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NIGERIA FAMILY HEALTH PROGRAM

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EXECUTIVE SUMMARY

Improved maternal and child health (MCH) is a top priority among the Nigerian government's health objectives. In response to a request from the Federal Ministry of Health (MOH) of Nigeria to the American Embassy, Lagos, Nigeria, a team of consultants, recruited by the American Public Health Association (APHA), went to Lagos in June of 1983. The team was charged with the responsibility of developing recommendations which would enable the Federal MOH to provide increased services in family health, with a special emphasis on family planning services, treatment of diarrheal disease, and immunization.

The APHA team met with a number of officials at the Federal MOH and consulted the state officials and some of the commissioners of the National Population Commission.

At the end of the team's visit, following a final meeting with the Federal MOH, the team made recommendations in a number of areas. These are summarized below.

Training

There is an urgent need to train additional health care providers of all types and "motivators" who can increase the demand for services in diarrheal disease control, immunization and birth spacing. Thus, the team recommendation training at the federal, state, and local levels. It outlined training activities, specified the number of individuals who could be trained, and suggested sources from which they might be drawn.

Uniform Client Card and Services Statistics System

Records should be kept on the contraceptive chosen and the age and parity of acceptors; however, the team felt that it was premature to make recommendations concerning what other information needs to be compiled and analyzed at each level, believing that these decisions should be based on actual experience. However, it did recommend that all levels be involved in projecting their informational needs early on, and that analysis and reporting requirements be kept flexible during the early stages of program implementation. This approach would allow for learning by trial-and-error and for making adjustments in forms, data analysis tables, and reports before investing heavily in a set service statistics system.

Supplies and Distribution

The team recommended that an order for supplies be placed immediately or as soon as an intermediary who will act as the supply agent has been selected. The intermediary should work out the details of port clearance, transportation to the warehouse, and onward dispatch to service delivery points -- hospitals, clinics, and primary health centers. The team further recommended that in the first year of the program, a single distribution facility be established to supply all of Nigeria. Once the mechanics of warehousing and distribution have been established, additional zonal outlets or distribution centers can be established as needed.

Information and Education

An extensive review, the Information, Education and Communication Report, was prepared by the Population Communications Services of the Johns Hopkins University and submitted under separate cover.

Accelerated State Programs

The team concluded that it would be impossible to implement the proposed program in all of the states simultaneously. Therefore, it recommended that three states -- Ondo, Ogun, and Niger -- be provided with technical assistance, training, and commodities in order to accelerate service delivery on a pilot basis.

In order to expedite these programs, the team proposed a three-and-a-half week planning/technical assistance program in Atlanta, Washington, D.C., and Baltimore where information would be given on current methods of contraception and reproductive health care, and on program design and development. The participants would develop specific plans for their particular states, prior to returning to Nigeria.

The program would help the participants to focus more clearly on simple, cost effective, timely interventions. It would also provide those U.S. organizations that will be providing technical assistance and training to the Nigerian states with useful insights and an opportunity to assess needs. Thus the time between project planning and initiation should be shortened.

ACRONYMS USED IN THIS REPORT

AID	U.S. Agency for International Development
APHA	American Public Health Association
CDC	Centers for Disease Control
CEDPA	Centre for Development and Population Activities
CHO	community health officer
FH	Family health
FP	family planning
IEC	Information, Education, and Communication
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MCH	maternal and child health
MOE	Ministry of Education
MOH	Ministry of Health
ORT	oral rehydration therapy
PHC	primary health care
PPFN	Planned Parenthood Federation of Nigeria
TBA	Traditional birth attendant
WHO	World Health Organization

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INTRODUCTION AND BACKGROUND

Purpose of Assignment

While maternal and child health (MCH) has long been a top priority among the Nigerian government's health objectives, a new emphasis was placed on MCH in 1974 with the initiation of the Basic Health Services Scheme since re-named the National Primary Health Care (PHC) System. Among its major goals are the reduction of infant, childhood, and maternal mortality and morbidity rates.

Although the Federal Ministry of Health (MOH) has recognized the role of family planning in improving maternal and child health in the past, few resources have been committed to providing contraceptive services. Program directors, in general, have allocated the majority of their available funds to ante-natal care, attendance at child-birth, post-natal care and child immunization. In fact, until very recently, family planning services provided by the government were extremely limited and were offered primarily in urban areas.

In response to a request from the Federal MOH of Nigeria to the American Embassy, Lagos, Nigeria, a team of consultants recruited by the American Public Health Association (APHA) came to Lagos in June of 1983. The team was charged with the responsibility of developing recommendations which would enable the MOH to provide increased services in family health, with a special emphasis on family planning services, treatment of diarrheal disease, and immunization.

INTINERARY

The APHA team met with a number of officials at the Federal MOH. In addition, they consulted with state officials in Health, Education, and local government ministries in the States of Ondo, Ogun, Sokoto, Niger, Oyo, and Lagos. Finally, they had discussions with some of the commissioners of the National Population Commission.

COUNTRY PROFILE

In 1980, Nigeria was estimated to have a population of 80 million, over 47% of whom were under the age of 15. Although there are a number of surveys currently under way, the 1982 figures of the World Population Data Sheet on Nigeria provided by the Population Reference Bureau are believed to provide the best current estimates of the following basic indicators:

Population	82.3 million
Crude birth rate	50/1,000

Crude death rate	18/1,000
Rate of natural increase	3.2%
Total Fertility rate	6.9
Population doubling time	22 years

At present Nigeria is growing between 2.5 and 3.4% annually, with no evidence of declining fertility. In addition, there has been a fall in mortality rates, currently 17 per 1,000. This situation, particularly if the trend continues, would clearly result in an even greater expansion of the population.

Studies have shown that Nigeria scores low on many basic health indicators. For example, life expectancy at birth is 49 years. Infant mortality is 135/1,000 and the mortality rate for children ages one through four is 28/1,000. In other words, 16.3% of all children born will not survive to the age of five.

Nigerian women have numerous and closely-spaced pregnancies, as previously indicated by the crude birth rate of 50 and the total fertility rate of 6.9. Many of these births occur in women at high-risk: those under 18 years of age and over 35, those having given birth within the past two years, and those of parity greater than 5.

Maternal mortality rates are also high. For example, a recent study in the Ilesha area of southwestern Nigeria documented a maternal mortality rate of 9.18 per 1,000 live births, as compared with a rate of approximately 0.2 in developed countries.

Finally, maternal health risks are also increased by the conditions under which these women must give birth. At the present time in Nigeria, estimates are that there is only one nurse mid-wife for every 1,667 women, and only one physician for every 15,740 inhabitants.

It is now being more widely recognized in Nigeria that the country's rapid rate of population growth has serious economic implications. More and more money must be allocated each year to provide basic social services, including housing, sanitation, education, and health care. These funds must be diverted from investments in other areas, which could promote economic development.

An expanding population has also exacerbated numerous other problems. The first of these is unemployment; the economy's capacity to absorb new labor is now being outpaced by the number of workers entering the labor force each year. In the area of food production, increasing domestic demands have led to a growing

reliance on imports. Finally, rapid growth is occurring in the country's urban centers, some of which are increasing by 8-10% each year.

There has also been an increasing awareness on the part of the public of the advantages of limiting fertility, in spite of the high value which has traditionally been attached to children. Families today, particularly those in urban areas, are anxious to educate their children, and are concerned about the high costs of education. In addition, many couples are starting to recognize that multiple, closely-spaced pregnancies affect the health of both mothers and babies.

Recognition of the seriousness of these conditions has led to a reassessment of the country's social and economic situation by the federal government. Concern over the role which demographic factors are playing in impeding the attainment of development objectives resulted in the creation, in 1979, of a National Population Commission. Its stated function as to advise the president on population matters and to assist in policy formulation and implementation.

