

PD-ABH-557

86129

**NIGERIA TRIP REPORT**

**September 21 - November 24, 1992**

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**Report prepared for the  
Agency for International Development  
Contract # DPE-5966-Z-00-8083-00**

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## **ACKNOWLEDGMENTS**

Many people contributed to the work achieved during this visit. Special thanks are extended to:

The MotherCare staff- Mrs. 'Lola Payne and Mr. U.S.A Nnanta

Miss Oshinaike from the Federal Ministry of Health

Mr. Gene Chiavaroli, Dr. John Mc William and their staffs at USAID and Family Health Services.

All the staff from Oyo, Osun, and Bauchi states who spent their time working with us and made the commitment to further work on Safe Motherhood work.

## ABBREVIATIONS

ACNM	American College of Nurse-Midwives
AIDS	Acquired Immuno-deficiency Syndrome
CHO	Community Health Officer
FHS	Family Health Services Project
FMOH	Federal Ministry of Health
HIV	Human Immuno-virus
IC	In Charge
IEC	Information, Education, Communication
LGA	Local Government Area
LSS	Life Saving Skills
MCH	Maternal Child Health
NERDC	Natl. Educational Research Development Commission
NMC	Nursing and Midwifery Council
PHC	Primary Health Care
PIH	Pregnancy Induced Hypertension
PPH	Post-partum Hemorrhage
POP	Public Opinion Polls, Inc.
PSM	Problem Solving Method
SMOH	State Ministry of Health
SNS	Senior Nursing Sister
TBA	Traditional Birth Attendant
TOT	Training of Trainers
VVF	Vesico-vaginal Fistula

## **I. EXECUTIVE SUMMARY**

This nine and a half week trip for traveller Margaret Marshall accomplished the following activities:

1. Both training sites for the Life Saving Skills trainings were visited. Inputs needed were discussed with staff and state level Hospital Management Board and Health Department personnel.
2. Four site preparation workshops of two and a half days duration were held at Adeoyo Maternity Hospital, Oyo State. Two of the workshops taught antenatal risk assessment. Two taught use of the partograph as a labor management tool.
3. Four site preparation workshops of two and a half days duration were held at Bauchi Specialist Hospital, Bauchi State. Two of the workshops taught antenatal risk assessment. Two taught use of the partograph as a labor management tool.
4. Ten Life Saving Skills trainers were selected using established criteria in collaboration with local staff.
5. A three and a half week Training of Trainers workshop was conducted at Bauchi Specialist Hospital for both the Oyo State and Bauchi State trainers.
6. Faulty surgical instruments were retrieved from both training sites and returned to the vendor for replacement with higher quality steel instruments.
7. Further equipment needs were determined in collaboration with the trainers, backup physicians, MotherCare coordinator, and hospital staffs.
8. The future training schedule was determined in meetings in collaboration with the two local training teams.

## **II. BACKGROUND**

The MotherCare project is a collaborative effort among the Federal Ministry of Health Nigeria, the several state ministries of health, and the centrally funded USAID project named MotherCare. The project is funded from March of 1992 through August of 1993. The primary aim of the project is to address the high maternal mortality ratio seen in Nigeria by 1) updating and expanding the skills of midwives to address obstetrical emergencies, and 2) to address the information needs of communities so that they may better prevent and treat maternal health needs and eliminate barriers to good care.

Several needs assessments have been conducted over the past year seeking two states whose personnel are committed to improving maternity care. States chosen must also have a maternity service with sufficient volume of antenatal clients and deliveries to permit clinical continuing education for midwives.

Project personnel then updated national policy makers, finished development of the needed curriculum, obtained consensus that the curriculum already developed fits the education needs of midwives in Nigeria, and started to fit the designated training centers with needed equipment and supplies. Additionally, trainers were identified, a training schedule developed, and equipment ordered. Forms were printed and new forms developed to address evaluation, record keeping, as well as trainee handouts. The project was now ready to start an intensive training phase. During the first part of this visit Dr. Barbara Kwast assisted teaching two partograph trainings at Adeoyo Maternity Hospital and two partograph trainings at Bauchi Specialist Hospital. During the later part of this visit Ms. Gail Allison assisted with the Training of Trainers workshop held at Bauchi Specialist Hospital.

