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A REPORT ON  
CLINICAL CONTRACEPTIVE TRAINING  
FOR NURSE-MIDWIVES  
DOWNSTATE MEDICAL CENTER  
STATE UNIVERSITY OF NEW YORK

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**A REPORT ON  
CLINICAL CONTRACEPTIVE TRAINING FOR NURSE-MIDWIVES  
BY THE  
DOWNTOWN MEDICAL CENTER, STATE UNIVERSITY OF NEW YORK**

**Introduction**

In February 1971 Downstate Medical Center, State University of New York, was approved for project Clinical Contraceptive Training for Nurse-Midwives (N M) 931-11-570-918. The program goal for this project was the development of more adequate multi-purpose institutions and trained manpower for support of LDC population programs. The objective was to stimulate LDC governments, institutions, and medical establishments to identify and train existing auxiliary personnel in family planning theory and techniques, and to utilize paramedicals to expand family planning services. The project design included the establishment of agreements with LDC countries interested in expanding family planning services for the identification and selection of nurse-midwives/midwives who would be trained in contraceptive services at Downstate Medical Center. Upon returning to their home countries they would provide contraceptive services and form a core of trainers to implement in-country training of auxiliaries. The program would thus achieve a "multiplier" effect.

Beyond the initial training of selected nurse-midwives, Downstate Medical Center agreed to:

1. Provide technical assistance to establish pilot programs in family planning clinical training in up to ten selected nurse-midwife training institutions located overseas.
2. Supply the resources needed to support and expand nurse-midwifery training in family planning at the Downstate Medical Center in Brooklyn, which functions as the intermediate institution from which technical assistance is supplied to the overseas programs and at which the instructional staffs for these programs are trained.
3. Facilitate the process of training other nurse-midwives who will provide service and training at LDC institutions by means of the expanded training capacity in family planning for those paramedicals trained at the Downstate Medical Center.

The Downstate program projected the training of about 250 foreign nurse-midwives in New York during the five years of the project and the training of about 2500 nurse-midwives/midwives in the overseas programs to be assisted.

Downstate Medical Center, with its associated basic training program for American nurse-midwives, has long established that nurse-midwives can deliver contraceptive care safely and at a performance level satisfactorily comparable to that of the physician. A family planning clinic which conducts upwards of 7,000 clinic visits per year has been fully staffed by nurse-midwives who are the primary contact for the acceptors, using physicians as consultants for problem cases. This clinic serves as the training facility for the LDC participants. The trainees are assigned to instructors at a ratio of two trainees to one trainer. The curriculum until recently consisted of a twelve-week course containing didactic sessions on family planning theory and practice, clinic management, and supervised clinical experience. Since early 1975 the course has been shortened to nine weeks, including one week of field observation at Frontier Nursing Service, Kentucky.

#### Purpose and Scope

This report seeks to assess the output of the Downstate training program to date and to make constructive recommendations for continuing AID activity in the field of paramedical training. In the effort to determine the degree to which the goals of the five-year project have been achieved, a consultant team consisting of Donald H. Minkler, MD, MPH, an Obstetrician-Gynecologist with experience in LDC family planning programs, and Miss Rosemary Mann, a Certified Nurse-Midwife with experience in nurse training, were recruited. The team has based its report on: (1) a visit to AID/W for briefing and review of relevant documents (see Appendix ), (2) two visits to the Downtown Medical Center, Brooklyn, for direct observation of training in progress and interviews with the staff, (3) site visits to two countries (Thailand and Philippines) where training programs using Downstate trainees as trainers have been established, and (4) a review of the reports of additional LDC training programs established by the Project.

Wherever possible, the consultants attempted to base interpretations of goal achievement on quantitative data. In addition, anecdotal material, impressions gleaned from on-site encounters, and clinical experience relevant to project outputs will be cited.

The review included the following itinerary:

8-11-75	Visit to Downstate Medical Center
8-12-75	Briefing and Conferences, AID/W
8-31-75	Begin site visits in Thailand
9- 4-75	Begin site visits in Philippines
10-13-75	Second visit to Downstate Medical Center
10-19-75	San Francisco conference and report preparation by consultant team

## I. DOWNSTATE MEDICAL CENTER

### A. Staffing.

It was the intent of the project at the outset to expand the core staff to accommodate an eventual doubling of the number of trainees to twenty per course. This has not proved feasible despite a doubling of the Downstate clinic caseload since the onset of the project. Based on experience to date, increasing the number of trainees per year has been accommodated more by increasing the number of courses per year than by adding trainees per course, and more recently by shortening the course duration from 12 to nine weeks. This has permitted continuation of the desired ratio of trainees to trainer (2:1) without appreciable modification of the core staff.

An examination of the accounting of salaries paid and proportion of work allocated to this project reveals that:

1. The number of nurse-midwife trainers has increased from three (before AID funding) to five (after AID funding).
2. The number of physicians available to the program has increased by one full-time position, bringing the total to two full-time and two part-time positions.
3. The number of clerical workers and supporting staff has increased to five with the addition of one secretary who handles all of the paper work for the program as well as the travel arrangements and scheduling for the students.
4. Overseas evaluation and screening trips have increased to meet the projected "three to four man-years of service." The staff now makes at least one 3-4 week trip each year to screen potential applicants and foster in-country commitment to the training program. In addition, four nurse-midwife trainers have spent extended periods of time overseas (1-3 months) in Thailand, Zaire, Kenya, Senegal, and Mexico, establishing and implementing in-country training programs. Shorter trips are also made by the physician staff for the purpose of consultation and evaluations.

These include visits to Mexico, Africa, the Philippines, and South America. One midwife remained in-country for 15 months implementing training programs and evaluating progress.

The following observations are offered as evidence of achievement of the project purposes in regard to staffing of the Downstate program:

1. The continuity of leadership of the program, with Dr. Schuyler Kohl as Director and Mrs. Elaine Pendleton as the Senior nurse-midwife, has lent valuable experience to the evolution of the present curriculum and has added to the stature of the program in the eyes of the various LDC officials consulted.
2. The staff of the family planning program has been maintained in the face of "hiring freezes" by the City of New York and the State University of New York. This is, of course, because of the federal source of funding for the program. However, state and city frozen funds do influence the number of support persons and supplies available to the program. It is evident that, due to the current financial situation in New York, any expansion of staff and/or support services would have to be based on federal funding.

Members of the Downstate Faculty consulted during the initial team visit included:

Dr. Schuyler Kohl  
 Dr. Donald Helbig  
 Mrs. Elaine Pendleton  
 Dr. Theodore Grundfast  
 Dr. Gwen Gentile  
 Ms. Thelma Grant  
 Nurse-midwife preceptors

**B. Instructor-student ratio.**

Adherence to the ratio of two students to each trainer has been maintained. This ratio has proved optimal, on the basis of clinical experience, in order to insure direct supervision of patient examinations and technical procedures. It is compatible with efficiency of clinic operation and permits monitoring of the congruence of examination findings between student and trainer. Inasmuch as the training curricula in the LDC institutions visited by the

consultant team are modeled closely on the Downstate example, this ratio is important to maintain.

During the visit to a clinic session at Downstate, five nurse-midwife trainers were responsible for two trainees each, with three physicians available for consultation. In a 45-minute period of observation two trainees conducted three clinic visits, alternating as observer and care-giver. They established contact with the patient, obtained the pertinent history, devised a plan of action, and consulted with their trainer who provided correction and assistance as necessary. Another trainee was observed conducting a family planning visit in French under the supervision of a bi-lingual trainer.

The present instructor-student ratio permits the conduct of between 50 and 70 family planning clinic visits per day, with all care being provided by the nurse-midwife trainees and trainers. The latter inspect each patient record, recheck each trainee examination, supervise IUD insertion by the trainee, and provide immediate feedback to the trainee on each clinic transaction.

During the intervals between programs when the trainees are not present, the nurse-midwife trainers are responsible for the maintenance of clinic services and the supervision of students and internes from the basic nurse-midwifery program to the family-planning program (notably by Ms. Lilly Hsia, a nurse-midwife and pediatric nurse practitioner who provides all of the pediatric content now in the curriculum).

Despite the complex scheduling and logistic problems represented by overseas travel and vacation, the number of instructors present in the clinical area at any one time is three to four. This is compatible with the number of trainees present in maintaining the instructor student ratio of 1:2 (2-4 trainees being absent from the clinical area each week for rural health experience).

#### Adequacy of Clinical Teaching Facilities.

The original Project Authorization was based upon the 1969 clinic statistics of the Downstate Medical

Center. During 1969 a total of 3984 patients were seen in 7576 family planning clinic visits. Since that time the clinic caseload has virtually doubled, while the "mix" among methods prescribed has also changed.

The most recent report of clinic activity represents the first six months of 1975. During this period the Downstate Center conducted 7907 family planning clinic visits of which 4957 were registered patients and 2950 were referred from community clinics. The percent of IUD acceptors, reported as 42.1% in 1969 has decreased to approximately 20%, divided among patient categories as follows:

Post-Abortal insertions . . . . .	24.5%
Post-Partum visit insertions. . . . .	13.1%
Walk-in patient insertions. . . . .	12.4%

During the same period the percentage of pill acceptors has increased, with approximately 43% of post-abortal and post-partum and 66% of walk-in patients selecting oral contraception.

In a statistical breakdown of procedures performed by individual trainees, during the four courses provided in FY 1974, the following average number or procedures per trainee were reported:

Pelvic examination. . . . .	237
Breast examination. . . . .	201
Pap Smear . . . . .	130
IUD insertion . . . . .	20
Diaphragm fitting . . . . .	12

The reduction in the number of required observed IUD insertions for completion of the course to 20 (vs "30 to 50" in the original curriculum) is based not upon unavailability of acceptors, but rather upon a conviction on the part of the faculty that a minimum of 20 supervised insertions is adequate for acquisition of the principles and basic skills of insertion technique, provided careful supervision and instruction accompanies each training insertion. This conviction, based upon training experience, is shared by the evaluation team.

D. Number of Trainees Completing Program.

The number of LDC trainees completing the family planning program by fiscal year is as follows:

<u>FY</u>	<u>Number of Trainees</u>
1971	25
1972	27
1973	44
1974	44
1975	<u>31*</u>
Total	171

\*This figure reflects a change in the starting times of the programs so that in FY 1975 there were three programs as opposed to four programs in the two preceding years.

The expansion in number of trainees in fiscal years 1973 and 1974 over fiscal years 1971 and 1972 is due primarily to improved selection processes and better coordination of travel arrangements. In addition, delays in funding in fiscal year 1971 and 1972 restricted the number of students that could be accommodated. By experience, the Downstate program has found that when the staff has direct input into the selection of students in-country, more appropriate selections can be made of teams of students who can directly implement family planning programs in their own countries. They have also found that when travel arrangements are made by the Downstate staff there is less confusion and less delay in the arrival of students in the program.

The total number of students completing the program (171) does not meet the projected goal of 250 trainees outlined in the training proposal. The consultant team recognizes that the goal outlined in the project proposal was conjectural rather than experiential and also recognizes the conviction on the part of the program staff that 40 to 50 trainees per year reflects a more realistic goal based on current staffing patterns and clinical facilities as well as pressures for overseas travel. This would mean that the staff would offer five nine-week training programs per year with ten students in each program. An alternative to be considered would be offering four programs per year with 12 students per program if more staff could be hired to maintain the instructor-student ratio.

The program staff and the consultant team share the conviction that the instructor-student ratio must be maintained, both to ensure quality of instructor and supervision and to enable the trainees to use the program as a role model for in-country training.

It is worthwhile to note some of the problems in the student selection process as these problems directly influence the productivity of the Downstate program. Such problems are:

1. Students selected lacked the educational background required for the program.
2. Students selected were not able to implement either family planning services or training programs in their countries upon return because of the politics of their selection.
3. Students selected were unable to attend the program because of physical illness or pregnancy.
4. Students selected as the sole representative of their country or cultural group faced overwhelming cultural and social problems when in this country. Not only does the student have adjustment problems, but the staff devotes much time and energy in assisting the student to adjust. Many of these situations can be alleviated by selecting teams of students from each area and thus preventing social isolation.
5. In selecting teams of students it is necessary to ensure that no top level person is forced to lose face by experiencing the same training program as lower level personnel in the same team.