The Fourth National Development Plan, 1981-85, calls attention to the negative impact, both social and economic, that demographic trends such as high fertility and the resultant unfavorable dependency ratio are having on the country. The plan states, "Since mortality rate is already on the decline, it is clear that fertility rate will have to move in the same direction in order to bring the overall growth rate of our population down to a level which will not impose excessive burden on the economy in the long run." It further states that the government should attempt to meet this goal by "encouraging the provision of facilities for family planning in its health institutions and educating couples to take advantage of such facilities to regulate the size of their families." Thus, a family planning service appears on a list of preventive service programs "with highest priority of implementation" in the fourth National Development Plan.

In Nigeria, despite the government's awareness of its importance, family planning remains an extremely sensitive issue, both culturally and politically. The concept of "family planning" is associated in some people's minds with control of births for economic or political reasons. Thus, policymakers are sometimes quite reluctant to address the issue, since the allocation of resources for each state is based upon the size of its population.

It was frequently pointed out to the team by government officials that family planning could only be accepted as a health not a population measure. Thus in the program designed by the team, child spacing has been placed within the context of other basic health services, namely oral rehydration therapy

(ORT), and immunization. The training programs and the curricula are aimed at conveying explicitly that family planning is a health measure, taught in the context of an integrated approach.

TRAINING

In recent years, considerable progress has been made by a number of agencies in assisting Nigerians to obtain training abroad and in developing Nigerian institutional capacity for in-country training. However, the MOH has repeatedly stated that it is essential to train additional personnel in family health/family planning skills. Areas which have been identified fall into several categories: planning and management, information, education and communication, clinical and non-clinical service delivery, supervision and evaluation, survey methodology, analysis of survey results, utilization of micro-computers, and curriculum development for all levels of health workers.

Health Professionals in Nigeria

The health professionals who are the most directly involved in actual service delivery fall into the higher echelons of professionals: doctors, community and public health nurses, registered nurse/midwives, registered nurses, and registered midwives. The majority of health professionals in Nigeria are in this group, as can be seen in Table I. Registered nurses and midwives form the largest cadre of health professionals by an overwhelming majority.

Nursing, midwifery, and post degree training are formal degree programs. Both men and women are trained, but the majority are women. The public health nurse must have a minimum of nine years of formal schooling, followed by three years of nursing and a year of public health training. A midwife/nurse also must have a minimum of nine years of formal schooling, followed by two and a half to three years of nurses training. A registered midwife must have the same minimum of nine years, plus two and a half to three years of nursing training and a year of on-the-job training or specialization.

The curricula at these degree levels prepare the students to carry out medical tasks under supervision. The areas in which they can function after graduation are directly applicable to present needs in family health/family planning, diarrheal disease control, and immunization.

Post-degree programs for registered nurses/midwives and public health nurses prepare their students to take leadership roles in health posts, especially in rural health facilities where there are no physicians. Community health officers from the primary health care cadre, previously trained as nurse/midwives or having advanced nursing degrees, may be the ranking professionals in these facilities in the absence of a doctor.

TABLE I

CATEGORIES OF HEALTH PERSONNEL
AVAILABLE FOR HEALTH DELIVERY AS OF 1981

TYPE	1981	1981 GRADUATES	RATE OF INCRE 1980 - 1981
REGISTERED MEDICAL PRACTITIONERS (ALL)	10,399	12 med.. schools	23 %
REGISTERED NURSES	29,962	2,644	9 %
REGISTERED MIDWIVES	24,112	2,518	11 %
COMMUNITY MIDWIVES	2,533	?	9 %
COMMUNITY HEALTH OFFICER	280	26 schools	65 %
CERTIFIED COMMUNITY HEALTH ASSISTANT	2,288	"	45 %
CERTIFIED COMMUNITY HEALTH AIDES	2,371	"	50 %

Dr. B.A.A. Dada (Nov. 1982)

Federal Republic of Nigeria Health Profile - 1981/1982

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The higher echelon health workers are impressive, both in terms of their professionalism and their motivation. From among their ranks come the health administrators and managers who staff ministries of health at both federal and state levels. Actually, it is they, particularly the nurses and midwives, who are currently managing the health service delivery system of Nigeria.

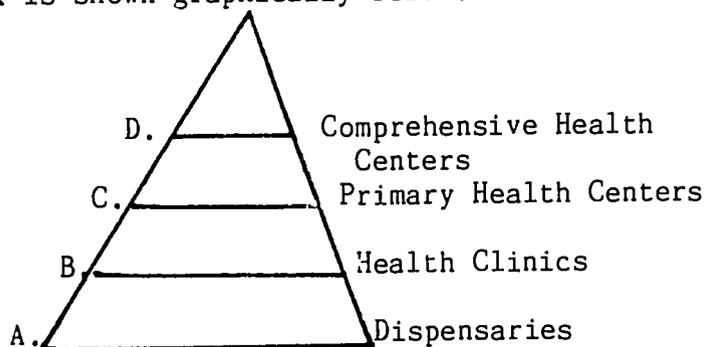
These individuals are key to the delivery of family health services because they are trusted by the medical establishment, recognized as professionals through membership in national associations, credible to the community at large, and able to prescribe contraceptives, to give advice on oral rehydration, and to provide immunizations.

It may also be noted from Table I that increasing numbers of health care professionals are becoming available. The number of physicians is increasing at a higher rate than any other group. There are 12 medical schools in operation at present, and the training is generally considered to be good. In addition, a number of physicians go abroad for post-graduate training in medical specialties and in public health.

The Primary Health Care System

Facilities. The most basic health unit in the Nigerian PHC complex is the dispensary. The facility the next level up is the health clinic. This is followed by the primary health centers; these usually have four to eight beds for MCH, two emergency beds, and four to six overnight beds. The top of the PHC pyramid is the comprehensive health center, usually located in an urban hospital.

The PHC complex is shown graphically below.



The health care personnel normally found in these facilities is given below.

Dispensary

Dispensary Assistant - 1
Community Health Assistant - 2
Community Health Aide - 1

Health Clinic

Community Health Officer - 1
Community Midwife - 1
Community Health Assistant - 2
Community Health Aide - 2

Primary Health Center

Community Health Officer - 2
Community Health Assistant - 4 to 6
Community Health Aide - 8
Midwife - 2

Staff, community health officers (CHOs) are the highest level level PHC workers in the community. They are recruited from several sources.

- . Community Health Supervisors and Assistants
- . Community Midwifery Sisters
- . Higher Rural Health Superintendents
- . Nursing Sisters/Superintendents
- . Trained Nurses/Midwives
- . Post Degree Nurses
- . Sanitary Engineers

The CHO has eleven years of formal education (High School diploma) and a year of training at the Federal MOH in management techniques, logistics, technical education, and supervisory skills. A CHO carries out all the administrative functions of the PHC complex, but it is usually only a nurse/CHO who is given the responsibility of supervising a MCH center or comprehensive health center (these names are used interchangeably). Other CHOs

have less status and, therefore, less responsibility. Nurse/CHOs may carry out the same duties as nurses and midwives and are therefore an important resource for the delivery of family health/family planning services.

Community Health Supervisors are deputy CHOs and are trained in supervision skills. They are selected from the following pools of health-workers:

- . Community Health Assistants (with a minimum of 24 months in the field)
- . Nurses
- . Community Midwives
- . Rural Health Inspectors
- . Assistant Rural Health Superintendents

Community Health Assistants must have a High School diploma, and must complete 24 months as a worker in the basic health services program under the supervision of the CHO or the Community Health Supervisor. Community Health Assistants are responsible for the supervision of Community Health Aides.

Community Health Aides must have a minimum of nine to eleven years of formal education. They receive a year of on-the-job training in family and community health and work as part of the basic health service team. They are supervised by Community Health Assistants.

Dispensary Aides must have a High School diploma. This cadre of community workers accounts for the smallest percentage of existing trained health personnel but represents the most rapidly increasing group in manpower development as seen in Table I.

Services. The delivery of services at the community level is carried out by PHC workers listed above. This health care program is quite new, being only four years old, and is undergoing the usual development problems of federally funded programs being implemented at the state level. As previously described, PHC services are delivered in comprehensive health centers, MCH centers, health centers, and dispensaries (clinics).