### **III. PURPOSE**

The purpose of this visit was to:

1. Assist the Lagos MotherCare Coordinator with preparation of equipment and training materials for the nine scheduled workshops.
2. Conduct four site preparation workshops of two and a half days duration at Adeoyo Maternity Hospital, Oyo State- two which address antenatal risk assessment and two which address the partograph as a labor and delivery management tool.
3. Conduct four site preparation workshops of two and a half days duration at Bauchi Specialist Hospital, Bauchi State- two which address antenatal risk assessment and two which address the partograph as a labor and delivery management tool.
4. Complete the process of selecting LSS trainers in collaboration with local staff using established criteria.
5. Conduct a three and a half week Training of Trainers workshop at Bauchi Specialist Hospital for both the Oyo State and Bauchi State trainers.
6. Establish a training schedule for the rest of project in conjunction with the ten trainers.
7. Review progress made at the two training sites with MotherCare Coordinator and State Ministry of Health and local hospital staff on changes needed prior to the conduct of the January trainings.
8. In conjunction with the Lagos Project Coordinator and LSS trainers, determine what further equipment needs exist for both the two training centers and the ten sub-centers.

### **III. ACTIVITIES**

#### **A. ADEYOYI TRAINING CENTER VISIT**

Since the MotherCare project was already in an advanced planning stage when these two states separated, it was decided that Osun would become a sub-center and contribute 20 participants to the LSS program. It is anticipated that in the next phase of the project that Osun will become a full fledged training center. This group was urged to include private sector midwives in their participant selection and to concentrate their selection of trainees in groups which would provide a critical mass for transfer of skills to their colleagues upon return to the work site.

The staff at Adeoyo have made efforts to improve conditions at the hospital. However, inputs requiring additional funding have not occurred on the units. There are still no emergency drugs available on the units. If family members are not available, patients can not get drugs needed. In one incident during the training period a woman started seizing. No family member was present. For the lack of \$2.00 US worth of drugs, the woman would have lost her life if staff did not rush around begging for the needed funds. Nor is the transit blood bank in place or operation. There is a new 40 unit refrigerator there in readiness. However, the systems for operation of the blood bank and other needed equipment are not in place. Cleanliness and basic asepsis continues to be an issue. The industrial cleaners have not been hired due to lack of funds.

Renovation of the physiotherapy department as a hostel for trainees has made great progress. New bathrooms, flooring, kitchen, and electrical wiring are done. Furniture has been bought and is in storage awaiting occupancy for security reasons. There is locked (burglary proof) storage space in the hostel and on labor and delivery for storage of LSS equipment and supplies. They have also obtained a new delivery bed (couch) and stretcher.

Further consideration needs to be given to staffing patterns. It appears too many midwives are scheduled on the day shift and too few on afternoons and nights. High risk women often do not get more attention than normal women. A system whereby one midwife is responsible for a reasonable number of patients and is also held accountable for the quality of care rendered, would make a significant contribution to individualization of care and improving quality of care.

There is little awareness of the universal precautions for the prevention of AIDS. The quality of aseptic technique is very poor. Neither patients nor providers are protected. Staff go from patient (vaginal exam) to patient (vaginal exam) without washing their

hands between. They also dip gloved hands into one instrument basin to retrieve instruments for three different deliveries going on simultaneously. They do not have perineal sheets, cover gowns, goggles, mackintosh aprons, gauntlet gloves, or separate delivery packs. Staff do deliveries in white uniforms which they then wear around the hospital, to meals, and into the street coming and going from home. They have engaged a tailor to start making scrub dresses for labor and delivery staff. They have plans to buy rubber sandals for use on the unit as well. Staff also clean up blood and amniotic fluid spills and wash instruments bare handed. Such practices can contribute markedly to sepsis among patients and spread of AIDS among staff and patients.

Issues of aseptic technique and AIDS precautions were addressed during the short sight preparation workshops. They were addressed in much greater depth with the Adeoyo trainers during the TOT in Bauchi. It will take some time however, once returning home for the trainers to introduce the new decontamination/disinfection system. The Adeoyo chief trainer will additionally travel to Oshogbo to teach Osun staff the decontamination/disinfection method. They are very anxious to get their Safe Motherhood Program into action and wanted all the staff trained even before sending their trainees for LSS training.