#### E. Downstate Family Planning Program Curriculum.

The curriculum for the Downstate program has recently been shortened from twelve to nine weeks. Effective in January 1975, this decrease in overall length of the program does not represent a decrease in the requirements for acquiring practical skills which continue to remain at 20 IUD insertions, 10 diaphragm fittings and an average of over 200 pelvic examinations. The program staff are agreed that these training requirements represent the minimum experience required to achieve proficiency and safety and that

these requirements can be met in nine weeks. Included in the nine weeks is a one-week observation experience in a rural health center (Frontier Nursing Service, Hayden, Kentucky). This experience, it is felt, provides the trainee with a broader view of the American system of health care and allows the trainee to observe nurse-midwives providing comprehensive health care in a disadvantaged setting. The trainees are rotated through the rural experience one week at a time and, upon their return to the Downstate Center attend make-up classes for the content of the week they missed.

In the 300 training hours available during the nine weeks, approximately one-fifth, or 60 hours, represents didactic presentations and the rest is allotted to clinical experience. Sixty per cent of the didactic content is focused upon family planning techniques, reproductive physiology, and related gynecological disorders. Forty per cent of the didactic content concerns areas such as sexuality, demography, pediatrics, clinic management, and the development and presentation of teaching projects. The program staff feel that the focus of their efforts should be in the area of family planning services and that the curriculum should be tailored to meet the individual needs of each group in terms of pediatrics, demography, etc. Experience has shown the staff that each class comes with strengths that are difficult to predict, but which may well include knowledge of an area such as pediatrics that would preclude the necessity for repeating such content in the curriculum. They also feel that selection of an homogenous group with common needs greatly enhances the effectiveness of a curriculum tailored to meet those needs.

In general, the program staff identify as highest priority a curriculum oriented toward the direct provision of family planning services. Proficiency, safety, and quality of care are ensured by the high number of clinical hours demanded by the program and the immediate supervision afforded by 2:1 ratio of trainees to trainers. Related areas such as pediatrics, clinic management, demography, and teaching methods are of secondary importance in their opinion and the number of hours devoted to these areas should be adjusted according to the needs and expectations of each individual class. (See Appendix A. for details of current curriculum.)

#### F. Publications and Production of Training Models.

The Downstate program has published a training manual, "Family Planning Procedure Manual for Nurse-Midwives," which is used as the basic text for the program. This manual has been prepared in English, Spanish and French for use in the three training languages utilized at Downstate. In addition, this manual has been available for general circulation in the three languages and each trainee is provided with a copy for reference upon her return home. In the years 1974-75, 976 training manuals in English were distributed; 156 training manuals in Spanish were distributed, and 128 training manuals in French were distributed. These manuals have been distributed primarily to individuals and groups involved in training programs in family planning, both in this country and abroad. In the overseas training centers visited by this team, this manual was also used as a basis for training. In Thailand, projections for future demands for the manual involved the use of 10,000 copies which would be translated into the Thai language and dialects. In the Philippines, an estimated 2000 nurses and midwives could be trained by 1977, thus creating a demand for 2000 copies of the manual in English. In addition, attempts are currently being made to translate this manual into languages such as Tagalog and Sengalese for added distribution.

The staff at Downstate University along with support from the Pathfinder Fund have developed a training model for pelvic examination, IUD insertion and diaphragm fitting. This model, which is compact and weighs less than one pound, has the advantage of moving parts so that pelvic organs can be placed in different positions. Because of minimal weight, the model can be shipped in bulk to overseas training programs at little cost. Both of the overseas training programs visited by this team were using the Pathfinder model as an adjunct to training.

#### G. Recommendations.

1. The training goals announced in the original Project Agreement should be revised according to actual experience of the first five-year project.

- a. A realistic target of 40-50 trainees per year in keeping with the staffing pattern and curriculum that has proved workable.
  - b. Establishment of overseas training centers, while still a prime objective of the program, should not be targeted numerically, in view of experiences indicating that LDC readiness, capacity for implementation, and compliance with policy pre-requisites are unpredictable.
2. Consideration should be given to more flexible curricula for selected groups of trainees, or even to alternative courses for different groups of LDC trainees. Variables in content suggested by various informants in the field include:
- a. a course for future trainers of auxiliaries to be utilized primarily for family planning motivation, with emphasis on IEC and motivation,
  - b. course content in the planning and execution of training programs, teaching methods, clinic management, supply and logistics,
  - c. course content on preventive health measures, the need for which may vary among groups of trainees; i.e., nutrition, well child screening, immunization, etc., and
  - d. course content focused on one or more family planning procedures, such as IUD insertion (cf. Thailand) vs. courses in integrated Family Planning/MCH.
3. A ratio of 1 trainer to 2 trainees for practical clinical experience has proved appropriate and should be continued.
4. Frequent overseas visits and close liaison between the Downstate staff and LDC training centers is desirable.
- a. Close supervision of, and direct participation in, the screening of applicants for Downstate training correlates closely with training outcomes, and should continue.

- b. Short term visits to Downstate Medical Center by LDC physicians responsible for LDC policy and programs utilizing nurses and midwives have proved useful and should continue.
- c. Presence of a Downstate faculty member for an extended period in countries where early attempts at in-country training are undertaken is critical to the success of these efforts. Consideration should be given to the establishment of full-time training personnel on a regional basis (possibly in cooperation with a multinational organization such as ICM) in order to assure continuing back-up and consultation for early in-country training exercises.

G. Establishment of LDC Training Centers

The effort to institutionalize training in various LDC sites, according to the project agreement, has met with predictable variable success. While a total of ten such centers have been listed as established, some have been quite successful, others have not progressed beyond rudimentary beginnings, and several are finally beginning to materialize after long delays. A simple tabulation, therefore, is not possible for assessment of this aspect of the project, nor was it possible for the team to visit or obtain quantitative data from each LDC center. For this reason, this aspect of the report is confined to LDC training in two countries in which in-country training was directly observed, and two others representative of the newer LDC training projects from which indirect but useful information was obtained. These form the basis of the remainder of the report and are felt to be sufficient to afford a reasonable, albeit incomplete, assessment of the LDC-based aspects of the project.

## II. EVALUATION OF TRAINING OF PARAMEDICALS IN THAILAND

The experience of Thailand typifies the application of the conceptual basis of the Downstate project. Thailand began its National Family Planning Program in 1968. It is administered by the MCH Division of the Department of Health and Rural Health Division of the Department of Medical Services, both under the Ministry of Public Health. The Third National Five-year Development Plan 1972-1976 includes the following objectives of the National Family Planning project: (1) to reduce population growth from 3 to 2.5 percent by 1976; (2) to provide family planning knowledge and services to all eligible women, and to motivate them to accept contraceptive methods; and (3) to integrate family planning with the MCH service delivery system.

While condom and injectable contraceptives have recently been added to the "mix" of available methods, principal reliance has been on IUD's, oral contraceptives, and sterilization. In the 1974 NFPP report, orals accounted for 62% of all new acceptors (total 479,000) in contrast to 18% for the IUD. However, the IUD, with an average retention time of 2-1/2 years, is regarded as more effective than oral pills and less expensive than sterilization. Therefore, in order to increase the number of IUD acceptors in the face of physician shortage, especially in rural areas, steps were taken beginning in 1972 to train midwives to perform IUD insertions.

A total of 18 Thai nurse-midwives were trained at the Downstate facility between 1967 and 1973. Their roles in the evolution of the Royal Thai Government (RTG) capability in nurse-midwife training in family planning can best be evaluated in the context of the following steps in the direction of self-sufficiency by the RTG.

1. Official policy regarding acceptance of paramedicals in delivery of family planning services.

While informal on-the-job training of midwives to insert IUD's and administer orals has been done by local physicians in areas of personnel shortage for a number of years, official sanction has been slow in coming. Only in March 1975 was a regulation allowing nurses and nurse-midwives to insert IUDs put in force by the Ministry of Public Health. Accordingly, the utilization of the 18 Downstate trainees and the

25 trained in-country through 1973 had to be in the context of a "Pilot Project."

Official recognition of the paramedicals' extended family planning role has been equally slow in the revision of the curriculum of the six government nursing schools. The curriculum now includes 36 hours of family planning clinic experience in addition to the basic sciences and Obstetrics, Gynecology, and MCH content of the didactic courses. However, practical experience in IUD insertion will not be implemented at these six institutions until completion of the course for trainers which began in September 1975 at Chulalongkorn. With completion of these two necessary steps in 1975, official government recognition and incorporation into the nurse-midwifery curriculum, it may finally be said that official policy in Thailand satisfied the LDC policy objective set forth in the Project Agreement.

Even though some dissemination of the concept of the expanded paramedical role obviously occurred under the project, and via informal training by individual physicians, the consultant team agrees with the opinion expressed by a number of our informants in Thailand that the rate of utilization of paramedicals in the field has been retarded by delays in the realization of these two important steps. Accordingly, we feel that in future agreements with LDC governments, AID would be well advised to require tangible evidence of official endorsement of utilization of paramedical personnel prior to undertaking the training of LDC trainers in the Downstate program.

B. Utilization of Downstate trainees in clinical services and as trainers in Thailand.

All 18 of the Downstate-trained nurse-midwives were among the forty-three who participated in the Pilot Project, which included special training at Chulalongkorn hospital. Since the evaluation of the pilot project (see Appendix B) does not distinguish between these 18 and the remaining 25, it is not possible to evaluate their performance separately, nor is it possible to determine how much of their performance reflects the Downstate training and how much reflects the special training they were subjected to at Chulalongkorn.

These limitations notwithstanding, the data reported in "Paramedical Insertion of IUD's in Thailand" by Nicholas H. Wright of the Population Council, March 19, 1975, supports the acceptance of nurses in the extended role. His evaluation concludes that:

1. nurse performance with the Copper T-Loop is comparable to that of physicians, and
2. consumer satisfaction indicates broad approval of the nurse's performance.

An attempt was made to establish the current professional activity of all 18 of the Thai personnel who had been trained at Downstate. The results of this investigation are as follows:

Current Professional Activity of 18 Thai Trainees

Involved primarily in training activities. . . . .	10
Involved primarily in FP/MCH service activities. . . . .	3
Involved primarily in administrative/supervisory activities . . . . .	1
Emigrated to USA . . . . .	2
Unaccounted for. . . . .	<u>2</u>
 Total. . . . .	 18

In the course of providing this data our informants (chiefly training personnel in the NFPP) noted that most of the Downstate trainees have moved into positions involving supervision, administration, or training which would indicate leadership roles which foster the dissemination of the knowledge and skills acquired at Downstate. The training staff at Chulalongkorn noted with justifiable pride that one of their trainees has accounted for 4100 insertions, but noted that others were unable to utilize their skills because of assignment under physicians who are not sympathetic to the extended paramedical role.

C. Establishment of in-country training centers in Thailand.

Training activity involving paramedicals in Thailand is focused upon IUD insertion, since the provision of oral contraception has been included in the basic family planning training course beginning in 1970 and following a successful pilot study of oral contraceptives administered by auxiliary midwives.

Thus, the training program for paramedical personnel can be summarized in three phases.

1st Phase: "Pilot Project." Training of 43 nurse midwives (in five groups of up to ten each) since 1972. The first group was selected from the supervisory level of the MCH Division in order that they might serve as supervisors for the groups to follow. Following training of this initial group at Chulalongkorn Red Cross Hospital, three MCH centers in rural areas were selected as additional training sites. It is these first 43 trainees who form the basis of the evaluation by N. Wright previously cited.

2nd Phase: Following the issuance of the regulation allowing nurses and nurse-midwives to perform IUD insertions, a two-year plan to train 550 additional nurses or nurse midwives in this procedure was initiated.

In the first year, beginning September 15, 1975, 150 trainees will be selected from 70 provinces and MCH centers where there is high IUD acceptance. These trainees, who are required to have two years prior experience in family planning or OB/GYN, will become training supervisors for the 400 trainees selected in the second year. The course lasts six weeks, with the first two weeks of didactic material at Chulalongkorn followed by four weeks of practical experience in the provincial and MCH centers. This adaption is necessary since rebuilding of the Maternity Section of Chulalongkorn Hospital has temporarily reduced its obstetrical caseload from 1800 deliveries per month to 900 per month during construction, and IUD insertions have fallen to about 100 per month accordingly. Throughout the course, the ratio of 2 trainees to 1 trainer will be maintained, as at Downstate.