In assuming the major responsibility for health service delivery at the community level, the PHC worker plays an important role in preventive health care. PHC workers receive formal training and carry out their duties according to a procedures manual, National Basic Health Services Scheme; Community Health Officers, Supervisors and Assistants Standing Orders, that defines the limits of treatment. Less qualified PHC workers (Community Health Supervisors Assistants and Aides) are

limited by the Standing Orders to referral and resupply of contraceptives. All cadres of PHC workers are responsible for the treatment of diarrheal disease through ORT and for immunization.

PHC workers, as well as the traditional birth attendants (TBAs) who will be described next, will perform increasingly important functions as new community level facilities are developed. They offer certain clear advantages. They are the first available source of service, especially in rural areas. In addition they are the same status as the users; they live where the users live, share their language and culture; and they are therefore trusted by the users.

Traditional Birth Attendants

The role of the TBA in the delivery of health care in Nigeria has been greatly influenced by recent social and economic changes triggered by the oil boom. The need for additional health manpower stimulated the government to sponsor programs for the TBA training.

The functions of the TBA differ considerably from one part of the country to another. Federal government officials sponsoring the training of TBAs are of the opinion that those from the northern states are better accepted and more respected than those from the South. In the North, TBAs are seen as community service providers whose role is described by the community and whose skills are passed on from one generation of women to the next. Conversely, in the South, TBAs are frequently men who gain the respect of their patients more through fear than through technical ability.

The Oni-Segun or herbalist (who is also a TBA) is a multi-purpose practitioner, generally believed to possess supernatural powers. The training and utilization of the Oni-Segun have not proceeded as smoothly in the South as in the North. The untrained Oni-Seguns come into conflict with those who are trained. In addition, those who are trained have tended to expand their services and to demand higher fees.

Practicing TBAs receive three months of training, are given UNICEF kits, and then return to their communities. The government training of the TBAs utilizes the same basic curriculum that is used for the other categories of PHC workers described above. They are taught about basic human reproduction and thus can provide child spacing advice to women. They are also trained to provide immunization referral and to keep records of births and deaths.

Role of Community Based Resources

Local Governments. It is part of the overall plan for improved

health care in Nigeria for each local government to have a health committee. At present, basic services are being provided primarily through community development programs. With continued and expanded training capabilities, these units most likely will play an increasingly important role in the health care system.

Teacher Training Schools. Since they provide direct access to key groups, teacher training schools are next in importance to secondary schools. First, during their schooling, the students are part of the critical 11 to 18 year-old age group. Later, as teachers, they have access to primary and secondary school youth. In addition, in some states in the northern part of Nigeria, some teacher training schools specialize in teaching in Arabic. Thus, teachers from these centers have access to Moslem youth.

Significant interventions are possible within the existing curricula of health education taught at both the federal and state levels. The standard curriculum of all training centers includes courses in such subjects as communicable diseases and family life education. Information on ORT, immunization, and child spacing methods could be integrated almost immediately within the existing curriculum, which would be far easier to accomplish than to add a new curriculum. The MOH has indicated its willingness to collaborate with the Ministry of Education (MOE) in developing this training component.

National Youth Corps. The National Youth Corps Service could also be used to train motivators and providers of ORT, immunization, and child spacing services. The Youth Corps consists of newly graduated university students who are obligated to serve for one year as teachers, health providers, or community development workers in one of the states. National Youth Corps members themselves are a target audience, and later, in their various roles in the communities, they have access to additional critical target groups.

Recruitment of the Youth Corps is carried out by the federal government and, therefore, it is a centralized organization. Training and orientation programs for recruits are carried out initially by the federal government office. Once recruits are posted the state governments take over supervision. Training interventions in child spacing technologies, ORT, and immunization could be given to the students at the time of their induction and orientation, before they go out to their permanent posts.

Organizational and Management Functions in Health

Care Delivery Systems

In order to see how the implementation of relevant programs could be facilitated, it was felt that it might be useful to examine the functional responsibilities for health care delivery

TABLE II

SUMMARY OF FUNCTIONAL RESPONSIBILITIES IN GOVERNMENT.

FEDERAL LEVEL

- . STANDARD PROCEDURES + POLICIES
- . CURRICULUM AND MATERIALS DEVELOPMENT
- . TRAINING OF TRAINERS/TUTORS
- . CERTIFICATION (THROUGH COUNCILS)
- . LOGISTICS AND SUPPLIES
- . INFORMATION SYSTEM
- . DATA COLLECTION, EVALUATION AND RESEARCH

STATE LEVEL

- . TRAINING
 - clinical
 - technical
 - management
- . MANAGEMENT AND ADMINISTRATION
- . SUPERVISION
- . LOGISTICS AND SUPPLY
- . DATA COLLECTION AND ANALYSIS
- . MONITORING, EVALUATION AND REPORTING
- . COORDINATION AND LIAISON WITH LOCAL LEVEL
- . SERVICE DELIVERY
- . PATIENT MANAGEMENT AND CARE
- . HEALTH EDUCATION AND OUTREACH
- . COMMUNITY DEVELOPMENT
- . DATA COLLECTION, ANALYSIS AND REPORTING

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at the federal, state, and local levels. These are outlined below and are shown graphically in Table II.

The responsibilities of the federal government can be summarized as follows:

- . Establishment of standard procedures and policies
- . Development and standardization of materials and curricula
- . Training of trainers and tutors
- . Certification (to be carried out by the Councils)
- . Logistics and supplies
- . Information systems
- . Data collection and analysis
- . Monitoring, evaluations and research

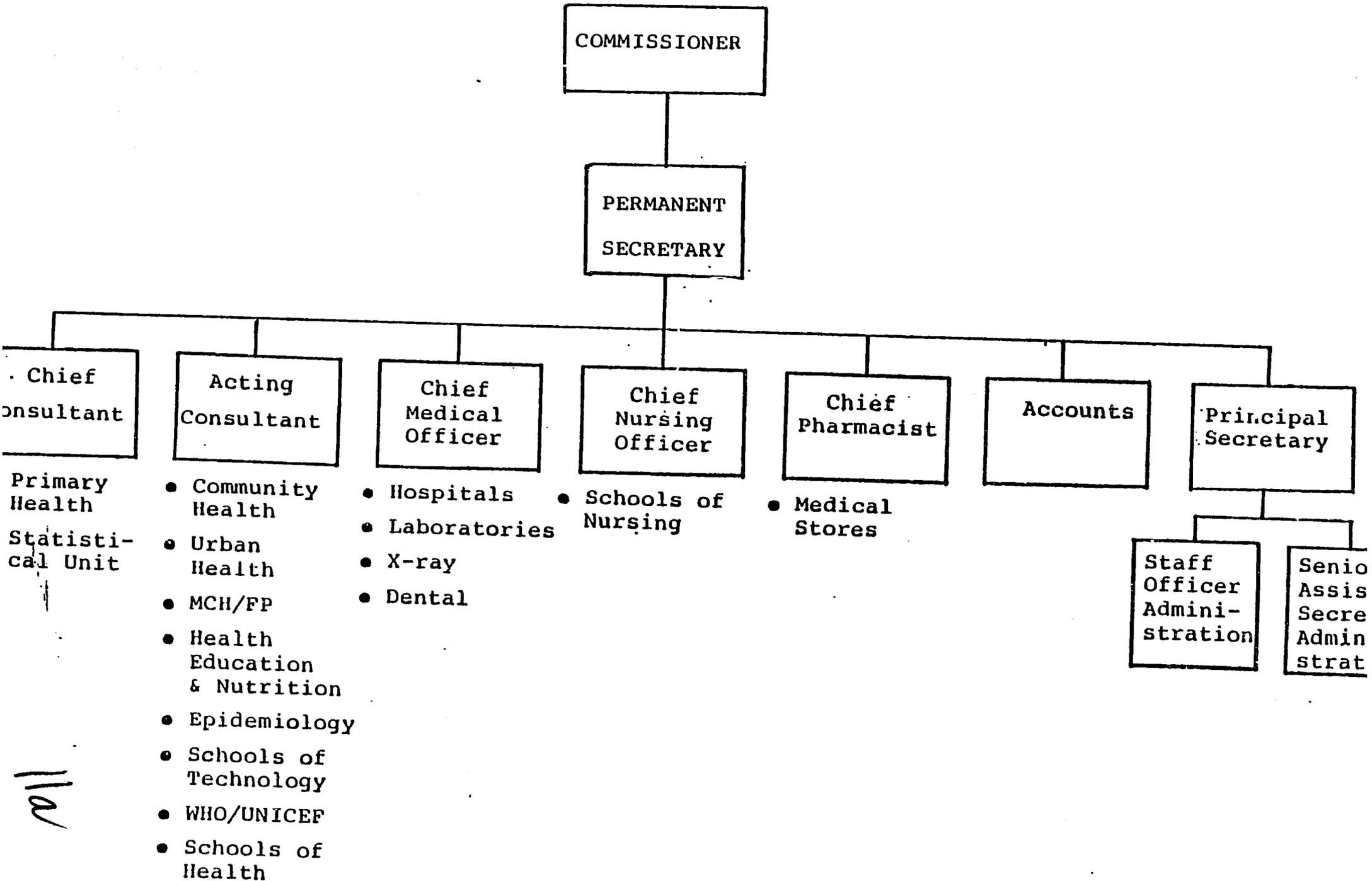
At the state level, the responsibilities fall into the general area of program implementation, as follows:

- . Training in technical, clinical and managerial skills
- . Management and administration functions
- . Supervision
- . Manpower development and allocation
- . Logistics and supplies
- . Data collection and analysis
- . Monitoring, evaluation and reporting
- . Coordination and liaison with local level organizations

The organizational chart of the Niger State Ministry of Health is shown in Figure I, to show who is involved in the implementation of programs and how they are interrelated. While the chart is not directly applicable to all of the other states, it does provide a typical example.

Local governments, in coordination with state governments, have training centers for community leaders. These leaders or "development agents," are recruited from the community. After completing their training, they return to their respective homes.

NIGER STATE MINISTRY OF HEALTH ORGANIZATIONAL CHART



The coordination and liaison functions carried out by the local level with the state level are in the following areas:

- . Service delivery
- . Patient management and care
- . Health education and outreach
- . Community development
- . Data collection, analysis and reporting

Local governmental bodies in the states also have community development programs into which the basic health services of diarrheal disease control, immunization and birth spacing could be effectively integrated. The infrastructure of the local government institutions reaches the grass roots levels in each of the states. Ondo, for example, is divided into nine operational zones, each of which is headed by a senior community development local bodies. Each zone is divided into community development blocs, which consist of a number of small towns and surrounding village settlements. Bloc sub-committees are responsible for various community activities, including such things as women's programs and adult literacy.

Information on ORT, child spacing, and immunization should be integrated into the health component of community leader training curriculum. This step would help significantly in reaching rural communities in Nigeria with improved health care information and services.

Identification of Training Needs, Opportunities and Constraints

Training Needs. In training PHC workers, attention must be focused on health interventions that have the greatest impact on maternal and infant morbidity and mortality. Three core subject areas have been identified by the Federal MOH as critical to the overall implementation of basic PHC services -- birth spacing, diarrhea disease control, and immunization. It is important to note that these subjects are also in keeping with World Health Organization (WHO) initiatives and U.S. Agency for International Development (AID) health policies.

Specific skills and levels of comprehension are needed for competency in each of these areas; however, these will vary by category of worker. Table III outlines the specific skills and competency levels needed by each category of health professional or motivator. Management skills needed have also been included since they are equally important to program implementation.

Training Opportunities. There are three key points at which it

TABLE III

FAMILY HEALTH TRAINING

CURRICULUM	MINISTRY OF HEALTH										OTHER LOCAL GOV'T
	PHYSICIAN	PUBLIC HEALTH NURSE	MIDWIFE / NURSE	REGISTERED MID-WIFE OR NURSE	HEALTH EDUCATORS	HEALTH OFFICER	COMMUNITY HEALTH ASSISTANT	COMMUNITY HEALTH AIDE	TRADITIONAL BIRTH ATTENDANT		
- Not required											
+ Overview											
++ General Presentation											
+++ Detailed Presentation											
FAMILY PLANNING - DIDACTIC											
1 - Counseling											
a) Cultural	+	+	+	+	+	+	+	+	+	+	+
b) Medical	+	+	+	+	+	+	+	+	+	+	+
2 - Reproduction											
a) Anatomy	+	+	+	+	+	+	+	+	+	+	+
b) Physiology	+	+	+	+	+	+	+	+	+	+	+
3 - Technology											
a) Methods	+	+	+	+	+	+	+	+	+	+	+
b) Indications/Contraind.	+	+	+	+	+	+	+	+	+	+	+
c) Side Effects	+	+	+	+	+	+	+	+	+	+	+
d) Effectiveness	+	+	+	+	+	+	+	+	+	+	+
e) Acceptability	+	+	+	+	+	+	+	+	+	+	+
f) Continuation rates	+	+	+	+	+	+	+	+	+	+	+
4 - Infertility	+	+	+	+	+	+	+	+	+	+	+
5 - Sex. Transm. Diseases	+	+	+	+	+	+	+	+	+	+	+
FAMILY PLANNING - CLINICAL											
1 - Clinic procedures	+	+	+	+	+	+	+	+	+	+	+
2 - Clinic supplies	+	+	+	+	+	+	+	+	+	+	+
3 - Patient care	+	+	+	+	+	+	+	+	+	+	+
4 - Record keeping	+	+	+	+	+	+	+	+	+	+	+
DIARRHEAL DISEASE CONTROL											
1 - Rehydration theory	+	+	+	+	+	+	+	+	+	+	+
2 - Rehydration formulae	+	+	+	+	+	+	+	+	+	+	+
3 - Patient care	+	+	+	+	+	+	+	+	+	+	+
IMMUNIZATION											
1 - Mother/Child	+	+	+	+	+	+	+	+	+	+	+
2 - Administration	+	+	+	+	+	+	+	+	+	+	+
3 - Cold chain	+	+	+	+	+	+	+	+	+	+	+
MANAGEMENT											
1 - Objectives	+	+	+	+	+	+	+	+	+	+	+
2 - Workplans	+	+	+	+	+	+	+	+	+	+	+

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is possible to make effective inputs into training during a worker's career: in-school, post-degree, or mid-career training. Each one demands different approaches and methodologies. In a training design for strengthening family health service delivery, these three stages are important entry points for training interventions.

The most obvious and practical way to initiate a program focused on effective family planning, ORT, and immunization is to work within the existing structure of health training institutes. The formal educational programs are well defined and already include some information on all three subject areas. However, these institutions vary considerably in the amount of their resources, the calibre of their instructors/tutors, and in the emphasis they give to these subjects.

The Federal MOH provides guidance to institutions in the form of set curricula. These outline the learning objectives, the hours of instruction by unit and, in some cases, provide samples of learning reinforcement materials (handouts). The actual content of each session is left to the individual instructors. There is an excellent opportunity to standardize the curriculum by creating plans for each session of the units on the three subject areas.

These session plans would include an instructor's guide that would provide a theoretical framework for the subject area. It would include quotations from standard medical texts, excerpts from recent journal articles and manuals developed by WHO and other relevant organizations. The session plans would be divided into time units, each with its learning objectives and a text that the instructors could either follow or adapt, as appropriate. The plans would also give instructions for a clinical practicum and set a standard number of hours to be devoted to hands-on clinical experience. Handouts for each session would be provided which could be cyclostyled or copied by the students. Thus, at the end of each unit they would have developed a set of reference materials for later use.

Introducing session plans of this sort as a supplement to the existing curricula would standardize and update technical information, build in practical experience, provide a more participative methodology, and reinforce learning through handouts.

An example of such a session plan, an outline for clinical training, is included in this report as Appendix D. The actual content and degree of emphasis would vary depending on the level of trainee, as noted in Table III.

There is an opportunity to train recent graduates to use the new session plans during the six week period between graduation and certification. This would test the new curriculum before it

was formally introduced. If the curriculum is to be introduced simultaneously in all institutions, this "testing" should be done on a one-time-only basis. If, on the other hand, the curriculum is to be introduced in phases by different states, each graduating class could be trained in the use of the new plans until they are universally adopted.