At the end of the TOT in Bauchi, Peg Marshall travelled back to Ibadan to determine how implementation of the two new techniques (antenatal risk assessment and partograph) were progressing. The partograph was not being used. The antenatal risk assessment forms were being used sporadically. However, even though in excess of 800 women had been registered for care since starting use of the risk assessment, only one woman had been identified as high risk or in need of special attention. The trainers have a tremendous workload in helping local staff with these two areas plus disinfection plus consolidating their own new skills.

Mrs. Payne, MotherCare Coordinator travelled back to Ibadan during the TOT training to meet with senior staff from the Health Management Board and SMOH. She laid out very plainly our distress that critical changes in the training site had not been achieved. She shared with them that we will not do a January 1993 training as they are not ready. She also noted that she would return in December to evaluate cleanliness of wards, institution of a revolving emergency drug fund, and institution of a blood banking system. Peg Marshall would also return to Ibadan in mid-January to see if serious progress was being made to utilize the antenatal risk assessment, partograph, and disinfection method. If these six areas have not markedly improved, Adeoyo Maternity Hospital will not be used as a training site; and alternate arrangements for training the Osun participants will be made.

## **B. BAUCHI TRAINING CENTER VISIT**

Since the last visit, Bauchi staff have made significant steps to improve their work site. All beds with the exception of the delivery room have been scrubbed, repainted, and had new springs installed. They also have established a secure area (burglary proofed) for storage of LSS equipment and supplies. They have made scrub dresses for the new trainers (but not all labor staff yet), new rubber sandals, perineal sheets, mackintosh aprons, scrub caps, etc.

Progress had been made on the hostel renovations but they were not completed in time for the TOT. Disagreement between the contractor and the Ministry of Health brought work on the hostel to a stand still. The course coordinator, Mrs. Helen Jammal, spent a significant portion of each day trying to resolve the problem. Meanwhile the Oyo trainers were housed at a local hotel for the duration of the training at the expense of the Ministry of Health.

## **C. SITE PREPARATION WORKSHOPS**

Four site preparation workshops of two and a half days duration were held at Adeoyo Maternity Hospital, Oyo State. Two of the workshops taught antenatal risk assessment. Two taught use of the partograph as a labor management tool. A total of 48 were trained.

Four site preparation workshops of two and a half days duration were held at Bauchi Specialist Hospital, Bauchi State. Two of the workshops taught antenatal risk assessment. Two taught use of the partograph as a labor management tool. A total of 46 were trained.

Dr. Barbara Kwast led the trainings in partograph and Peg Marshall in antenatal risk assessment. Individuals who were already identified as trainers were invited to attend both workshops. A midwifery tutor was included in each of the eight workshops. There is a strong effort to integrate pre-service educators into the whole LSS training process to facilitate incorporation of LSS skills into pre-service curriculum at the first opportunity.

### **Evaluation**

Each participant filled a registration form. See Appendix F for a copy. Midwives were asked to estimate how many deliveries they had conducted thus far in 1992. Estimates ranged from zero to 500. None of the midwifery tutors from either education program has conducted a delivery this year. Others who have not conducted deliveries this year are those who have been in antenatal clinic the entire year.

Twenty-three of the trainees from Bauchi State (total of 46) and fifteen trainees from Oyo State (total of 48) note that they have not attended any continuing education programs since graduating from midwifery training. Of those who have attended workshops, family planning is the most common training received. The second most frequent training was a workshop on use of the Nursing Process. Four trainees from Oyo had attended a three day workshop on AIDS (though three could not articulate the causative agent of AIDS) and one had attended a workshop on STDs. Two trainees from Bauchi have attended a TBA trainers workshop.

Daily evaluation forms were given at the end of the day during the site preparation workshops. It was clear from comments offered that participants found both the partograph and antenatal risk assessment relevant to their practice, somewhat difficult to grasp, and intellectually challenging. They requested more time for both theoretical and clinical practice. Many requested that other topics be offered in continuing education seminars to be offered from time to time. Some suggested the seminar should last longer-up to three to six months!