3rd Phase: The Government of Thailand recognizes the need to expand the participation of auxiliaries in family planning activities as rapidly as possible if its Third Five-year Plan targets are to be achieved. Encouraged by the results of the Pilot Project in IUD insertion by nurse-midwives, and the performance of auxiliary midwives in administration of oral and injectable contraceptives, the RTG is seriously interested in extending the skills of auxiliary midwives to include IUD insertions. While there are only 300 first-class health centers which include nurse or nurse-midwives among their personnel,

there are over 3000 small rural health centers where auxiliary midwives work alone or with a junior sanitarian, providing MCH and family planning to three to five villages each.

Accordingly, a new pilot project to train selected auxiliary midwives in IUD insertion has been suggested as a logical next step, and a proposal for a 24-month pilot project has been submitted to the Pathfinder Fund. It is a modest project involving 40 auxiliary midwives and costing \$45,820, but its completion, coinciding with the expanded in-country training capability which is now underway, stands to accelerate the extended role of the auxiliary midwife who is the key to making modern contraceptive technology accessible to rural women.

#### D. Conclusions.

1. The training of Thai nurses and nurse-midwives at Downtown Medical Center has contributed to the acceptance of paramedicals as a means of rapid expansion of contraceptive availability in Thailand.
  - a. Returned Downstate trainees are functioning in training, supervisory, and administrative roles in the NFPP.
  - b. The AID and Population Council supported Pilot Project since 1972 has successfully demonstrated the capability and acceptance of nurse midwives in the insertion of IUD's in Thailand. Their role in provision of other methods, including orals, had previously been established.
  - c. Eighteen of the 43 nurses who participated in the IUD pilot project had been trained at Downstate Medical Center.
2. In-country clinical contraceptive training of paramedicals has been established in Thailand.
  - a. A six-week course for nurse-midwives has begun at Chulalongkorn Hospital with the first groups of trainees destined to become trainers, utilizing the regional MCH centers as training sites.

- b. A pilot project to extend training in IUD insertion to auxiliary midwives has been proposed in an effort to expand accessibility of contraception to rural women more rapidly.
3. Official recognition has been given the role of paramedicals in family planning by the Royal Thai Government. Since 1970 auxiliary midwives have been permitted to administer oral contraceptives, and in March 1975 official sanction was given for insertion of IUD's by trained nurse-midwives.

E. Recommendations.

Evaluation of the utilization of Downstate trained nurse-midwives in Thailand suggests that while the basic objectives of the Downstate project have been met, improvements in the application of the concept of U.S. training of LDC nurse-midwives to Thailand would enhance the effectiveness of the program. They include:

1. Acceptance of nurse-midwife trainees should be based upon prior assurance of their official sanction to perform the procedures for which they are trained upon return to their home country.
2. Future assistance to Thailand should seek to foster an institutional relationship between Downstate and the Chulalongkorn Training Center rather than simply train more Thai nurse-midwives as before. Downstate could provide U.S. backup in the form of:
  - a. periodic curriculum review and revision based upon technologic advances and refinement of training techniques,
  - b. translation and adaptation of the Downstate Training Manual to fit Thailand circumstances,
  - c. provision of training aids, audiovisual materials, clinic models and equipment to enhance contraceptive training, and
  - d. technical backstopping for pilot projects (such as the proposed auxiliary midwife IUD project) and for evaluation of the in-country paramedical training program.

**III. TRAINING OF NURSES AND MIDWIVES IN COMPREHENSIVE  
FAMILY PLANNING DELIVERY IN THE PHILIPPINES**

**A. Background of paramedical roles in the Philippine  
Family Planning Program.**

The basis for the current Philippine national population program is expressed in Presidential Decree No. 79 (The Revised Population Act), issued December 8, 1972. Along with its other mandates, the decree authorizes the Population Commission (POPCOM) to utilize nurses and midwives along with physicians to administer "all acceptable methods" of contraception, assuming suitable training and licensing requirements are met.

POPCOM's implementation strategy for this section of the decree includes a training scheme utilizing fourteen "Core-Trainers" prepared by the Downstate Medical Center Program as the nucleus of a "multiplier effect" within the Philippine in-country training program. The agencies involved in training to date include: (1) the Department of Health/Office of Health Education and Personnel Training (DHEPT), (2) The Institute of Maternal and Child Health, Quezon City, (3) Jose Fabella Memorial Hospital, Manila and (4) the Family Planning Organization of the Philippines, Manila. All of these agencies were visited by the consultant team.

**B. Progress toward training goals through FY 1974-1975.  
(See Appendix C. for chart)**

Preparation of the fourteen Core Trainers at Downstate was completed in 1974. These in turn trained fifteen trainer-practitioners, and by the end of FY 1974-1975 a total of 159 persons had completed the twelve-week course, as follows:

Core Trainers.....	14
Trainer Practitioners.....	15
Nurse-Midwife Practitioners.....	117
Nurse Supervisors.....	13
TOTAL.....	<u>159</u>

Table I indicates the Agency affiliation of the trainees, and Table II provides a breakdown of courses given by place of training and categories of trainees.

Table I

Agency Affiliation of the Trainees

Agency	Core Trainer	Trainer- Practitioner	Practi- tioner	Nurse Supervisor	Total
Department of Health	8	10	78	11	107
Institute of Maternal and Child Health	1	-	4	1	6
Jose Fabella Memorial Hospital	4	-	1	-	5
Family Planning Organization of the Philippines	1	4	21	1	27
Davao City Health Department	-	1	6	-	7
Iglesia Ni Cristo	-	-	6	-	6
Department of National Defense	-	-	1	-	1
	<u>14</u>	<u>15</u>	<u>117</u>	<u>13</u>	<u>159</u>

Source: FY 1974-1975 Program Review: Training and Utilization of Nurses and Midwives in Comprehensive Family Planning Services, USAID/Manila.

Table II

Cumulative Report on Training Courses and Trainees  
FY 1974-1975

Training Course	Place of Training	Target	Trained		Drop- outs <sup>a</sup>	Non-completed Target
			Nurse	Midwives		
Core Trainer	Downstate Medical Center, New York USA	14	14	-	-	-
Trainer- Practi- tioner	Baguio City, Region I	4	4	-	-	-
	Cebu City, Region VII	4	4	-	-	-
	Davao City, Region XI	4	4	-	-	-
	JFMH, Manila	<u>3</u>	<u>3</u>	<u>-</u>	<u>-</u>	<u>-</u>
		15	15	-	-	-
Practi- tioner	Baguio City, Region I	24	20	4	-	-
	Cebu City, Region VI	24	20	4	1	-
	Davao City, Region XI	24	18	5	-	1
	IMCH, Quezon City	12	10	2	4	-
	JFMH, Manila	18	11	7	-	-
	FPOP, Manila	<u>20</u>	<u>16</u>	<u>-</u>	<u>-</u>	<u>-</u>
		122	95	22	5	5
Nurse Super- visor	IMCH, Quezon City	12	11	-	1	1
	JFMH, Manila	<u>2</u>	<u>2</u>	<u>-</u>	<u>-</u>	<u>-</u>
	14	13	-	1	1	

Source: Program Review: Training and Utilization of Nurses and Midwives in Comprehensive Family Planning Services, USAID/Manila.

C. Training of Physicians and Nurse Supervisors.

In order to provide consultation, back-up service and supervision to the Comprehensive Family Planning Nurse/Midwife practitioner, a special eight-week course was given to 13 Nurse Supervisors, and a one-week orientation course to 138 physicians, including clinic physicians and OB/GYN physicians attached to hospitals.

D. Expansion under the 1975-1976 subagreement.

A sub-agreement, under the current Project Agreement between AID, The Philippine National Economic and Development Authority (NEDA), and Commission on Population (POPCOM), became effective 16 July 1975. The Sub-agreement, dealing with Community Health Workers (nurses and midwives) has three components: training, services, and IEC. The specific training objectives of the sub-agreement include the following:

1. Training of 80 nurse/midwives and 80 back-up physicians in the IMCH National Training Center and three regional training centers using a two month curriculum recently developed.
2. Utilization of two or more additional DOH-NEPTRA Regional Training Centers in the family planning training of nurses and midwives.
3. Preparation of additional trainers for the two additional Regional Training Centers to be utilized this year.
4. Continuation of present program of three month comprehensive family planning training courses for 420 nurse/midwife practitioners, 342 back-up physicians, 20 nurse-supervisors, 70 supervisors/coordinators, and two Regional Training Center chiefs of DOH-National Family Planning Training.
5. Regulation of comprehensive family planning nurse-midwife practice through standardized accrediting and licensing procedures.

E. Evaluation of training sites and practitioner.

In addition to discussions with GOP and USAID officials and with visits to the four central training centers,

the consultant team selected training and service sites representative of all levels of decentralization for site visits. The locations visited in the field provided an opportunity for firsthand observation of the various levels of personnel in action and to gain insights into the program through their observations and recommendations based upon experience in the field. The site visited included:

1. Training sites:

Manila: JFMH, FPOP  
 Quezon City: IMCH  
 Region I: Baguio General Hospital  
 Dagupan Regional Training Center

2. Hospitals:

Quirino Memorial Hospital, Quezon City  
 Jose Fabella Memorial Hospital, Manila  
 Baguio General Hospital  
 Pangasinan Provincial Hospital, Dagupan City

3. Urban Clinics:

Galas Health and Family Planning Center  
 FPOP, Manial  
 Baguio City Health Department

4. Suburban and Rural Clinics:

Pasig Puericulture Center  
 Aurora Hill Health Station, Baguio  
 La Trinidad Rural Health Unit, Bengeret  
 Rural Health and Family Planning Center,  
 Naguilian, LaUnion  
 Cavite Municipal Clinic  
 Bacoor Family Planning Center

These site visits yielded a variety of opinions, suggestions, and questions regarding the Comprehensive Family Planning project. Nevertheless, the following summary represents a distillation of these and, at the risk of over-simplification, is nevertheless relevant and is accordingly reported.

There was unanimous approval of the extended role of nurses and midwives in family planning delivery, and general endorsement of the adequacy of the in-country training course. Some qualifications regarding the latter included the observation that the practical

clinical skills should take precedence over didactic teaching, that midwives need additional tutoring when mixed with nurses in the same course (especially in such subjects as endocrinology), and that more content in IEC and teaching techniques are desirable. In general, physicians were regarded as accepting of the paramedics extended role, although some references to conservative attitudes toward paramedics by physicians were made. Prior announcement of the program with conferences and in-service orientation of physicians was felt to be important in gaining acceptance.

A number of the sites visited showed statistics indicating a rapid improvement in clinic performance, especially in IUD acceptance, since the advent of the trained paramedics. There was everywhere strong support for continuing the diffusion of this concept as a practical step toward making oral and intrauterine contraception available in rural areas. Considerable interest was expressed in the planned shortening of the training course and the opinions of former trainees on this issue will be dealt with under that topic.

F. Unresolved issues in the Philippine program.

While the GOP program has made excellent use of the Downstate-trained "Core-Trainers" to date, and has multiplied their effect in the overall training plan, three issues remain to be clarified before the potential contribution of trained paramedics can be fully realized. These are: (1) progress toward certification of trained paramedics, (2) proposed shortening of the training course to eight weeks, and (3) coordination with the IBRD project in training of midwives for rural health care.

1. Certification. Presidential Decree No. 79 provides for training of midwives and nurses in administration of acceptable methods of contraception, assigning training and authorization to POPCOM "in consultation with the appropriate licensing bodies." These bodies, the Nursing and Midwifery boards, have now been merged into the "Professional Regulation Commission." According to a memorandum of agreement entered into by the PRC and POPCOM, a licensing committee has been appointed and charged with developing licensing procedures. According to the FY 1974-1975 program review prepared for USAID, the Paramedic Certifying Committee has

developed oral and written examinations as the basis for licensing of nurses and midwives who complete the prescribed training. However, a final approval of this plan has not been announced, and according to several of our informants (notably Dr. Justiniani, Mrs. Nery-Pasqual, and Dr. Infantata) it has not yet been decided whether licensing shall be on the basis of certifying examination of individual trainees or on an institutional basis according to completion of an accredited training curriculum.