Providing experienced personnel with additional training is an exciting opportunity. Mid-career training can serve to bring personnel up-to-date and to add to their technical knowledge and skills. It also offers an opportunity to provide management training to those workers who have had management responsibilities added to their job description.

The design of mid-career training must be based on adult learning principles. The prior work experience of the participants should be utilized to provide problem solution opportunities, case study methodology, and active participation in clinical and classroom work. At this level of training the instructors can benefit from the participants' real life experience. In this way, the training can be refined over time to be highly relevant to actual service delivery needs.

Training Constraints. There are numerous constraints to the rapid implementation of these training inputs. First, it may be difficult to reach a consensus on the course content at the Federal level. Second, the session plans must be adapted to the various levels of students, i.e. nurse, midwife, post-graduate, nursing and PHC workers. Third, the session plans must be integrated into the institutions' set curricula at the state level. Fourth, additional resources will be required for mid-career training. Finally, there is resistance to changing the Standing Orders to conform with the more current information on the treatment of certain conditions (e.g., the side effects of contraceptives and feeding during episodes of diarrhea). If the Standing Orders are not changed, confusion will be created by the new curriculum content.

Strategy

Training Institutions. Adding relevant basic health training to the existing training programs would require interventions on the national, state, and local levels. To speed the implementation and acceptance of these health-related interventions, the following three phase approach could be used:

1. Key personnel at the federal level would be trained so as to familiarize policymakers in non-health areas with the three areas of intervention. At this level, a committee not more than five professionals directly involved in the implementation of services would receive training focused on the importance of the three areas.

2. Federal organizations would demonstrate their commitment to the need for additional training in the three basic areas by strengthening the standard training curricula with the new information.
3. At the state and local levels, relevant staff at existing institutions would be trained to utilize the standard session plans in diarrhea disease control, birth spacing, and immunization.

Interventions Outside the Health Structure. Limited resources and lack of skills act as constraints to strengthening the health related services and should be corrected by local government bodies. The training of trainers in the relevant health technologies and in communications skills would be logical first step. Information, Education, and Communication (IEC) materials that are developed for other health educations and motivators could be used effectively as back-up to the relevant standard session plans. For example, Appendix C enumerates the materials requested by the Ondo State local government.

Training for motivators should be implemented in those programs which are already in place. Strengthening of existing capabilities would require training key personnel at the federal level so as to familiarize policymakers with the subjects of family health/family planning. In addition a formalized curriculum at both the federal and state levels should be instituted and relevant staff members at existing institutions should be trained to utilize the standard session plans and IEC materials in oral rehydration, birth spacing, and immunization.

Finally, attempts should be made to increase, in every way possible, the demand for basic services in immunization, oral rehydration, and child spacing. It is particularly important to reach the Nigerian youth since they are potential users of these services and they constitute almost half of the national population. Therefore, efforts should be made to integrate these three subjects into the existing training programs of community leaders, teachers, and National Youth Corps. This will not only educate the youths themselves in these basic health areas, but will also provide future trainers for other youths.

UNIFORM CLIENT RECORD AND SERVICE STATISTICS SYSTEMS

Uniform Client Record System

The Nigerian Health Planning Board has expressed its desire to establish a uniform client record for all clinics and hospitals delivering family health services. Such a uniform system can be an excellent management tool as well as a training aid, particularly in the case of family planning services, since this is an area of expanding activity in Nigeria.

There are a number of client records in use in Nigeria at the present time. In general, they all collect the information required by both administrators and medical personnel in the clinic. However, it might be simpler to analyze the data if information on client characteristics and choice of contraceptive method was separated from the medical information (results of physical examinations, medical history, etc.).

A good client record should have the following characteristics.

1. It should not interfere with clinic operations.
2. It should not require more than ten minutes to complete.
3. It should be easy to use.
4. It should be inexpensive, both in terms of printing and in use of labor.
5. Information for reporting or evaluation should be easily abstracted from it.
6. It should serve as an ongoing aid for staff training and for quality control of the services provided.
7. It should be expandable, so that additional information be added at a later date if the program expands.
8. It should be usable at most levels of sophistication.

A model client record card is shown in Table IV. General information about the client is collected in the first part of the client card; the second is used to record medical information.

A two-part client card is well adapted to a triage approach to staffing a clinic. That is, a receptionist or nurse's aide can be used to interview the client and fill in the general information in the first part. If the client falls into the high risk group of women (e.g., older, high parity), she can be referred to a clinician with more training and experience.

TABLE IV

MODEL CLIENT RECORD CARD

A. General Information (Part I)

1. Clinic identification
2. Client identification number
3. Client's name
4. Client's address
5. Age
6. Education
7. Number of living children
8. Number of other pregnancies and their outcomes
9. Months since termination of last pregnancy
10. Method previously used, if any.
11. Months since terminating use and reason for termination
12. Method elected and date

B. Medical Information (Part II)

1. Last menstrual period
2. Blood pressure
3. General history
4. Examination (general, pelvic)
5. Pregnancy history

Front		Back	
Personal: Medical		1	
data	: Record	2	Follow-up
		3	detail
I	II	4	III

C. Follow-up Record (continuation sheets)

1. Date
2. Complaints and treatment

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Otherwise, the client can be referred to another clinician with less experience. In this manner, staff time is used to its best advantage.

In order to implement this program, a forms design specialist -- preferably a person who combines this skill with knowledge of the computer -- should be brought in to design the card.

Service Statistics System

The data collected on the client cards can be used in three ways:

1. Patient Care - To assess the client's response to her contraceptive method over time and in relationship to her medical history; to adjust the pill dosage; to change the type or size of the IUD, or to advise the client to switch methods if necessary, etc.
2. Administration - To monitor and thus be able to adjust the quantities of contraceptives to be supplied to specific clinics or administrative areas, based on the observed method mix; to monitor new acceptor and client continuation rates in order to project staffing, equipment, space, and commodity needs, etc.
3. Program Evaluation - To monitor aggregate new acceptor rates, continuation rates, and complication rates; to assess deviations from medical protocol; to identify needs for in-service refresher training; to monitor the characteristics of users of different methods (age, which motivational, counseling, and service delivery methods are well adapted to the users, etc.

Since data collection and analysis are time consuming and costly, they should be done principally in order to provide information to those who need to make decisions. Certain administrative decisions will be made at all levels. Such things as staffing patterns will be established or adjusted at individual clinics; whereas, the deployment of staff will be decided at the state or state area level. Patient care decisions are almost always made at the clinic level. However, evaluation and research questions may be raised and require answers at all levels. For example, the clinic director may wish to know if client discontinuation is a problem so that follow-up home visiting can be initiated. Training requirements will need to be assessed periodically at the state and federal levels. Finally, information about complication rates, by method, will need to be assessed at the national level in order to formulate and test policies.

The service statistics system should be able to give

managers at all levels -- local, state and national -- a quick overview of the temporal changes in contraceptive preference, the extent to which the outreach workers are contacting the most critical target groups and the number of acceptors who discontinue the method recommended for whatever reason.

COMMODITY SUPPLY AND MANAGEMENT

The Nigerian federal government should reserve for itself, under the Health Planning Board, the procurement and distribution of contraceptives and selected medical supplies. In order for central procurement to function effectively, it will be necessary to establish three interrelated activities:

1. A centralized projection of requirements, based on a projected acceptor rate for the cohort of eligible women and a minimum stock-in of all modalities at all potential supply points (720 hospitals and 1,300 clinics in 1986).
2. A commodity management and logistics system that is responsive to and can measure, in a timely manner, the drawdown against the initial stock, in order to avoid outages or over-stockings.
3. A uniform client record and service statistics system (as discussed in the previous section of this report) that will enable management to verify overall utilization levels, changes in contraceptive preferences, changes in characteristics of users and changes in acceptance rates.