At the end of the eight two and a half day workshops a final evaluation form was filled. See Appendix G to see the form. Almost all participants rated questions one through seven as "highly agree" or "agree". The one exception was question number 3 "Both the amount of material covered and the time for the workshop were about right." Many marked disagree and noted in written comments what the time for both theory and clinical practice was insufficient. Participants appreciated receiving the whole Life Saving Skills Manual for Midwives even though they did not go through the three week training. A number of compliments were given regarding the high quality of audiovisual aids used during the course of the training. Several appeals were received to give LSS manuals to those colleagues who were not able to attend the workshops and multiple copies requested for the midwifery training programs.

It is clear from the pre-post test scores from the eight site preparation workshops that some learning occurred but much less than in the three and a half work TOT. See Appendix L to review these scores.

#### **D. TRAINING OF TRAINERS WORKSHOP**

A three and a half week workshop was conducted for five trainers from Bauchi State and five trainers from Oyo state. The chief midwives in the antenatal clinics were asked to participate as part time trainers covering antenatal risk assessment at their respective sites. However, they did not attend the complete TOT

which is heavily labor and delivery focused. The two antenatal clinic midwives attended the site preparation workshops in antenatal risk assessment but will need special technical support to assist them in teaching it the first time through.

The ten trainers attended the three and a half week workshop. The first three days were devoted to communications skills and an introduction to the problem solving method and community assessment. This portion was taught by Mrs. Data Phido from the JHU IEC department with the assistance of Mrs. Margaret J. Bodede Mrs. I.V. Mako, and Mrs. Mini Soyoola. This curriculum was developed last July by a group of educators, policymakers and clinicians; and has been undergoing revision/editing from Mrs. Phido. The current draft can be found in Appendix B.

The clinical portion of the LSS training was taught by Gail Allison and Peg Marshall with guest lectures from Dr. Sholo Franklin, Dr. Chima, Mrs. Sugra Mahmood, Mrs. Egun Oyediji, and Mrs. Habiba Ali. Participants worked a minimum of ten eight hour shifts in addition to attending classes and demonstrations. The enthusiasm and participation was excellent with participants often working longer than scheduled based on their own interest.

The content areas are described below under the goal and objectives for the course. Vacuum extraction was taught only theoretically. It was not possible to teach vacuum extraction clinically as the vacuum extractors were sitting in the port awaiting clearance by AID. They were still awaiting clearance at the end of this visit. This skill will be taught by the backup physicians if they clear port prior to my next trip. If not, I will teach the skill in the clinical area during the next trip. All other clinical areas described below were dealt with in detail. For a copy of the training schedule, see Appendix J. At the end of the clinical training, sessions were held on how to organize a training, principles of adult learning, and teaching techniques. Lesson plans were developed and revised.

## **Goal and Objectives for LSS Midwives Training and Training of Trainers**

### **Goal**

1. To assist the midwife to revise her midwifery skills and develop proficiency in Life Saving Skills.
2. To prepare the LSS trainers to conduct training of sub-center midwives in Life Saving Skills.

### **Objectives**

- A. At the end of the Life Saving Skills training, the midwife

will be able to achieve a satisfactory rating as a LSS midwife to:

1. Describe and demonstrate the problem solving method of providing care and timely referral for women during pregnancy.
2. Demonstrate in antenatal clinic; medical history, physical examination, laboratory tests, and completion of the antenatal risk assessment form which will alert her to identify problems with anemia, pregnancy induced hypertension and fetal growth. Skills include monitoring fundal height, visual and laboratory anemia screening and recording information on the antenatal form.
3. Describe and interpret information on the monitoring labor progress form (partograph) including latent and active phases of labor including use in safe management of laboring women.
4. Demonstrate taking of routine medical history and physical examination including abdominal and vaginal examination on a woman in labor in order to identify problems/needs and take needed action.
5. Demonstrate procedures of (a) episiotomy and repair using protective equipment of needle holder, tissue forceps and gloves, (b) giving local anesthesia, (c) cervical and vaginal inspection, (d) repair of lacerations, (e) choosing suture and (f) principles of knot tying.
6. Demonstrate the problem solving method to diagnose causes of bleeding in the antenatal, intrapartum and postpartum periods; and also procedures of (a) active management of third stage, (b) manual removal of a placenta, (c) bimanual compression of the uterus and (d) digital evacuation of products of conception.
7. Identify signs and symptoms of respiratory and cardiac dysfunction in newborns and adults including APGAR scoring and demonstrate procedures of (a) infant resuscitation, (b) care of the baby at birth, (c) adult resuscitation and (d) Heimlich Maneuver.
8. List causes, describe prevention, and demonstrate treatment of sepsis in the antenatal, intrapartum and postpartum periods for the mother and baby.
9. Describe life saving steps to prevent shock and demonstrate using the problem solving method to identify the cause of shock and the necessary action to be taken.