The prevailing opinion in the field is that resolution of the licensing issue is a prerequisite to the widespread acceptance of the paramedic role by physicians, and that further delay will be costly. The matter appears to lie with POPCOM at present, and the USAID staff in Manila feels it is essential that it be resolved soon.

2. Proposed Shortening of the Training Course.

A two-week workshop involving core-trainers, supervisors, and representatives of the training institutions, was held in May 1975. The workshop was expected to revise the training curriculum and to develop a two-month course to be tested in four training sites early in 1976. A report of the proceedings of the workshop was not available to the evaluation team during the visit to the Philippines, nor has one been sent to us as of this writing. It is therefore possible to report only subjective reactions to the workshop by several of our informants.

There was apparently considerable dissent on the part of trainers over the proposed shortening of the course. While opinions sampled in the course of our visits were not unanimous, the majority (trainers and physicians alike) felt that retention of the three-month curriculum is necessary if quality of performance of trainees is to be assured. In particular, a distinction was drawn between midwives and nurses as trainees; the prevailing opinion being that midwives are less well equipped for didactic or theoretical subjects and require a separate, if not longer, training course. It was expressed that the shortening of the Downstate curriculum is not analogous to the revision of the in-country course, since more time is required of in-country

trainees (especially in the Regional Training courses) in home visits, IEC and motivational work in order to achieve the requisite acceptors for IUD insertion experience. There is general consensus that the number of insertions previously required (40) can safely be lowered without sacrificing the quality of training, and at least one observer suggested that completion of the practical portion of the course should be based upon demonstration of proficiency in performing technical procedures under supervision rather than an arbitrary number of insertions.

Despite the acknowledged dissention over shortening of the course, the proposed trials of the two-month curriculum are scheduled, and evaluation of this experiment is planned before any large scale revision of the present three-day course is undertaken.

3. Coordination with the IBRD Project in Training of Midwives for Rural Health Care. The IBRD project proposes to train an additional 2500 midwives for delivery of basic health services in rural areas. Basic training in family planning has already been decreed by Presidential order, and consists of a three-week course provided for physicians, nurses, and midwives at the outset of employment in the national health program. With the assistance of WHO advisors, a "Manual for Rural Health Unit Operations" has been issued, in which functions of the various health care personnel have been spelled out. In addition, a revised training manual for midwives, including family planning content, has been prepared with WHO assistance.

It is generally felt that the IBRD project will complement the comprehensive paramedics project in that the IBRD trained midwives will be equipped to instruct and motivate rural women, while the comprehensive family planning paramedics will actually deliver and monitor the IUD and oral contraceptive service. Nevertheless, the implementation of the IBRD project will have a significant impact on the Comprehensive Paramedic Training program in two respects. On the one hand, trainers are needed for the ambitious training requirements of the IBRD project, and already concerns over "pirating" of trainers from the

Comprehensive Paramedics program are being raised. Secondly, the presence of IBRD-trained midwives in the field is expected to relieve Comprehensive Paramedic Trainees of some of the time-consuming IEC and motivation work they now must do via home visits, thus freeing them for more rapid completion of training requirements at clinic locations and establishing a pattern for future referral relationships among these levels of health personnel.

In order to prepare for these eventualities and assume an orderly progression of these mutually reinforcing programs, more coordination is needed regarding recruitment of training staffs, content of training curricula, and orchestration of field placement of trained personnel. The consultant team interviewed Dr. Richard Herniman of WHO, who is very receptive to the sharing of experience, training materials, and planning between these complementary projects.

#### G. Conclusions.

The review of the Philippine training experience confirms the basic assumptions underlying the Downstate program. Although several details of implementation remain unresolved, the role of trained nurses/midwives in the delivery of clinical contraceptive services has been established, the Downstate trained "Core Trainers" have achieved a multiplier effect through their in-country training activities, and the Comprehensive Paramedic project has resulted in rapid and significant increases in acceptance of oral and intrauterine contraception in the field. Downstate training materials have been adapted for use locally, and Downstate consultation has been utilized in planning for expansion of the Philippine program. The procedural steps toward licensing of Comprehensive paramedics, the testing and evaluation of a revised and shortened training curriculum, and the coordination of the Comprehensive paramedic project with the IBRD supported project for training of midwives for rural health services are the major issues yet to be resolved.

While a continuing role for the Downstate program in preparing Core Trainers for the rapid expansion of the Philippine program has been suggested, it is the opinion of the consultation team that sufficient in-country resources for preparation of trainers now exist. The future contribution of the Downstate

program in the Philippines might better be in the direction of: (1) refresher courses for updating of contraceptive technology and IEC techniques for key training personnel, (2) consultation to the Philippine training program as requested, and (3) provision of improved manuals, models, visual aids, and other periodically updated training materials.

#### H. Recommendations.

1. Future agreements dealing with utilization of paramedical personnel for delivery of family planning services should be conditional upon completed and approved certification and licensing procedures to assure acceptance of paramedical roles in the field.
2. Support for the Comprehensive Paramedic project should be continued, as a major ingredient of rapid expansion of the overall population program for the Philippines.
3. Technical assistance should be made available in the evaluation of the early 1976 trials of a shortened training curriculum, and change to an eight-week curriculum throughout the program should be deferred until this evaluation is completed.
4. Appropriate steps should be taken to assure coordination of the Comprehensive Paramedic program with the IBRD training project for midwives in rural health service.

#### IV. TRAINING CENTERS IN KENYA AND MEXICO

##### A. Kenya.

This information was collected during an interview between Marilyn Wender, CNM, assigned to Kenya to assist with the first training program, and Rosemary Mann, CNM, of the consultant team. Training centers in Kenya and Mexico were not visited by the team.

In 1974, five nurses from Kenya completed the LDC training program at Downstate University. They returned to their country with the intent of establishing short-term family planning training programs for nurses. In May 1975, the Downstate faculty received an urgent request to send a staff member to assist in the first training program which was to start shortly. A staff member, Mrs. Marilyn Wender, CNM, was dispatched and she offers these points as background for her activities in Kenya.

1. Prior to the Downstate training, eight Kenyan nurses were sent to Meharry University for training in family planning. They received the bulk of their training in didactic form and carried away with them the idea that they did not receive clinical experience because they could not be allowed to "practice" on American patients. Understandably this idea resulted in hard feelings about family planning training programs in the United States.
2. Representatives in the National Family Welfare Center, which is the section on the Kenyan government that controls training of health professionals, related that they felt that they had been forced to sign a written agreement stating their commitment to in-country family planning training utilizing the nurses trained at Downstate. They felt that the local AID representatives had exerted undue pressure in requiring this written agreement. This also resulted in hard feelings.
3. Perhaps because of the above factors, Mrs. Wender expressed her feeling that the Kenyan officials sponsoring the training had little commitment to the success of its outcome. She felt that many of the logistic problems, such as transportation to and from the training and clinical sessions

and the scheduling of clinical sessions for students, occurred because of this lack of commitment. Mrs. Wender also felt a lack of support from the local USAID Mission.

When Mrs. Wender arrived in Kenya she found that no curriculum had been set up, no clinical facilities had been obtained, and the prospective students and just been notified that they were expected to attend this program.

The staff of the training program included two of the nurses trained at Downstate and one of the nurses trained at Meharry. All were experienced practitioners but none, with the exception of Mrs. Wender, had experience in teaching.

Mrs. Wender identified and used the following people for assistance and support:

- Dr. Lickamani--Medical Director of all services.
- Dr. Kanani--Director of the National Family Welfare Center.
- Dr. Roggen--Training Director of the National Family Welfare Center.
- Mrs. Kiereini--Chief Nursing Officer.
- Ms. Wachira--Deputy Nursing Officer.
- Ms. Aune Brotherus--a nurse trained in family planning at Downstate, and currently with WHO in Kenya.
- Ms. Otete--Deputy Secretary to Dr. Kanini.

In making contact with these people she found that family planning training was already incorporated into the curriculum for the enrolled midwives (auxiliary midwives) under the supervision of Dr. Roggen. Consequently, Dr. Roggen played a very limited role in the establishment of this training program. She also found that Kenyans value highly the establishment of in-country training, but wish it to be part of an integrated, multi-purpose program for general health maintenance and prevention of illness.

Mrs. Wender and the training staff initiated an eight-week training program beginning in early June 1975 with seven students. The curriculum, modeled after the Downstate program, was composed of approximately 40% didactic material and 60% clinical experience. It focused on family planning techniques and clinical

proficiency. Of the seven students, five were from outlying districts and two were from Nairobi; five were involved with giving direct service and two were tutors who were to establish family planning training within their nursing schools. All seven completed the program successfully.

At the completion of this initial training program Mrs. Wender felt that the following points were valid and had a significant influence on the outcome of the program:

1. Because of the limited time available to her (six days) to develop a curriculum, the course focused heavily on family planning with little content in related areas such as nutrition and pediatrics. Mrs. Wender found that the students seemed to enter the program well grounded in basic community health concepts but felt that, with additional time, new concepts of health care and family life could be incorporated.
2. There seemed to be no support source firmly committed to provide or arrange for transportation, space for teaching, and teaching supplies. They eventually had access to two cars but no drivers. The manuals and teaching models did not arrive until one week before the end of the program. In addition, only one of the training staff, Mrs. Wender, had any experience in teaching.
3. Again, because of limited time, clinical arrangements were made hurriedly and inadequate preparations were made for the students.
4. Despite these factors the seven students completed the program successfully and proficiently.

Future plans for training in Kenya envision the goal of 5000 trainees within five years. However, as yet only five programs per year are planned with ten students per program. A subsequent training program was planned for September 1, 1975 designed for nurse-supervisors, trainers, and service-educators. However, prior to the onset of this program, problems were already arising in the release of the students from their positions for training.

The National Family Welfare Center has planned the utilization of these trainees in "service delivery

points." These out-reach areas would be staffed by one professional nurse-midwife and one enrolled midwife who would provide integrated services for health care.

In summary, an in-country training center has been established in Kenya for family planning education under the National Family Welfare Center. Downstate has provided consultation and assistance to the first training program as well as direct training of two of the instructors. Although the first training program was completed successfully, factors have been identified involving commitment to training and support of on-going programs which would seem to directly influence the long-range success of this training center.

#### B. Mexico.

A training center has been established in Durango, Mexico under the supervision of Dr. Roberto Rivera, University of Juarez. Although the consultant team was not able to visit this center, the following is offered as an innovation to established models for training.

Dr. Rivera, with four nurses trained through the Downstate program, has established "training in stages" for Mexican nurses. The impetus for this concept has been the problem of releasing desperately needed health personnel for a lengthy training program. Therefore, Dr. Rivera has staged the curriculum into week-long sessions each designed to teach a specific skill. Subsequent training builds skills upon the foundation already established. The stages begin with the theory and utilization of hormonal contraception, progress to skills of pelvic examination, and culminate with IUD insertion techniques. In addition to the advantage of short intensive training sessions which circumvent the problem of releasing trainees, the program also allows each trainee to practice and perfect the newest skill taught before encountering further content.

#### C. General Recommendations for Downstate Support of LLC Training Centers.

1. Some mechanism for continuing liaison with the overseas training centers is desirable. This may take the form of:

- a. a "newsletter" type of communication with the field;
  - b. an ad hoc publication of updating nature on subjects covered in the curriculum;
  - c. circulation of new training materials (visual aids, models, etc.);
  - d. occasional workshops or "refresher" courses in the LDCs themselves for trainers originally trained at Downstate, and/or
  - e. frequent visits by Downstate staff and/or a regionally based liaison person. (See recommendation 4c under Downstate section).
2. Translation and adaptation of Downstate training manual should be undertaken as a separate bilateral project in advance of initiation of any specific LDC training program. Content should be modified according to the pattern of health/family planning delivery peculiar to the host country.
  3. Assistance by Downstate faculty should extend to integration of Family Planning content into existing training projects for health personnel in addition to new projects specifically involving nurses and midwives.
  4. Innovation in LDC Training Centers should be encouraged (cf. shortened curriculum in Philippines, auxiliary midwife training in Thailand, training "in stages" in Mexico), with active participation of the Downstate staff in evaluation of these experiments, publication of results, and direct collaboration among LDC training centers where indicated.

