority countries and training needs?

Should JHPIEGO consider employing country representatives (LDC nationals) - on a part time or full time basis - to help develop and monitor programs in countries such as Brazil and Nigeria where JHPIEGO supports such extensive training activities?

C. Reaching LDC Medical Schools

Does JHPIEGO systematically endeavor to find and train LDC medical faculty members whose schools have not yet been reached by JHPIEGO-supported training? How is this evaluated.

D. Institutionalization

Are JHPIEGO in-country training programs planned so as to lead to institutionalization of the type of reproductive health training they provide? How successful is this effort proving to be?

E. Coordination

In its in-country training programs does JHPIEGO promote service delivery by coordinating with other organizations which can help provide trainees with medical supplies, work space and funds, where these are needed to support services? Is coordination with other AID-funded F.P. training programs taking place? How is this done?

#### F. Training Materials and Medical Equipment

Are JHPIEGO training programs and/or trainees provided with needed training materials? Is promised medical equipment being provided by JHPIEGO and does it generally arrive on schedule? Is it presently functional? Can it be readily serviced or repaired in-country?

#### G. Training Activities and Procedures

Do training activities observed include active trainee participation? Do trainers appear skilled and knowledgeable? Does clinical training follow accepted medical guidelines. Are lectures enthusiastic. Do classes include a useful mix of individuals?

#### H. Field Support and Evaluation

Does JHPIEGO have an efficient and effective system for following up subagreements, obtaining reports, advancing funds, and monitoring and evaluating programs? If not, what additional actions are necessary?

#### I. Fiscal Management

Is JHPIEGO unduly cautious in obligating AID funds? If so, how can this be remedied? If not, why does JHPIEGO's pipeline of unobligated AID funds sometimes appear excessive?

#### J. General Effectiveness

How effective has JHPIEGO training assistance been in a particular country? Has it led to or is it leading to institutionalization? Has it led to Government policy changes? Has it had a general effect on reproductive health training in the medical schools and/or training hospitals of the country. If not, what steps should be taken by JHPIEGO and AID to help accomplish this?

#### K. Evaluation Procedure and Proposed Schedule

##### A. Procedure

The evaluation will involve interviews with JHPIEGO staff, with AID/W staff members concerned, with USAID Mission Population/Health Officers, with host country project directors, with pertinent host country government officials and with selected past and present participants of training programs. Project documents, records, reports, summaries and evaluations will be examined. Visits, by one or more members of the evaluation team, will be made to five or six of the developing countries listed below, in which JHPIEGO has had major involvement since the last evaluation five years ago.

The percentage and actual expenditures by region and by country (exclusive of costs of medical equipment and educational materials provided) for the years 1980-1984 are also listed.

*5 year expenditures*

<u>Latin American Region</u>		<u>\$3.3 Million</u>	<u>32%</u>
* Brazil	\$1.90M	57%	
Mexico	\$ .53M	16%	
* Columbia	\$ .34M	10%	
Peru	\$ .16M	5%	
Jamaica	\$ .15M	5%	
		<u>93%</u>	
<u>Africa Region</u>		<u>\$ 2.8 Million</u>	<u>27%</u>
Nigeria	\$1.69M	60%	
Kenya	\$ .50M	18%	
Somalia	\$ .17M	6%	
Sierra Leone	\$ .13M	4%	
Zimbabwe	\$ .09M	3%	
		<u>91%</u>	
<u>Near East Region</u>		<u>\$2.5 Million</u>	<u>25%</u>
* Egypt	\$1.10M	44%	
* Tunisia	\$ .92M	37%	
Morocco	\$ .28M	11%	
Turkey	\$ .20M	8%	
		<u>100%</u>	

\* = Countries visited during 1980 Evaluation.

All planned in-country visits are subject to approval of the USAID Mission/U.S. Embassy concerned.

B. Proposed Schedule

The evaluation should begin in April 1985 and take approximately four work weeks. A debriefing should be held in AID/W in late May or early June.

First Week - One day

Meet with the chief of the Information and Training Division, Office of Population, and with the POP/IT Project Manager. Joint Meeting with Director, Deputy Director, Associate Director and Program Officer of the Office of Population, followed by a meeting with an AID Contracts Office Representative. (Copies of Basic AID/W documentation on JHPIEGO will have been provided to Evaluation team members before their arrival in AID/W).

First Week - Three or Four days

Meet jointly or separately with President, Director, Deputy Director, Special Assistant to the President and with the Regional Development Officers and their deputies.

Meet with Director of Support Services, Director of Resource Management, Equipment manager and with project evaluation staff. Review selected subagreement documents and the process by which they are prepared, approved and renewed. Review any other pertinent JHPIEGO documents.

Two Work Weeks (Not necessarily continuous)Visiting overseas programs

The team should visit two countries in each of the three regions listed, if at all possible. It is pointed out that visits to one or more of the countries on the list, during the period of the evaluation may not be feasible. Flexibility will be required.

During each in-country visit team members should meet with USAID Mission/U.S. Embassy officers concerned to discuss JHPIEGO in-country activities including JHPIEGO responsiveness and effectiveness, and JHPIEGO collaboration with host country government officials and with other AID-funded organizations working in-country.

Team members should also meet with host country Project Directors and with selected past and present JHPIEGO participants including those trained in Baltimore and those trained regionally or in-country. During in-country visits, the team members should examine progress being made toward institutionalization of JHPIEGO-initiated training and procedures.

The team members should also observe the status and usefulness of JHPIEGO equipment and educational materials.

Final Three or Four days

The team will spend this time in Baltimore and/or Washington drafting its evaluation report and consulting, if necessary, with JHPIEGO staff members and/or AID/W.

One day Debriefing in AID/W - Late in May or early in June