10. Demonstrate procedures of (a) starting an intravenous infusion in a peripheral vein, (b) giving fluids by rectum, (c) choosing intravenous solutions and dosages, and (d) preparing oral rehydration fluids.

11. Describe the indications for, dangers to mother and baby and demonstrate the use of a vacuum extractor in hospital maternities.

B. At the end of the TOT, Life Saving Skills Trainers will be able to:

1. Describe the maternal mortality and morbidity situation in Nigeria and the potential role of the LSS midwife.

2. Identify barriers to care and define values and interpersonal communication.

3. Describe factors important to adult education and demonstrate learning methods appropriate for qualified midwives.

4. Develop lesson plans to accompany the Life-Saving Skills Manual for Midwives.

5. Develop a timetable for LSS Midwives Training.

6. Describe the steps in implementation of an LSS training program.

Although the program is competency based, it was not possible for all trainers to master all skills during this short time frame. However, check list evaluations for each skill were completed at each clinical experience filled in by the trainer and trainee together. Therefore, each trainer is quite clear about her own level of performance in relation to each skill. The two month interim prior to starting the first training is for consolidation of skills. Drs. Franklin and Chima will serve as backup and supervisors at each training center during this consolidation phase. Skills which proved difficult to obtain sufficient clinical experience for all trainers were vacuum extraction (discussed above), treatment of sepsis, digital removal of products of conception, and internal bimanual compression of the uterus.

## **Training Schedule**

At a meeting of the trainers, the training schedule was established. Care was taken to avoid National Midwifery Examinations (March 9-20) which requires significant amounts of time from six of the ten trainers. The dates are:

### **Bauchi State:**

February 1-19  
March 29-April 16  
April 26-May 14  
May 24-June 11

### **Oyo State:**

March 22-April 9  
April 19-May 7  
May 17-June 4  
June 14-July 2

## **Evaluation**

Each trainer filled a registration and final evaluation form. They requested more time for both theoretical and clinical practice. See Appendices F and G to see the forms. Almost all participants rated questions one through seven as "highly agree" or "agree". The one exception was question number 3 "Both the amount of material covered and the time for the workshop were about right." Many marked disagree and noted in written comments what the time for clinical practice was insufficient. They looked forward to two months without trainees in which to work on their own skills. The tutors noted an increased confidence in their clinical skills and appreciated this means of getting back into the clinical area.

Evaluation of trainees went on at each clinical session with direct observation and participation of the trainers and mutual filling out of check list evaluations by the trainee and trainer.

#### **E. MEETINGS WITH OTHERS**

##### **FEDERAL MINISTRY OF HEALTH**

In review of the Life Saving Skills manual, the several physicians reviewing it held diverse opinions on what the malaria protocol should be for both prophylaxis and treatment. Therefore, a meeting was held during the prior trip with Dr. Okokon J. Ekanem, Chief Consultant Malariologist for the Federal Ministry of Health. He shared with us the current national policy for treatment of malaria which will be incorporated into the protocols taught during LSS trainings. Modifications to the LSS manual/protocols can be found in Appendix E.

A meeting was held with FMOH staff during this visit to brief and update them on the progress of the training site visits and curriculum development workshop. Dr. Okungbowa was not available for briefing or debriefing. Mrs. 'Lola Payne will meet with him to apprise him of project progress. He was invited to visit the TOT workshop in Bauchi but was unable to attend.

##### **USAID STAFF**

Meetings were held with Mr. Gene Chiavaroli and Mr. Rudolph Thomas upon arrival, mid-visit, and end of visit. Meetings were held with Dr. John McWilliam mid-visit and end of visit. Briefings were given related to progress of the project. Our ideas were sought regarding how maternal health might be addressed in the follow on project currently being written. Mr. Chiavaroli emphasized his interest in seeing LSS included in pre-service training.