## V. SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

In the opinion of the consultant team, the basic goals of the project have been achieved. Over the five years of the project an effective and internationally highly respected training program has evolved, based upon prior experience and reputation of the Downstate Medical Center in paramedical training. One hundred and seventy-one trainees representing 25 countries have participated, and have become a nucleus for in-country training programs in their home countries. LDC's have been assisted in institutionalizing an extended role in contraceptive service for paramedicals, in-country training courses have been established, and the dissemination of modern contraceptive technology accordingly assisted.

The evolution of the Downstate-based portion of the project has occurred within the time frame of the Project Agreement. The initiation of LDC training centers have proved more difficult, and has been delayed by the inevitable bureaucratic, political, linguistic and cultural barriers which must be overcome in translating the project into action overseas. Nevertheless, sufficient success in establishing LDC in-country training capability has been demonstrated to justify continuation of the project, with suitable modification based upon experience to date. In our judgement the project is conceptually sound and its multiplier effect has proved workable. The lessons learned, insights gained, and associations nurtured over the past five years can be expected to bear fruit as the project continues.

The recommendations previously cited under the various sub-titles are, for the sake of convenient reference, re-iterated in the following list.

### A. The Downstate Medical Center.

1. The training goals announced in the original Project Agreement should be revised according to actual experience of the first five-year project.
  - a. A realistic target of 40-50 trainees per year in keeping with the staffing pattern and curriculum that has proved workable.
  - b. Establishment of overseas training centers, while still a prime objective of the program,

should not be targeted numerically, in view of experiences indicating that LDC readiness, capacity for implementation, and compliance with policy pre-requisites are unpredictable.

2. Consideration should be given to more flexible curricula for selected groups of trainees, or even to alternative courses for different groups of LDC trainees. Variables in content suggested by various informants in the field include:

- a. A course for future trainers or auxiliaries to be utilized primarily for family planning motivation, with emphasis on IEC and motivation.
  - b. Course content in the planning and execution of training programs, teaching methods, clinic management, supply and logistics.
  - c. Course content on preventive health measures, the need for which may vary among groups of trainees, i.e., nutrition, well child screening, immunization, etc.
  - d. Course content focused on one or more family planning procedures, such as IUD insertion (cf. Thailand) vs. courses in integrated Family Planning/MCH.
3. A ratio of 1 trainer to 2 trainees for practical clinical experience has proved appropriate and should be continued.
4. Frequent overseas visits and close liaison between the Downstate staff and LDC training centers is desirable.
- a. Close supervision of, and direct participation in, the screening of applicants for Downstate training correlates closely with training outcomes, and should continue.
  - b. Short term visits to Downstate Medical Center by LDC physicians responsible for LDC policy and programs utilizing nurses and midwives have proved useful and should continue.
  - c. Presence of a Downstate faculty member for an extended period in countries where early attempts at in-country training are undertaken

is critical to the success of these efforts. Consideration should be given to the establishment of full-time training personnel on a regional basis (possibly in co-operation with a multinational organization such as ICM) in order to assure continuing back-up and consultation for early in-country training exercises.

#### B. Training in Thailand

Review of the utilization of Downstate trained nurse-midwives in Thailand suggests that while the basic objectives of the Downstate project have been met, improvements in the application of the concept of U.S. training of LDC nurse-midwives to Thailand would enhance the effectiveness of the program. They include:

1. Acceptance of nurse-midwife trainees should be based upon prior assurance of their official sanction to perform the procedures for which they are trained upon return to their home country.
2. Future assistance to Thailand should seek to foster an institutional relationship between Downstate and the Chulalongkorn Training Center rather than simply train more Thai nurse-midwives as before. Downstate could provide U.S. backup in the form of:
  - a. Periodic curriculum review and revision based upon technologic advances and refinement of training techniques.
  - b. Translation and adaptation of the Downstate Training Manual to fit Thailand circumstances.
  - c. Provision of training aids, audiovisual, materials, clinic models and equipment to enhance contraceptive training.
  - d. Technical backstopping for pilot projects (such as the proposed auxiliary midwife IUD project) and for evaluation of the in-country paramedical training program.

#### C. Training in the Philippines.

1. Future agreements dealing with utilization of paramedical personnel for delivery of family planning services should be conditional upon

completed and approved certification and licensing procedures to assure acceptance of paramedical roles in the field.

2. Support for the Comprehensive Paramedic project should be continued, as a major ingredient of rapid expansion of the overall population program for the Philippines.
3. Technical assistance should be made available in the evaluation of the early 1976 trials of a shortened training curriculum, and change to an eight-week curriculum throughout the program should be deferred until this evaluation is completed.
4. Appropriate steps should be taken to assure coordination of the Comprehensive Paramedic program with the IBRD training project for midwives in rural health services.

D. General Recommendations for Downstate Support of LDC Training Centers.

1. Some mechanism for continuing liaison with the overseas training centers is desirable. This may take the form of:
  - a. a "newsletter" type of communication with the field;
  - b. an ad hoc publication of updating nature on subjects covered in the curriculum;
  - c. circulation of new training materials (visual aids, models, etc.);
  - d. occasional workshops or "refresher" courses in LDCs themselves for trainers originally trained at Downstate, and/or
  - e. frequent visits by Downstate staff and/or a regionally based liaison person.
2. Translation and adaptation of Downstate training manual should be undertaken as a separate bilateral project in advance of initiation of any specific LDC training program. Content should be modified according to the pattern of health/family planning

delivery peculiar to the host country.

3. Assistance by Downstate faculty should extend to integration of Family Planning content into existing training projects for health personnel in addition to new projects specifically involving nurses and midwives.
4. Innovation of LDC Training Centers should be encouraged (cf. shortened curriculum in Philippines, auxiliary midwife training in Thailand, training "in stages" in Mexico), with active participation of the Downstate staff in evaluation of these experiments, publication of results, and direct collaboration among LDC training centers where indicated.





<p><b>AUGUST 25</b></p> <p>#s:1,2/Abortion Observation</p> <p>8:00/Clinic</p> <p>10:30/Pediatrics Ms. Hsia</p> <p>12:00/LUNCH</p> <p>1:00/#s:3,4,5,6 Pediatric Observation</p> <p>2:30/Menstrual Disorders - Dr. Grundfast</p>	<p><b>26</b></p> <p>#s:3,4/Abortion Observation</p> <p>8:00/Clinic</p> <p>12:00/LUNCH</p> <p>1:00/Post Abortion Clinic</p>	<p><b>27</b></p> <p>KCH</p>	<p><b>28</b></p> <p>#s:5,6/Abortion Observation</p> <p>8:00/Clinic</p> <p>12:00/LUNCH</p> <p>2:00/FPIA Trip Miss Johnson</p>	<p><b>29</b></p> <p>8:00/Clinic</p> <p>12:00/LUNCH</p> <p>1:00/Seminar</p>
<p><b>SEPTEMBER 1</b></p> <p>LABOR DAY HOLIDAY!</p>	<p><b>2</b></p> <p>8:00/Clinic</p> <p>12:00/LUNCH</p> <p>1:00/Post Abortion Clinic</p>	<p><b>3</b></p> <p>KCH</p>	<p><b>4</b></p> <p>8:00/Clinic</p> <p>12:00/LUNCH</p> <p>1:00/Project Presentations</p>	<p><b>5</b></p> <p>8:00/Clinic</p> <p>11:00/Tour</p> <p>12:00/LUNCH</p> <p>1-2:00/#s:5,6,7 Infertility Clinic Observation</p> <p>2:00/Project Presentations</p>
<p><b>SEPTEMBER 8</b></p> <p>#s:7,8/Abortion Observation</p> <p>8:00/Clinic</p> <p>11:00/OB Conference</p> <p>12:00/LUNCH</p> <p>1:00/#s:1,2,7,8 Pediatrics</p> <p>2:30/Tour of KCH/OBS</p>	<p><b>9</b></p> <p>8:00/Clinic</p> <p>10:30/Final Exam</p> <p>12:00/LUNCH</p> <p>1:00/Post Abortion Clinic</p>	<p><b>10</b></p> <p>KCH</p>	<p><b>11</b></p> <p>8:00/Clinic</p> <p>12:00/LUNCH</p> <p>1:00/Evaluation</p>	<p><b>12</b></p> <p>8:00/Clinic</p> <p>12:00/GRADUATION LUNCHEON &amp; CERTIFICATES</p>

**SYNOPSIS OF THE PATHFINDER FUND'S FOLLOW-UP STUDY OF THE TRAINEES  
OF THE DOWNSTATE MEDICAL CENTER'S NURSE-MIDWIFERY TRAINING PROGRAM  
IN FAMILY PLANNING**

- 1) Follow-up questionnaires were sent to trainees of Downstate's Nurse-Midwifery Training Programs from October 1966 - June 1973 inclusive.
  
- 2) Ninety-Nine follow-up questionnaires (59%) have been received by Pathfinder to date (November 1, 1973).  
 Twelve follow-up questionnaires (7%) have been returned to Pathfinder with a notation of an incorrect address.  
 Sixty-four follow-up questionnaires (34%) have not been returned to Pathfinder to date.
  
- 3) 68 percent (67) of the respondents indicated that they are working in family planning clinics or in any type of health facility which offers family planning services.\*
  
- 4) 54 percent (36) of the nurse-midwives who indicated that they are working in a family planning clinic or health facility which offers family planning services have some responsibility for the insertion of IUD's at this time.  
 45 percent (30) of the nurse-midwives who indicated that they are working in a family planning clinic or health facility which offers family planning services do not have the responsibility of IUD insertion.  
 1 percent (1) of the nurse-midwives working in a family planning clinic or health facility which offers family planning services has this responsibility of IUD insertion only in "extreme cases when a doctor is unavailable" (Trinidad respondent).

\* An additional 15 percent (15) of the respondents who were not working in a family planning clinic or in any type of health facility which offers family planning services were engaged in some type of family planning work. These respondents were not providing direct family planning services but generally were employed by a governmental agency or department in training, tutoring or advising in the family planning-health field or were responsible for the organization, supervision and planning of family planning projects, clinics or national training programs. Only one of these respondents had any responsibility for IUD insertions.