Estimating Contraceptive Requirements

According to the best estimates available, the current level of contraceptive use in Nigeria is less than 2% of all eligible couples, although there may be some couples practicing traditional methods of fertility control who are not included in this figure. Estimates of annual sales of oral contraceptives through the private sector are less than one million cycles for all companies combined. The current birth rate of 50/1,000 and the 3.2% rate of population growth are near the maximum for human reproduction. Hence, it is safe to assume that family planning programs are in the very early stages of development. Furthermore, the effectiveness of the existing programs are limited by sporadic and inadequate supplies of contraceptives.

A model of contraceptive requirements for one million women, 15 to 44 years old, with contraceptive preferences observed in pilot programs in Nigeria, is presented in Table V. The quantities required assumes coverage for 10% of the eligible women for one year of use. The model further assumes that 15 to 44 year old women make up 20% of the total population.

Using these assumptions, it is possible to estimate the requirements for the separate states and for Nigeria as a whole. Since there are 16 million eligible women in Nigeria, 16 times the total shown in the model would be needed to provide the

TABLE V

SUPPLY REQUIREMENTS

<u>Contraceptive</u>	<u>Distribution of Users</u>		<u>Quantity Required for 1,000,000 WRA (10% prevalence)</u>	<u>Quantity Required for all of Nigeria 16,000,000 WRA (10% prevalence)</u>
	<u>Percent</u>	<u>Number</u>		
Oral contra- ceptives	30	30,000	390,000*	6,240,000*
Depo Provera	10	10,000	40,000	640,000
IUCDs	25	25,000	25,000	400,000
Condoms	30	30,000	3,000,000	48,000,000
NeoSampoon	<u>5</u>	<u>5,000</u>	500,000	8,000,000
TOTAL	100	100,000		

Estimated supply requirements for a population with one million women (ages 15-44), assuming coverage for 10% for one year as a start-up supply level.

* Recommended ratio of 40% = .1 + 50
60% = .50-35

Assuming that the low dose pill is the initial method issued to new users.

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requirements for 10% of the women 15 to 44 years old in the nation (Table V, column 5). In accordance with these calculations, action should be taken as soon as possible to order 7.3 million cycles of oral contraceptives. If the decision is made to use the .50-35 as the contraceptive at first issue, the distribution should be 60% to 40% or 4,700 cartons of 1,000 cycles each and 3,000 cartons of 1-50. AID could also provide an Ortho Vaginal tablet and Copper - TS as well as condoms. The latter are packed in cartons of 40 boxes of 1,000 units each, so it would require 12,000 cartons to fill the 48 million initial requirement.

If the federal government is unable to purchase Depo Provera - 640,000 doses - with government funds, they should seek support from other donors for this commodity. At present it is not available through the commodity procurement program of AID.

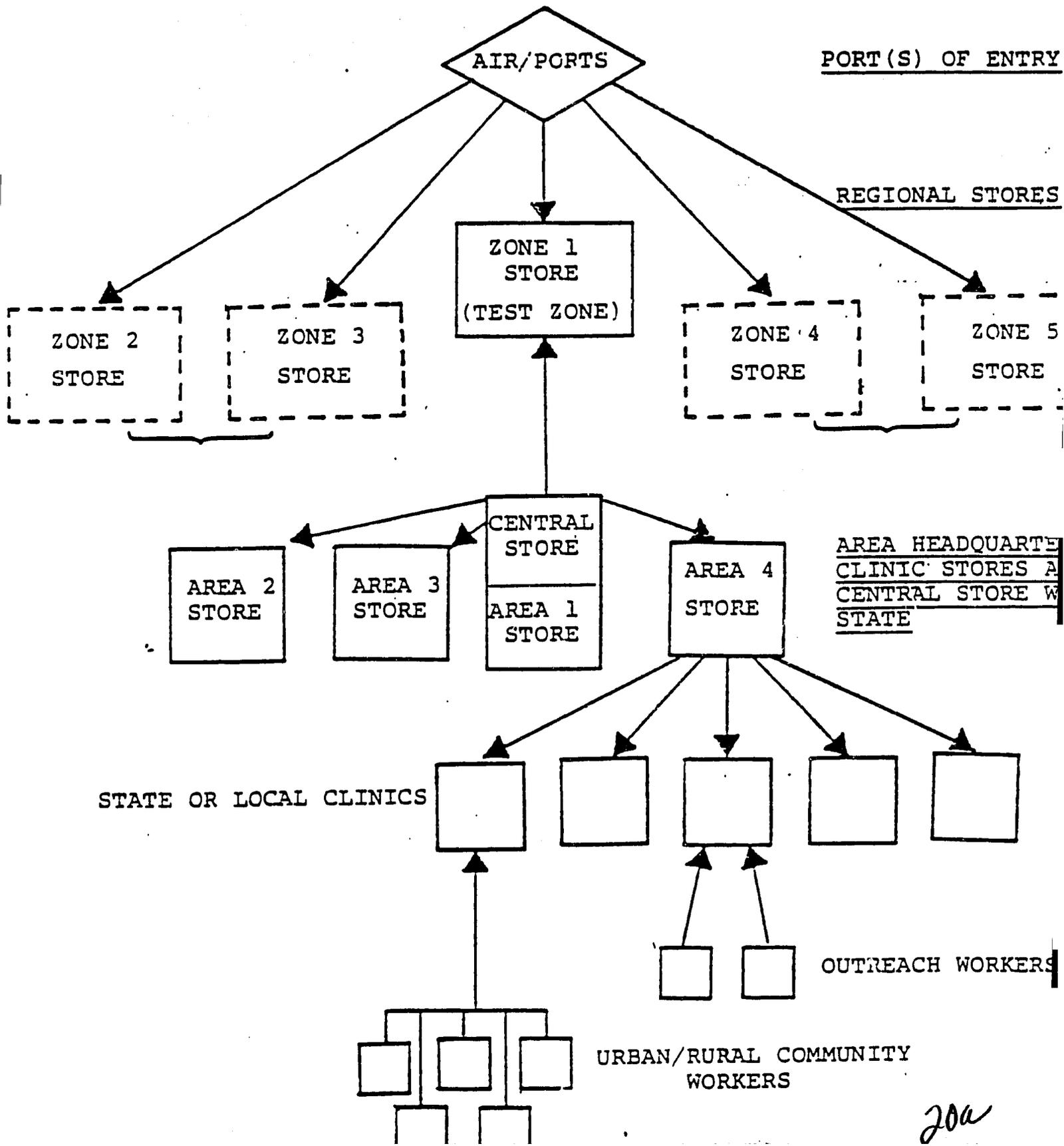
Logistics Management

The present commodity supply system is project-specific, no interrelationship having been established between or among the various projects. For example, the evaluation team found 6,000 cycles of Noriday in Blue Lady packets of 3 cycles at the Maternity Hospital Clinic in Lagos, whereas other clinics were hoarding scant supplies of oral contraceptives in order to resupply continuing users. New clients are frequently sent into the marketplace to find either injectables or IUDs which the clinic personnel then administer or insert. Alternatively, a few clients are provided with pills donated by a number of pharmaceutical companies including Wyeth, Schering, and Organon.

The Federal Planning Board proposes to establish a system for federal procurement and commodity management. Since there is no bilateral program, it will be necessary to work out an arrangement whereby an intermediary can establish a presence and develop a logistic management system. The system envisaged is shown in Figure II. Eventually there will be five zones with a commodity warehouse at each zone headquarters. The draw-down against warehouse stocks is dependent on state program initiative. The states will requisition the needed supplies and send their own trucks to pick them up from the zone warehouses. It is further envisaged that the zone headquarters will have the necessary transport to pick up their allotment from the custom shed at the port or warehouse.

FIGURE II

COMMODITY SUPPLY SYSTEM



INFORMATION AND EDUCATION

A full discussion of this topic may be found in the Information Education and Communications Report prepared by the Population Communication Services, Johns Hopkins University, in June 1983 at the request of the Federal MOH of Nigeria. The following is a general summary of that report.

Recently, the concept of providing family health IEC to the public has become more acceptable to the government of Nigeria. There is a severe shortage of IEC materials, however, and to date very little family health (FH) or family Planning (FP) IEC has been undertaken on a national scale.