Mr. Chiavaroli also noted that teaching universal AIDS precautions to health workers is not part of the mandate of the new USAID funded AIDSCAP project. The serious need for such education was emphasized. He suggested contacting AIDSCAP upon return to the US and sharing concerns/observations with them.

#### **COMMISSIONER OF HEALTH MEETING BAUCHI**

Mr. Eugene Chiavaroli AAO from USAID Lagos visited the training program and met with the commissioner of Health. Attendees at that meeting were Alhaji Yarima Babayo Misau, Commissioner of Health, Alhaji Mohamed Baba Ahmed, Director General, Mr. Gene Chiavaroli, USAID, Mrs. 'Lola Payne, MotherCare Coordinator, Mr. Caleb Maina, PHC Coordinator, Mrs. Helen Jammal, Bauchi Course Coordinator, Mrs. Salome Sambo, Chief Trainer, Mrs. Mishanu, Training Coordinator Management Board, Mr. Tula CNO, Gail Allison, ACNM Consultant, and Dr. Margaret Marshall, Training Coordinator.

Mr. Chiavaroli urged us all to think in terms of a five to seven year plan for improving maternal and infant care. The Commissioner voiced pleasure that Bauchi State had been chosen as one of the first training centers and expressed his long term interest and commitment to the goals of the project.

#### **RESEARCH ORGANIZATIONS**

A number of interviews and working sessions were held with various research groups interested in conducting the MotherCare utilization study to be conducted in two LGAs in Bauchi State. Four meetings were held to assist staff from the Polytechnic School Bauchi State to assist them in identifying local talent and construct their proposal. Two meetings were held with staff from the Ministry of Health Division of Research, Statistics, and Planning. One meeting was held with faculty from Jos University. Rough proposals were

accepted from each and forwarded to Washington MotherCare project through the local MotherCare office.

## **V. FINDINGS AND RECOMMENDATIONS**

Several recurring themes pervaded this visit. They were: need for accountability in clinical management of patient care, poor aseptic technique, lack of AIDS precautions, poor quality instruments, and ethnic unrest.

### **1. Need for Accountability in Clinical Management of Patient Care**

The problem at Adeoyo Maternity Hospital regarding distribution of midwives over the various shifts and need for assignment of patients in labor to specific individual midwives was addressed briefly with the matron of labor and delivery during the last trip and at greater length (particularly with the trainers) this trip. The concept of accountability needs to be addressed at the staff and management levels. This is true for both antenatal and intrapartum clinical areas. See the sections on visits to Adeoyo and Bauchi for greater detail.

### **2. Poor Aseptic Technique**

Very poor aseptic technique was observed in practice for both obstetricians and midwives. The site assessment workshops were revised to include emphasis on this topic. Both demonstrations and discussions were included. Written materials were given to every workshop participant regarding decontamination and disinfection. This will be included in the basic training as well as the sub-centers also need this information.

### **3. Lack of AIDS Precautions for Health Workers**

Teaching of AIDS precautions was integrated into the site preparation and basic LSS trainings. Both states were petitioned for basic inputs for the training centers which will permit good

technique (e.g. perineal sheets, scrub gowns, surgical towels, etc). The inputs not available locally (e.g. goggles) were purchased in Washington and brought in. It was found that these new concepts are slow to be truly understood and internalized. Even after the classes, midwives and cleaners could be found to clean up large blood and amniotic fluid spills bare-handed. Many dozens of utility gloves were added to local supplies in an attempt to encourage protection. In Bauchi, cleaners were each assigned their own pair of utility gloves so they would never be without.

#### 4. Poor quality instruments

Thousands of dollars were spent through local purchase of surgical instruments made of Pakistani steel. When taken to the field they were found to start rusting after as little as two weeks use. They also developed fissures at the joint and a number of them broke in two. Additionally, the needleholders had too weak a grip and did not allow for moving suture through tissue without twisting round and round within the holder. All offending instruments were retrieved from the two training centers and returned to the supplier. He stated he had never seen such problems in his many years of business and would replace all. Pending and future orders with him are on hold awaiting settlement of the quality issue with this first order. He will make every effort to have the replacement instruments for us in time for the February trainings.

#### 5. Ethnic Unrest

Long standing, pre-existing religious and ethnic rivalry proved an impediment to smooth progress within the project. In Bauchi a member of the Hospital Management Board exerted considerable pressure to replace three of the five trainers chosen with persons of her choice. Selection criteria had been accepted by the training states months previously at the national policy meeting.