AREA LOCATION OF TRAINEES OF DOWNSTATE'S Nurse-Midwifery Program in Family Planning	NO. OF TRAINEE RESPONSES RECEIVED	FACILITY PLANNING CLINIC OR HEALTH FACILITY OFFERING FAMILY PLANNING SERVICES	NO. OF TRAINEES RESPONSIBLE FOR I.U.D. INSERTION	NO. AND TYPE OF MONTHLY I.U.D. INSERTIONS EACH TRAINEE PERFORMS*
<b>ORTH AMERICA, CENTRAL AMERICA AND MEXICO</b>	<b>7</b>	<b>2</b>	<b>2</b>	
Alaska	1	1	1	10 - 20 L & D
Florida	1			
New Jersey	1			
New York	3			
Mississippi	1	1	1	L & D (number not designated)
<b>CARIBBEAN, THE BAHAMAS AND THE CARIBBEAN</b>	<b>15</b>	<b>14</b>	<b>11</b>	
Antigua and Barbuda	1	1	1	6 TCU-300
Bahamas	2	1	1	12 L
Barbados	1	1	1	12 (type not designated)
Belize	2	2	2	50 L; †
Bonaire	1	1		
British Virgin Islands	2	2	2	20 L; 10 - 12 L
Cuba	1	1		
Dominica	2	2	2	6 L; ††
Dominican Republic	3	3	2	1 L; 12 L
<b>SOUTH AMERICA</b>	<b>12</b>	<b>8</b>	<b>3</b>	
Brazil	1			
Colombia	4	4		
Ecuador	5	3	3	9 L; 5 L; 10 L
Guyana	1	1		
Venezuela	1			
<b>AFRICA</b>	<b>26</b>	<b>21</b>	<b>13</b>	
Algeria	3	3	3	30 L & 20 M, 25 L & 25 M, 50 L, 10 M & 20 CU 7
Angola	3	3	2	4 L & 4 D, 20 L & 6 D
Benin	1	1	1	45 (type not designated)
Burkina Faso	7	7	6	20 L & 10 CU 7, 40 L, 10 L, L, 100-120 L, 24 L
Cameroon	1			
Cote d'Ivoire	1			
South Africa	10	7	1	> 20 L & > 6 D & M
<b>EUROPE AND THE NEAR EAST (TO IRAN)</b>	<b>10</b>	<b>5</b>	<b>1</b>	
Belgium	1			
France	2			
Netherlands	2	1	1	30 L & 4 M
Turkey	4	3		
Yugoslavia	1	1		

43

CU 7 (Copper 7)    TCU (Copper T)    D (Dalkon Shield)    L (Lippes Loop)    M (Majzlin Spring)  
 Has responsibility of insertions - has not reported  
 Has responsibility of insertions - has not begun insertions yet

<b>4 LOCATION OF TRAINEES OF DOWNSTATE'S SE-MIDWIFERY PROGRAM IN FAMILY PLANNING</b>	<b>NO. OF TRAINEE RESPONSES RECEIVED</b>	<b>NO. OF TRAINEES WORKING IN FAMILY PLANNING CLINIC OR HEALTH FACILITY OFFERING FAMILY PLANNING SERVICES</b>	<b>NO. OF TRAINEES RESPONSIBLE FOR I.U.D. INSERTION</b>	<b>NO. AND TYPE OF MONTH- I.U.D. INSERTIONS EACH TRAINEE PERFORMS*</b>
<b>A AND SOUTHEAST ASIA</b>	<b>29</b>	<b>17</b>	<b>7</b>	
Bhutan	2	2		
Indonesia	4	3		
Malaysia	1	1	1	3 - 5 spiral
Philippines	1	1		
Thailand	2	1	1	5 - 8 L
Taiwan	1	1	1	15 L, 5 CT & D
Vietnam	1			
Yunnan	3	1		
Other	12	7	4	10 L, 10 - 15 L; 30 L & 10 TCU 19L **

Physicians are not also offering family planning services in the facility in which the former trainee works.

Your Name

45

Date

Your Present Address

1) What were the dates of the course which you attended at the Downstate Medical College, N.Y

____ / ____	____ / ____
day month	day month
From	To

2) Were you able to stay through the entire course?

Yes

No

3) Are you now working in a family planning clinic or in any type of health facility which offers family planning services?

Yes

No

If "yes":

a) Please give name and address of this facility

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

b) How many hours a week is the facility offering family planning services?

\_\_\_\_\_  
number of hours

c) Please describe the services you personally are now involved in (Specifically, what are you doing?).

*advising, pills, clinic, books*

(Turn over)

d) At this time do you have any responsibility for inserting IUD's?

  
Yes

  
No

Comments: \_\_\_\_\_  
\_\_\_\_\_

e) If "yes," approximately how many IUD's do you insert in a month and what types are they?

Number	Type
_____	_____
Number	Type
_____	_____

f) Are physicians offering family planning services in the facility in which you work?

  
Yes

  
No

How many hours per week?

\_\_\_\_\_ Number of hours

Or, is a physician only on call?

  
Yes

  
No

4) If you are not presently working in a facility which offers family planning services would you please describe your present work:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

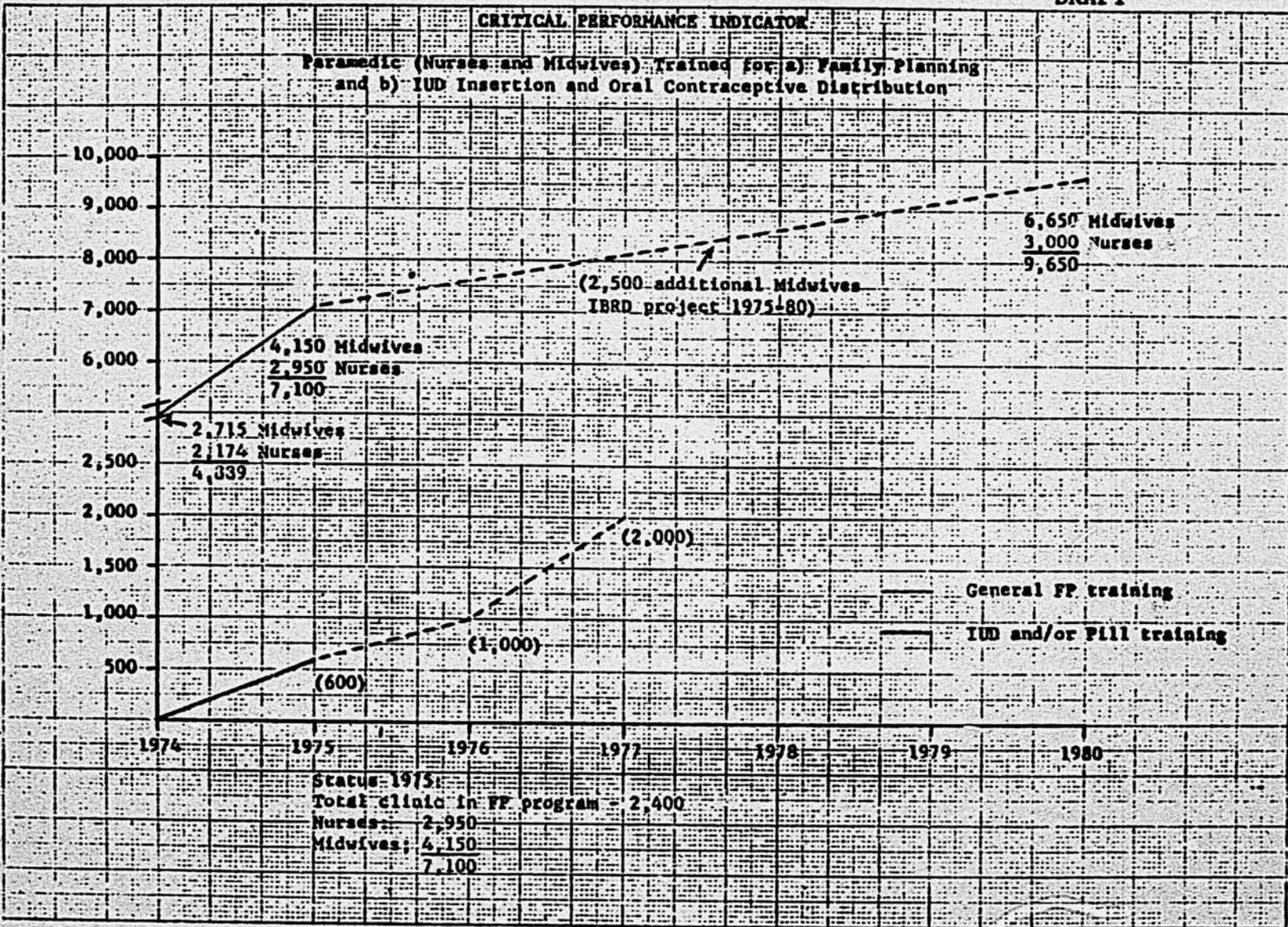
5) Would you like to have your name put onto Pathfinder's mailing list to receive publications relating to family planning/maternal and child health?

  
Yes

  
No

Thank you for your help with these questions. We would greatly appreciate it if you would keep us up to date on the progress of your work and the ways in which we can be of assistance.

DRAFT



AD/POP: July 1975

## SUB-AGREEMENT

between

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

NATIONAL ECONOMIC AND DEVELOPMENT AUTHORITY (NEDA)

and the

COMMISSION ON POPULATION

I. PROJECT TITLE : Community Health Workers (Nurses & Midwives)

II. BRIEF PROJECT SUMMARY

This sub-agreement sub-obligates the amount of P525,000 in accordance with the provisions of the Master Agreement for Phase II Activities.

The Community Health Workers (Nurses/Midwives) Project is a continuation of the existing POPCOM-administered project aimed at training and utilizing nurses and midwives in the delivery of comprehensive family planning services, including IUD insertion and pill dispensation. The main thrust this year (FY '75-'76) is the development of a 2-month training curriculum and the streamlining of implementing procedures for the eventual integration of the project into the regular service programs of the Participating Agencies. The significant activities in this year's program are: a) training of 392 additional practitioners and 10 trainers; b) utilization of 2 or more DOH Regional Training Centers, c) pilot testing of a two-month comprehensive FP Training Program in DOH-RHTC I, VII and XI and IMCH National Training Center. (The original training curriculum is 3 months.)

POPCOM will continue to provide adequate technical and administrative support to the Implementing Agencies until after effective integration of the project into their services will have been realized.

III. BACKGROUND INFORMATION

In pursuance of Presidential Decree No. 79, enhancing the role of nurses and midwives as providers of all acceptable methods of contraception, POPCOM mounted an experimental/demonstration study in FY 1974-1975. This was undertaken in coordination with the Department of Health (DOH), Institute of Maternal and Child Health (IMCH), Jose Fabella Memorial Hospital (JFMH) and Family Planning Organization of the Philippines (FPOP).

The objective of the demonstration was to determine the safety and effectiveness of training and utilizing nurses and midwives in the delivery of comprehensive family planning services, including IUD insertion. To this end, six (6) Training Centers were established; namely: (1) Regional Health Training Center (RHTC) I, Dagupan City; (2) IMCH National Training Center, Quezon City; (3) Jose Fabella Memorial Hospital, Manila; (4) FPOP, Manila; (5) RHTC VII, Cebu City; (6) RHTC XI, Davao City. From these centers, 14 core trainers were selected and sent to Downstate Medical Center in New York, U.S.A., to attend a paramedic trainers' course. Shortly after their training, the Core trainers trained 15 Trainor-Practitioners. To date, a total of 159 nurses and midwives have been trained in comprehensive family planning services.

The nurse-supervisor and physician of the clinic in which the trained midwife or nurse is attached have also been trained to provide them technical supervision and medical support.

Preliminary findings of a study conducted by POPCOM show that it is safe and effective to utilize trained nurses and midwives in the delivery of comprehensive family planning services. No major problems and complications were encountered during the initial program year.

#### IV. PROJECT OBJECTIVES

Following are the general and specific objectives:

##### 1. General Objectives

- a. To implement a nation-wide program on Comprehensive Family Planning for nurses and midwives that is responsive to the needs of the Population Program.
- b. To initiate the integration of the comprehensive family planning training in the curriculum of nursing and midwifery schools through the Professional Regulations Commission.

*if possible  
Suggestion to Streamline  
NOT done*

##### 2. Specific Objectives (FY 75-76)

- a. To develop a two-month training curriculum and to train 80 nurses/midwives and 80 back-up physicians using this curriculum in the IMCH National Training Center and DOH-National Family Planning Training (NFPTRA) Regional Training Centers in Regions I, VII and XI. *best accomplish*
- b. To utilize two or more DOH-NFPTRA Regional Training Centers in the training of nurse/midwife practitioners. *add'l*

*experiment*

- c. To train and develop 10 trainers (8 nurse/midwife and 2 nurse instructors) for the two DOH-NFPTRA Regional Training Centers that will be utilized this year. ) *enail*
- d. To continue to conduct three-month comprehensive FP Training courses for 312 practitioners (nurses/midwives); Refresher courses for 312 back-up physicians; 20 nurse-supervisors; 70 supervisors/coordinators; and 2 Regional Training Center Chief of DOH-National Family Planning Training. ) *on track!*
- e. To regulate comprehensive family planning nurse/midwife practice through standardized accrediting and licensing procedures. ) *not done!*

#### V. STRATEGIES AND METHODS

This program has three components, namely: Training, Service Delivery and IEC. Planned activities per component are described below:

##### a. Training

1. POPCOM will continue to coordinate the activities of participating agencies in the implementation of the training program: DOH-National Family Planning Training Center, IMCH, JFMH and FPOP.\* Training activities will be expanded by utilizing two or more FP Regional Training Centers of the Department of Health.
2. A one-week workshop involving the core trainers and Regional Supervisors will be held in Manila in June 1975. The expected result of this workshop is a revised two-month training curriculum that will be tested in the FP Regional Training Center (RTE) in Regions I (Dagupan City), VII (Cebu) and XI (Davao), and IMCH National Training Center (Manila) from January to March 1976. Performance evaluation of the trainees during this workshop will be conducted in the succeeding months to provide bases for a decision to adopt/reject the two-month curriculum. ) *Final*  
*See green sheet*  
*per very*

---

\*The Comprehensive FP Project of the Family Planning Organization of the Philippines (FPOP) shall be funded in full by the International Planned Parenthood Federation (IPPF) while the Jose Fabella Memorial Hospital's project will be partially funded (40% of total cost) by the Pathfinder, Inc.