This document is a five-year comprehensive national plan for the development of FH/FP IEC programs and activities. It is meant to be implemented along with parallel plans to provide FP commodities, FP client information systems and FH/FP training and manpower development.

The plan consists of four sections:

1. background on current FH/FP IEC activities and private and public sector resources;
2. needs, opportunities and constraints;
3. overall strategy; and
4. proposed programs and activities, including estimated budgets and timetables.

The first two sections are the basis for the overall strategy, detailed in section three, which discusses audience segmentation, message design, and media selection, and also outlines evaluation protocols and parameters. Finally, three specific projects are proposed, as well as an overall monitoring and evaluation system. A two-pronged approach is recommended which would seek, first, to improve the IEC capacity of the federal MOH and, second, to support several non-governmental organizations in three innovative projects.

1. The largest project, to be implemented by the Federal Health Education Division under the Federal MOH, would assist the federal government to provide support to the states in FH IEC. The project would utilize the extensive government health systems as distribution channels and, hence, provide visible proof to the states and the Nigerian people of official government support of FH/FP. Estimate five year cost: US \$2,770,000.

2. Another program, proposed with the Planned Parenthood Federation of Nigeria (PPFN), the Nigerian affiliate of the International Planned Parenthood Federation, would develop FP IEC materials (non-integrated) for specific hard-to-reach audiences. Although PPFN is a major FP service provider, its main role is FP IEC. The project would help expand PPFN capabilities and develop several specific campaigns. Estimated five-year cost: US \$1,172,000.
3. A smaller project with the Association for Family Life Education in Ibadan, would develop FP IEC materials for unmarried, sexually active youth. Estimated two-year cost: US \$237,000.

The estimated cost of the overall monitoring and evaluation over five years is US \$280,000, thus the total for the entire five year IEC plan is estimated to be US \$4,459,000.

GENERAL CONSIDERATIONS

The team was in Nigeria for three weeks. It met several times with various officials at the Federal MOH. However, most of its time was spent meeting with State Ministry of Health officials and key personnel in five states. In order to try to gain a better understanding of this vast and varied country the team visited a number of states.

1. Sokoto State, a large semi-arid region with a widely scattered population of 8.5 million.
2. Niger, one of the smallest states with the lowest per capita income and lowest population base (1.9 million), set in the central plateau area.
3. Ogun, another small but rich state on the Western Atlantic coast with a population of 2.5 million.
4. Oyo, a large densely populated state (8.5 million) in the tropical forest region in the west.
5. Ondo, a middle sized state in Central Nigeria with a population base of 3.0 million (probably underestimated).

Program Constraints

The climate in these various areas is both extreme and severe and is a major constraint to both program development and implementation. There are major roads allowing access to the main cities, but roads to minor cities and villages are unpassable during much of the rainy season. Furthermore, air transport is limited during the time of the harmattan winds.

For a country which has been independent for only 23 years, Nigeria has made remarkable progress, especially in the field of education. There are, for example, 12 universities with faculties of medicine. Attainment levels in primary and secondary school enrollment, however, vary widely from one state to another. Thus, Ondo has achieved close to 90% enrollment in both categories; whereas Niger has probably not yet reached 50%. In addition, there is a marked difference in the male/female enrollment ratio with rural females being significantly under-represented. Clearly these conditions make it difficult to implement health and family planning activities, particularly in certain parts of Nigeria.

Another constraint to successful program implementation is the unreliable communication system -- postal, telephone, and telex. This has a negative impact on logistics systems and

is not expected to improve significantly in the near future. Unfortunately unreliable communications are a fact throughout the country, even in Oyo State which has the largest city in Africa and two fine universities. For example, there is only one telephone in the Medical School in Ife University.

There are also fiscal constraints. In these days of austerity, caused by the drop in oil prices, Nigeria has made deep cuts in imports. Drugs imports are severely curtailed; the Federal MOH is purchasing no contraceptives and only a small amount of equipment. State budgets are tighter. For example the country did not even purchase sufficient Rinderpest vaccine to protect their 18 million head of beef cattle.

Health Constraints

There is a general fear in Nigeria of taking medicine such as oral contraceptives or malaria suppressants on a continuing basis in the absence of pain.

In addition, the fact that most females marry very young results in high rates of maternal and infant morbidity and mortality. The problems in nutrition and sanitation are severe and far from being solved.

Another hurdle to be overcome is the general lack of knowledge about modern contraception, immunization and oral rehydration, even among health professionals. Thus, it will be necessary to upgrade the level of training in all three of these areas.

Cultural Constraints

The lacunae in knowledge about the health benefits of family planning are compounded by a number of cultural constraints, the most important of which is the high value placed on large family size. Historically, a man's wealth and power were measured by the number of his offspring, particularly his sons. Moreover, Nigerian males are said to be opposing contraception because it might encourage female promiscuity. This may account, in part, for the fairly large number of condom acceptors among men who will not allow their wives to use contraceptives.

Migration to the large cities has ameliorated some of these cultural impediments. One would therefore expect a lower birth rate in the cities. Unfortunately, modern contraceptive usage remains low, in part because of the high cost for a cycle of pills and scarcity of contraceptives, even in Lagos. Moreover, urban couples have largely abandoned their traditional means of birth spacing, i.e., abstinence and two year breast feeding. A recent UNICEF survey indicated that only 20% mothers in Lagos nursed their infants beyond three months.

Because of perceived opposition to birth control (not birth spacing) by some religious groups, many politicians are sensitive to family planning as a subject for open discussion. Finally, as noted earlier, female illiteracy is high in most rural areas and in large areas of the northern states women are kept in purdah.

Team Observations

In spite of these multiple constraints, the team found much that was encouraging for undertaking an integrated nationwide program in family planning, oral rehydration and immunization. Two major positive changes are developing concurrently in Nigeria which are, in turn, reinforcing each other. First, the federal and state governments are modifying some of their policies. Second, potential acceptors of contraceptives are changing their attitudes toward contraception.

The current Five Year Plan has built demographic considerations into its development equations. Planned Parenthood Federation of Nigeria (PPFN) has worked actively to promote these concepts and has persuaded the president of Nigeria to serve as its honorary president. In addition, 11 of the nineteen governors are serving as honorary vice presidents.

The chairman of the National Population Commission has accepted family planning as a means of reducing maternal and infant morbidity and mortality rates and the rates of venereal diseases, sterility, and abortion. Family planning allows couples to space their children in a voluntary manner without resorting to illegal abortion. The chairman is not yet completely convinced that Nigeria has a population problem, but a number of his commissioners have identified the rapid rate of population growth as a major impediment to Nigerian development plans.

With regard to policy modifications, a number of recent changes have occurred under the dynamic leadership of Dr. Sulaiman, Director, National Health Planning and Research. Family planning is now an integral part of the basic health services developed by the Federal MOH and implemented by the State Ministries of Health. However, to date this plan has been more in principle than in deed because of the lack of contraceptives and the need for a fully trained staff.

Attitudinal changes are also taking place in Nigeria. It is difficult to categorize completely and accurately all of the reasons for the recent interest in modern contraceptives. No doubt, increased knowledge of the health benefits of family planning has played a major role. While there has been little coverage of the subject in Nigerian newspapers, which do not reach rural areas in any case, there has been full coverage including method-specific information on both local and national television stations. These programs, produced by State

Ministries of Health and PPFN, have been aired at no cost as a public service. Family planning programs had been shown, with no adverse public reaction, in every state visited by the team. Two states had shown TV programs in which teenagers were being given method-specific information. Some states, including Kano, a traditional society with a population of 9.5 million, have associated the economic welfare of the family and community, as well as family health, with contraceptives usage.

The team was advised that most men want to use family planning today because of economic conditions--the high cost of raising and educating children and the high unemployment rates. Most women want a rest from near-constant pregnancies. The third most frequently given reason was that both partners want to resume sexual relations after the birth of a baby without running the danger of the wife becoming pregnant too soon. Students want contraceptives so that they can complete their education. In one large city, the CMO advised the team that 60% of secondary school students are sexually active but are grossly uninformed about family planning and have limited access to services.