A large number of staff midwives in Bauchi pulled a "job action" contaminating instruments and refusing to work when trainers came onto the wards to work. Some of the issues involved were a) not being chosen as trainers themselves, b) the ethnic and religious distribution of trainers selected, c) that the trainers were receiving a per diem (rumored to be huge!), and d) that the new techniques introduced required staff to work harder. The Chief Nursing Officer called a meeting of disgruntled staff to air the issues, support the choice of trainers selected for merit (good clinical skills), and admonish staff that mutiny would not be tolerated. Some improvement was noted in the wards after this meeting; though it is clear that it will take a good deal of time for some of these issues to be worked through.

Based on a meeting with Mrs. 'Lola Payne, MotherCare Coordinator at the end of this trip, the following recommendations were developed:

1. If the Adeoyo Maternity Hospital improvements have not been made by mid-January (see Oyo section for details), all trainings will be cancelled and financial commitments be redeployed in favor of Bauchi State.
2. Two continuing education workshops for physicians should be added to the schedule (one in Bauchi State and one in Oyo State) to update physicians, medical officers, and house officers in management of PIH, avoidance of and treatment of obstructed labor, antenatal risk assessment and management of the high risk, among other topics. This program is aimed at overcoming knowledge deficits as well as seeking support and enthusiasm for the LSS program and acceptance of an expanded role for midwives.
3. Offer two more site preparation workshops on use of the partograph as a management tool at Adeoyo Maternity hospital to train the 31 labor and delivery staff which did not have access to

the site preparation workshops previously.

4. Develop some type of workshop or continuing education program to deal with the bad attitudes of staff especially at Adeoyo. It is not clear what exactly would be helpful though it is more than a simple communications techniques issue. Contributors to the problem seem to include long physician strikes, poor salary and benefits, huge patient loads with depersonalization and lack of commitment/responsibility for individual patients, chronic lack of essential drugs and supplies, competition for advancement within the ranks, etc.

5. Conduct hospital based research on the system breaks which prevent efficient adequate care, e.g. lack of oxygen, essential drugs, anesthetic agents, gauze, etc. Such a study might need to be deferred until a followup project. Either way, it is essential that we identify breaks in the system and obtain solutions if continuing education for midwives is to make any impact at all.

## **APPENDICES**

### **A. PERSONS AND INSTITUTIONS CONTACTED**

#### **United States Agency for International Development**

Mr. Eugene Chiavaroli, AID Affairs Officer  
Mr. Rudolph Thomas, Program Officer AID

#### **Family Health Services**

Dr. John Mc William, Project Administrator  
Dr. Akin Akinyemi, Deputy Project Administrator

Mrs. Abimbola Payne, MotherCare Project Coordinator  
Mr. Uzoma S.A. Nnanta, Administrative Secretary

Mr. George Oligbo, Director, Operations Division  
Mr. Mordi Goodluck, Transport Officer  
Mr. Celestine Onwuyali, Expeditor  
Mr. Innocent Chukwu, Expediter

Mrs. Susan Krenn, Director IEC  
Mrs. Data Phido, Program Officer (IEC)  
Mr. Nosa Orabaton, Acting Director, Program Evaluation  
Mr. Michael Egboh, Director, International

#### **Federal Ministry of Health**

Ms. Oshinaike, Principal Nutrition Officer, PHC  
Mrs. Fadele, Staff Nurse-Midwife  
Mrs. Ogunmayim, Staff Nurse-Midwife

## **Nursing and Midwifery Council**

Mrs. Yomi Abudu, Chief Examination Officer

### **Oyo State**

Mrs. A.O. Ladipo, Deputy Director PHC, SMOH

Mrs. Elizabeth Adejuwon, Asst. Chief Health Sister PHC, SMOH

### **Adeoyo Maternity Hospital, Yemetu, Ibadan**

Dr. Iyun, Chief Consultant (Radiologist)

Dr. Shola Franklin, Senior Consultant Obstetrician

Mrs. Ronke Apatira-Jawando, Principal Hospital Secretary

Mrs. S.T. Akinwale, Senior Matron

Mrs. R.O. Fadare, Matron

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