Not  
1971

3. A total of 714 nurses/midwives, back-up physicians, nurse-supervisors, supervisor-coordinators will be trained in three (3) batches using the current three-month curriculum. A common training schedule will be followed by the agencies involved in the project: (1) July 7 to September 27; (2) September 20 to December 20; (3) March 29 to June 19. Breakdown of the trainees by type, by training duration and by training institution are presented in Appendices A<sub>1</sub> to 3.
4. Eight nurse/midwife and two nurse instructors will be trained to implement and oversee the comprehensive training program that will be started in two other DOH Regional Training Centers. The Regional Training Center Chief will also be oriented to the Program.
5. The selection of trainees will be based on the following criteria:
  - candidate must be employed by a participating agency;
  - the mother agency or clinic of the candidate must program to reimburse the regular travelling allowance/honorarium which family planning program nurses/midwives are paid (this refer to DOH in particular);
  - candidate must be a registered nurse or midwife;
  - candidate must have completed basic family planning training with one year experience;
  - candidate must possess positive attitude toward her expanded role and be willing to undergo the special training of three months and stay in the family planning service for at least one year;
  - the physician and nurse-supervisor must be supportive of the expanded role of the nurse/midwife;
  - the number of nurse/midwife trainees per clinic will depend on the clinic's client caseload.
6. The practical minimum requirements for the three-month training of nurses and midwives, respectively are the following:

	<u>Nurses</u>	<u>Midwives</u>
IUD insertion	20	25
Complete Physical Exam.	100	150
Pelvic Examination	150	180
Pap Smear	15	15
Pill Dispensing	15	20
Diaphragm fitting	2	1

7. The training curricula of the back-up personnel, namely, the physician, and nurse-supervisor, have also been revised. The physician's 7-day training curriculum utilized during the demonstration has been expanded to 14 days with more emphasis in clinical skills, particularly IUD insertion. The nurse-supervisor's training curriculum will continue to be for two months but with emphasis on supervision.
8. The Professional Regulations Commission has authorized the Commission on Population to duly accredit Training Centers and certify/license graduated trainees according to agreed upon policies and procedures.

*Not done  
? what  
responsibility*

b. Service

1. The potential clients of the nurse/midwife practitioners are generally found in the barrios. They are mostly those who find difficulty in availing of the clinic services. Assessment of the initial project year showed that there have been minimal efforts on the part of the trained nurses/midwives to render ~~services outside the clinic~~ While it is understood that comprehensive services is an addition to a host of other tasks previously performed by the nurse/midwife in the clinic, more efficient management of their schedule is called for. Proper measures which would encourage the practitioners to reach the greater number of potential acceptors will be adopted this year.
2. New reporting format, consolidating existing Form I and Form I-X will be developed.

*role*

c. I E C

In order to generate demand for the services of the trained nurse/midwife, a Region-based campaign using mass media shall be integrated into the program. The campaign consists of posters, radio spots and jingles. A special poster will be developed in 3 languages: Tagalog, Ilocano and Cebuano. These posters will be placed in strategic places readily accessible to the practitioners.

IV. ORGANIZATIONAL STRUCTURE

1. The program functional chart is outlined in Appendix B.
2. The Executive Director of POPCOM, through its Project Staff assigned to this project, will be responsible for the overall management of the project. The project staff is composed of one project coordinator, a medical doctor, who will be hired to work full time on a contractual basis for FY 75-76 and two nurse consultants from DOH who will be detailed on full time basis to the Project.

*Who?  
just in case*

3. The Project Coordinator will coordinate and monitor the activities of the agencies involved and the inputs of the technical and support divisions of POPCOI assigned to the project. In cooperation with the nurse consultants, he will assist the POPCOI Associate Director for Training in the development of the program for the subsequent years. He will liaison with agencies, both here and abroad, engaged in similar activities. He will prepare and submit to the POPCOI Executive Director, quarterly reports on the Progress of the Project.

4. The Nurse consultants will provide technical assistance to the Heads of the Participating Agencies, Regional Health Directors, Regional Training Directors involved in the project. They will provide POPCOI with regular feedback on the progress of the project through quarterly reports and identify program needs, operational problems and recommend solutions as the need arises.

5. Project Officers of the technical divisions of POPCOI involved in the project in coordination with the Regional Population Office, will provide staff support to the Project Coordinator.

6. The Training Division, in coordination with the Planning Division, will evaluate and monitor the project implementation activities and processes against set objectives. The Clinic Services Division will provide back-stop support to the Project Coordinator in service-related activities; and will see to it that facilities in the training clinics are adequate. The IEC Division, will be responsible for the planning and implementation of the IEC program. The Logistics Division through USAID will provide IUD insertion kits. Mission excess equipment will be made available to the training centers, if needed. Supplies included in the Practitioners kit are enumerated in Appendix C.

## VII. FUNDING

Total and itemized financial requirements of this project is detailed in Appendix D.

This project will have a total cash budget of P525,000 for Fiscal Year 1975-1976.

Although the budget has been broken down by participating agency, the Commission on Population may authorize transfer of funds from one agency to another in the list or outside of the list in order to maximize project output. However, any increase or decrease of the total budget for this project shall be strictly in accordance with the 15% flexibility provided for by the Standard Provisions and the Master Sub-Agreement for Phase II Activities.

Who?  
V. Orain?

T. Orain

See Phase

VIII. EVALUATION & MONITORING

In order to determine the extent to which objectives set have been met, monitoring and evaluation shall be built into the project's operational system. Areas for monitoring shall include progress of the various program components: Training, IEC & Service & Management variables. Results/output over a specific period of time shall be assessed and compared against objectives set; also problems encountered and its causes; and fund usage. Monitoring procedures involve the setting up of standardized quarterly reports to be filled out by agencies/groups involved, and the conduct of structured field visits by the Project Staff.

Each training program completed will be evaluated using a pre-during-post design. Operational details will be worked out later.

\_\_\_\_\_  
 Assistant Director  
 UNITED STATES AGENCY FOR INTER-  
 NATIONAL DEVELOPMENT - POP

*[Signature]*  
 \_\_\_\_\_  
 Executive Director  
 COMMISSION ON POPULATION  
 (POPCOM)

\_\_\_\_\_  
 Date

*[Signature]*  
 \_\_\_\_\_  
 Date

wyg  
 6.24.75

**Target Trainees by Type and by Training Institutions\***  
**FY '75-'76**

**Training Institutions**

<u>Type of Trainees</u>	<u>FPRTC I</u>	<u>FPRTC X</u>	<u>FPRTC X</u>	<u>FPRTC VII</u>	<u>FPRTC XI</u>	<u>IMCH</u>	<u>JFMH</u>	<u>TOTAL</u>
Nurse/midwife(Practitioners)	75	40	40	75	80	60	22	392
Nurse/midwife (Trainers)	5			5				10
Nurse Instructors	1			1				2
Back-up Physicians	75	40	40	75	80	60	22	392
Supervisors/Coordinators			70					70
Nurse Supervisors						20		20
DOH-Regional FP Training Chief		1	1					2

55

Only USAID funded training activities are reflected in this table.

Table A<sub>2</sub> outlines total number to be trained in FY 75-76

**TARGET TRAINEES (PRACTITIONERS) BY TRAINING DURATION & BY TRAINING INSTITUTIONS\***

FY 75-76

<u>Training Duration</u>	<u>Training Institutions</u>							TOTAL
	FPRIC I	FPRIC X	FPRIC X**	FPRIC VII	FPRIC XI	EACH	JFMH	
Three-Month Course	55	40	40	55	60	40	22	312
Two-Month Course*	20	-	-	20	20	20	-	80

56

\*The 2-month experimental training program will be conducted from January to March 1976.

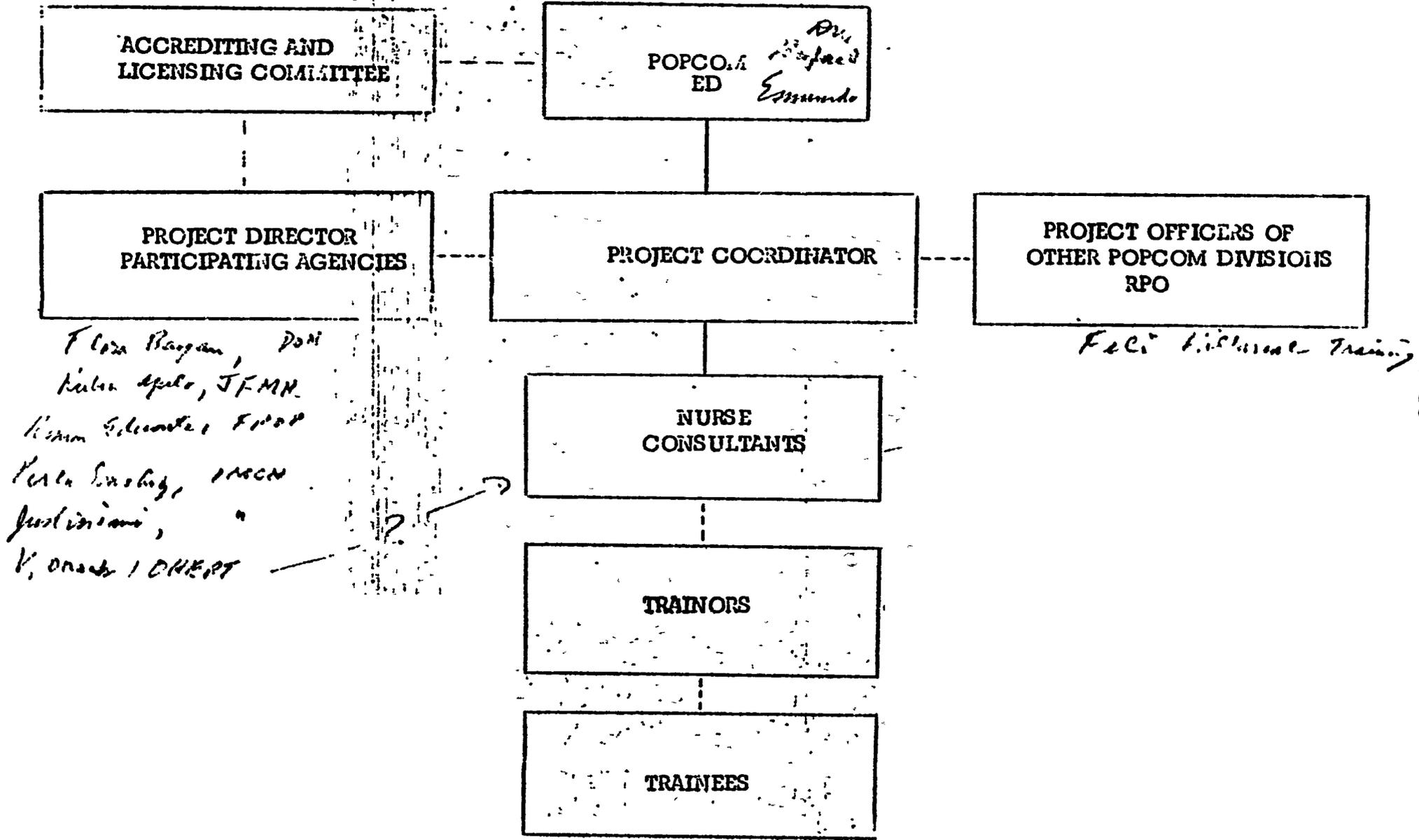
\*\* These regions are to be identified later.

**TOTAL TARGET NUMBER OF TRAINEES BY TYPE & BY AGENCIES**  
**FY 75-76**

<u>Agencies</u>	<u>Trainers &amp; DOH-RTC Chief</u>	<u>Nurse/midwife Practitioners (12 wks)</u>	<u>Nurse/midwife Practitioners (8 wks)</u>	<u>Back-up Physicians (2 wks)</u>	<u>Nurse- Super- visors</u>	<u>Coordinators Supervisors</u>
DOH-NFPTRA	12	250	60	250		70
DOH		40	20	60	20	
JFHE*		40	-	40		
FPOP*		20	-	20		

\*Of the 40 target trainees of JFHE, 22 will be funded by POPCOI-USIAD, the rest will be funded by Pathfinder, Inc. FPOP's Comprehensive FP Program will be funded by IPPF.

ORGANIZATIONAL CHART  
NURSES AND MIDWIVES COMPREHENSIVE PP TRAINING AND SERVICE PROJECT



Appendix C

IUD INSERTION KIT\*

<u>DESCRIPTION</u>	<u>QUANTITY</u>
1- Pan and cover .....	1 ea.
19- Forceps Pean Artery, straight 3".....	2 ea.
17- Forceps, uterine, tenaculum 9 1/2" Braun ...	1 ea.
13- Forceps, gauze, forrester, straight, serrated jaws, 9 1/2 .....	1 ea.
23- Gloves, Surgeon, reusable, latex	
Size 6 1/2 .....	12 pairs
Size 7 .....	24 pairs
Size 7 1/2 .....	24 pairs
Size 8 .....	12 pairs
39- Scissors, uterine, simas, 3" curved blunt-blunt .....	1 pr.
40- Sound, uterine, simpson malleable .....	3 ea.
41- Speculum, vaginal, graves, medium .....	2 ea.
42- Speculum, Vaginal, Graves, Large .....	1 ea.
43- Speculum, Vaginal, Graves, Small .....	1 ea.

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\*Flashlights which will be purchased locally will be included in this kit.

Commission on Population  
Community Health Workers (Nurses/Midwives) Project  
FY 1975-1976  
Phase II

	<u>TOTAL</u>	<u>CENTRAL OFFICE</u>	<u>REGIONS</u>	
			<u>X*</u>	<u>X*</u>
I. POPCOM	<u>67,240</u>	<u>67,240</u>		
A. Personal Services	<u>21,600</u>	<u>21,600</u>		
1 Project Coordinator at P1,800/mo. x 12 mos. (contractual)	21,600	21,600		
2 nurse-training con- sultants, f.t. (detailed from OHEPT)				
B. Maintenance & Other Operating Expenses	<u>45,640</u>	<u>45,640</u>		
1. Traveling Exepnses	<u>9,480</u>	<u>9,480</u>		
a. Reimbursable Trans- portation Expenses				
1 Project Coordinator at an ave. of P475/ trip x 12 trips	5,700	5,700		
b. Per diem & Daily Allowance				
1 Project Coordina- tor at P45/day x 7 days/trip x 12 trips	3,780	3,780		
2. Supplies and Materials	<u>13,000</u>	<u>13,000</u>		
Office Supplies	3,000	3,000		
Flashlights	5,000	5,000		
Bags & Other Supplies	5,000	5,000		
3. Other Services	<u>23,160</u>	<u>23,160</u>		
Evaluation	8,160	8,160		
Production of Mater- ials	15,000	15,000		
II. OHEPT	<u>319,400</u>		<u>159,700</u>	<u>159,700</u>
A. Personal Services	<u>2,000</u>		<u>1,000</u>	<u>1,000</u>
Honoraria				
P50/lecture x 10 lectures/ course x 2 courses x 2 regions	2,000		1,000	1,000
B. Maintenance and Other Operating Expenses	<u>317,400</u>		<u>158,700</u>	<u>158,700</u>
1. Traveling Expenses	<u>42,000</u>		<u>21,000</u>	<u>21,000</u>

a.	Reimbursable Transportation Allowance			
	4 RTC-based trainers			
	at P100/mo. x 9 mos.	3,600	1,800	1,800
	16 Clinic-based trainers			
	at P100/mo. x 9 mos.	14,400	7,200	7,200
	16 Clinic-based back-up Physicians at P50/mo. x 10 mos.	8,000	4,000	4,000
b.	Reimbursable Transportation Expenses			
	80 Nurses/Midwives at an ave. of P100 each	8,000	4,000	4,000
	80 Back-up Physicians at an ave. of P100 each	8,000	4,000	4,000
	Supplies and Materials	1,000	500	500
	Training Materials	1,000	500	500
	Other Services	274,400	137,200	137,200
	Training Stipend			
	80 Nurse/Midwives at P35/day x 84 days	235,200	117,600	117,600
	80 back-up Physicians at P35/d.y x 14 days	39,200	19,600	19,600
		<u>55,300</u>	<u>55,300</u>	
	Personal Services	500	500	
	Honoraria			
	10 lectures at P50/lecture	500	500	
	Maintenance and Other			
	Operating Expenses	54,800	54,800	
	Traveling Expenses	5,800	5,800	
	Reimbursable Transportation Allowance			
	8 Clinic-based trainers at P100/mo. x 2 mos.	1,600	1,600	
	8 Back-up Physician-trainers at P50/mo. x 2 mos.	800	800	
	Reimbursable Transportation Expenses			
	2 Trainers at an ve. of P200 each	400	400	
	20 Nurses/Midwives at an ave. of P100 each	2,000	2,000	

20 Back-up Physicians at an ave. of P50 each	1,000	1,000		
3. Other Services	49,000	49,000		
Training Stipend				
20 Nurse/Midwives at P35/day x 56 days	39,200	39,200		
20 Back-up Physicians at P35/day x 14 days	9,800	9,800		
V. JFMH	<u>83,060</u>	<u>83,060</u>		
A. Personal Services	<u>1,500</u>	<u>1,500</u>		
-Honoraria				
P50/lecture x 10 lectures/course x 3 courses	1,500	1,500		
B. Maintenance and Other Operating Expenses	<u>81,560</u>	<u>81,560</u>		
1. Traveling Expenses	<u>4,400</u>	<u>4,400</u>		
Reimbursable Trans- portation Expenses				
22 Nurses/Midwives at an ave. of P100 each	2,200	2,200		
2. Supplies and Materials	<u>1,700</u>	<u>1,700</u>		
Training Materials	700	700		
Medical Supplies	1,000	1,000		
3. Other Services	75,460	75,460		
Training Stipend				
22 Nurses/Midwives at P35/day x 84 days	64,680	64,680		
22 Back-up Physicians at P35/day x 14 days	10,780	10,780		
<b>GRAND TOTAL</b>	<u>525,000</u>	<u>205,600</u>	<u>159,700</u>	<u>159,700</u>

\* X - These regions are to be identified later.

Assistant Director  
UNITED STATES AGENCY FOR INTER-  
NATIONAL DEVELOPMENT - POP

Executive Director  
COMMISSION ON POPULATION  
(POPCOM)

7/16

## THE POPULATION COUNCIL

P. O. Box 2 - 75

Bangkok 2, Thailand

March 19, 1975.

## Memorandum:

To : Dr. Somsak Varakamin, Director, Family Health Division

From : Dr. Nicholas H. Wright, Population Council

Subject : Paramedical Insertion of IUDs in Thailand

In 1972, a pilot project was organized by you and others with AID and Population Council support to determine whether IUDs could be inserted safely by trained nurses. Forty-three nurses, 18 of them previously trained in clinical family planning at Downstate Medical Center in New York City, were given special training at Chulalongkorn Hospital in three groups. Emphasis was placed on the new Copper T-200 devices although, according to training consultant Jean Burt, some training was given in loop insertion.

Copper T insertions began in late 1972. By November 1973, there had been 3,315 insertions by 32 nurse-midwives. Four nurse-midwives performed 36 percent of the insertions, however, and individual variation in number of insertions was great.

A survey of 1,035 of these-acceptors was conducted in 1974 to assess event and continuation rates, and acceptor satisfaction with nurse insertion. The net event and continuation rates can be compared to other Thai data on physician insertion of Copper T-200 and Loops. The following table shows comparative first segment rates per 100 women at 12 months:

<u>Event</u>	<u>Copper T-200</u>		<u>Loop</u>
	<u>Nurse</u>	<u>Physician</u>	<u>Physician</u>
Pregnancy	0.9	1.0	1.7
Expulsion	2.9	6.6	10.0
Removal	6.4	5.1	4.1
Pain	2.3	3.2	1.7
Bleeding	2.3	1.0	1.0
Other Med.	1.8	0.9	1.4
Personal	3.0	5.0	3.5
Want Children	1.4	2.2	0.3
Other Personal	1.4	2.3	1.3
No Need/Other	0.2	0.5	1.9
Continuing Use	86.8	82.4	80.8

The table presents data collected at home interview plus clinic information for the minority of acceptors (21 percent only for Nurse Copper T sample) who could not be located.

It is clear that nurse performance with the Copper T-200 is comparable to that of physicians. Expulsion rates for the Copper T were somewhat lower, but medical removal rates slightly higher than for physician-inserted cases. As expected, loop expulsion rates were higher still. The slightly higher 12 month net continuation rate for nurses is not due to age and parity differences of the two Copper-T samples.

	<u>Copper T</u>	
	<u>Nurse- Midwife</u>	<u>Physician</u>
Mean Age	28.9	29.0
Mean Parity	3.3	3.7

On the basis of mean parity differences, one would have expected higher medical removal and also expulsion rates among the Copper T acceptors inserted by nurses. Medical removal rates are higher, but expulsion rates are unexpectedly lower. Overall, if the age and parity distributions of the Copper T samples had been the same, the difference in continuation of the Copper T would have been even more in favor of nurse-midwives.

The nurse and physician Copper T samples are probably different in other ways that might favor higher continuation among women inserted by nurses. It was not possible to randomize insertions, so the possibility that nurses selected cases more likely to cooperate and continue use cannot be ruled out.

At home interview, consumer satisfaction questions were asked. Nurses were sometimes present during the interview and this probably led to some bias in the responses, but the results nevertheless indicate broad approval of the nurses' performance. Some examples are:

	Percent		
	Yes	No	Don't Remember/ Not Sure
1. Did the personnel at the clinic explain the side effects of the Copper T completely?	83	16	1
2. Did you have a complete understanding of the Copper T method when you left the clinic?	81	17	2
3. Medical Complaints			
	Yes, treatment	Yes, but no treatment	No
a. Pain at insertion	21	18	61
b. Heavy bleeding, first week	16	29	55
c. Bleeding between periods after insertion	8	33	59

	Percent			
	<u>Better</u>	<u>Same</u>	<u>Worse</u>	<u>Not Sure</u>
4. How do you compare the clinic where the Copper T was inserted with other Government clinics?	60	18	1	22
	<u>Yes</u>		<u>No</u>	
5. Have you suggested to a friend that she should go to the clinic and get a Copper T?	79		21	
	<u>Male MD</u>	<u>Female MD</u>	<u>Nurse</u>	<u>Other</u>
6. If you had a choice, who would you want to insert an IUD?	1	40	41	18

It should be emphasized that, of the Copper T acceptors who sought or needed treatment for early medical complaints (question 3 above), only 2 percent needed to see a physician. Eleven percent were self-treated and 84 percent were dealt with by the nurse.

#### Policy Recommendations

1. The evidence suggests that IUD insertion by specially trained nurses is safe and effective. Early consideration should be given to approval of this practice. (As you know, the number of IUD insertions fell in 1974 for the first time since the NFPP began in 1965.) If approved, refresher training will need to be organized for nurses who are now inserting after informal, local instruction by a physician, and also longer training for nurses who have never performed insertions before. This might be done on a regional level at ECH Centers and large provincial hospitals. Similar training should also be included in the basic nursing curriculum as soon as possible. The 18 Thai nurses with training at Downstate will be able to make valuable suggestions as to how to proceed, and can provide needed supervision.

2. I think the next step is to begin a small, carefully-designed, and well-supervised pilot project to see whether selected auxiliary midwives can be trained to insert IUDs and perhaps handle other gynecological procedures. This is now being done on widespread basis in the Philippines. If the idea can be approved in principle, I think a good proposal could be put together.

NHW:11

cc : Dr. Suwanee  
Dr. Peter Donaldson