The health staffs of most of the clinical facilities are basically well trained and highly motivated. At every site the team visited, including several unannounced stops, the staff, chiefly nurses and midwives, were eager to add family planning to their services. Their chief constraints were lack of supplies and a need on the part of some for updated training in service techniques.

Unlike many countries, developed and otherwise. Nigeria is blessed with enlightened physicians who favor an arrangement whereby nurses and midwives provide family services. In contrast to physicians, who move quite frequently, nurses and midwives are assigned to the same clinic for years at a time and become trusted confidants of those attending the clinics. Nurses and midwives are well regarded in the community as role models. They also play key roles in developing health policy at the national and state levels and are more active than physicians in health promotion on TV and radio shows. Also, in contrast to most countries, Nigeria has a formal policy and curriculum to upgrade and certify TBAs and to add family planning knowledge and motivation to their skills.

With one exception, the clinics visited by the team were clean and well attended and had adequate space and time to add family planning services. Some equipment and all contraceptive supplies are required, however, to make them functional.

In brief, in spite of the enormous obstacles to the mounting of a national program in this fourth largest democracy in the world, the team is convinced that support in materials and training would enable the proposed program of the MOH to make a significant improvement in health and fertility rates over the next five years.

RECOMMENDATIONS

Training

The findings of the team and the expressed requirements of Nigerian government officials both demonstrate an urgent need to train additional health care providers at all levels. In addition, there is also a clear need to train motivators who could increase the demand for the delivery of basic health services in diarrheal disease control, immunization, and birth spacing. These motivators could educate target populations, particularly youths and mothers, about the importance of these services in contributing to the well being of the family.

In order to meet both the service and motivational needs, multiple training activities will be required. To reach the goals set by the Nigerian government, a key first step is to make services available to those who want them. At the same time, information programs should be developed to advise the public of their desirability and availability.

There is not enough data to make an accurate assessment of the amount of training required in order to provide adequate coverage in basic services of ORT, immunization, and child spacing. The recent addition of PHC services and the added categories of auxiliary health care providers will no doubt improve the services in these essential areas. However, these auxiliaries possess a wide range of skills and it is very difficult to determine whether or not they are able to deliver the basic services in ORT, birth spacing, and immunization.

Additional personnel who could provide information on these important health services would significantly help to reduce childhood mortality, improve the health of mothers, and reduce the high rate of adolescent pregnancy. Training programs that could substantially increase the pool of motivators at a minimum cost are an economically viable and realistically possible option. Institutions with access to the key target populations are in place. Furthermore, in most cases, a general educational system is also available. The strengthening of existing curricula with additional relevant information is a significant first step in training personnel. However, despite the urgent need to provide training for front line workers, this should wait until the curricula are revised. Training should then proceed simultaneously with curriculum changes.

Training should be carried out at the federal, state and local levels to try to meet the stated needs of the Nigerian Ministry of Health.

At the federal level the following options might be

considered.

1. Increase the centralized training resources for midwives so that more can be trained. At present, there is a proportionately larger number of physicians than midwives.
2. Hold a workshop on developing curricula for family planning, immunization, and ORT.
3. Develop a training course for the national co-ordinator in family planning, the national IEC systems, and the National Patient Record system.

At the state level:

1. Develop a training course for the State co-ordinators in family planning and management, patient information, and patient record systems.
2. Institute training to upgrade the skills of clinic personnel in family planning. This training should include information about new and existing family planning methods, management skills, and motivational skills.
3. Strengthen the teaching methodology for trainers in FH/FP skills in the relevant institutions. While these subjects are in the curricula of the various health work categories, the methods of teaching are often inappropriate, since health workers either do not understand or have forgotten much of the material. It should be possible to train approximately 160 individuals, drawn from the schools of technology, the teaching hospitals, and the schools of nursing.
4. Institute training for the TBA trainers in FH/FP.
5. Develop a half-month long training course for nursing personnel in the theory and practice of FP and the management of FP programs. The course should be run for professional nurses in service/clinical areas, educators in schools of nursing, midwifery, and public health, and student nurses. Following the course, a national certificate should be awarded.

At the local level:

1. Develop a training course in family planning for trainers of TBAs.
2. Speed the implementation and acceptance of institutional arrangements that would strengthen the administration of family planning, immunization, and ORT skills for the

relevant categories of health workers. This might be done by amending the Standing Orders in order to allow community health aides to prescribe ORT and contraceptives and by including the nursing councils in the certification of family planning and in the establishment of requirements for upgrading the skills of nurses in new contraceptive techniques.

3. Fund courses for the re-orientation of TBAs in family planning and record keeping.
4. Give training in management skills to CHOs who need to know how to manage resources in their clinics and in their communities.

Several tables have been developed in an attempt to simplify the recommended training activities. Table VI indicates how training could be carried out at the federal, state, and local levels in seven progressive phases. Table VII looks at the five-year time line for the different levels. Table VIII shows the number of individuals who could be trained in the various states and the sources from which they might be drawn. Finally, Table IX indicates the total number of health professionals that the team recommends be trained over the next five years. A comprehensive training plan is outlined in Figure III.

Uniform Client Card and Service Statistics System

Information on the contraceptive chosen and the age and parity of acceptors should definitely be collected. However, the team feels that it is premature to make definitive recommendations concerning what other information should be compiled and analyzed at each level. These decisions should be made once the program has been implemented in the pilot states of Ondo, Niger, and Ogun (see following section on accelerated state programs), so that they are based on actual experience.

It is recommended that all levels should be involved in projecting their informational needs early on and that analysis and reporting requirements be kept flexible during the early stages of program implementation. This approach allows for learning by trial-and-error and for making adjustments in forms, data analysis tables, and reports before investing heavily in establishing a set service statistics system.

There is an Apple II computer at the Population Commission and time is reportedly available for its use. It is recommended that the Federal MOH obtain technical assistance in developing or adapting existing software for the purposes of making commodity, equipment, and staffing projections; monitoring acceptor and user rates by state; and monitoring the acceptance of specific contraceptive methods.

TABLE VI

TRAINING ACTIVITIES CHART

	FEDERAL	STATE	TRAINING OF TRAINERS (TOT) INSTITUTIONS
Phase 1	Appoint curriculum development task force (TF)	Identify training team (T T)	Selection of first TOT institution
Phase 2	Technical assistance to TF to deliver session plans		Technical assistance to introduce session plans and methodology
Phase 3	Curriculum of session plans to relevant departments	Training at TOT institution	Training of three states teams
Phase 4	Evaluation of TOT training	Plan state level training	Technical assistance to 3 states
Phase 5	Printing of session Plans	Implementation of refresher training and in-school curriculum	Training state teams as needed
Phase 6	Dissemination to educational institutions	Evaluation of training in 3 states	Train trainees for second institutions
Phase 7		Conduct training as needed	Begin phase 1 in second institutions

TIME LINE FOR TRAINING ACTIVITIES

ACTIVITY	YR 1	YR 2	YR 3	YR 4	YR 5
<u>General</u>					
Appoint TF	—				
TA to TF	—				
Circulate Plans	—				
Evaluate TOT		—			
Printing		—			
Dissemination		—			
<u>State</u>					
Identify Training Teams	—				
Training Teams	—				
Planning	—				
Implementation		<u>TT₁</u> <u>TT₂</u> <u>TT₃</u>			
Evaluation					
Training		—	—	—	—
Refreshers		—	—	—	—
In - School		—	—	—	—
<u>Institution</u>					
TA to First Institution	—				
Training 3 State Teams	—				
TA to 3 States		<u>TT₁</u> <u>TT₂</u> <u>TT₃</u>			
Training for 16 State Teams		<u>TT_{4,5}</u> <u>TT_{6,7}</u>	<u>TT_{8,9,10}</u> <u>TT_{11,12,13,14}</u> <u>TT₁₅</u>	<u>TT_{16,17}</u>	
TOT for second institution		—	—	—	—

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TABLE VIII

NUMBER OF TRAINEES

	Number of Institutions Delivering Health Services				Number of Educational Institutions ***		Total	Batch of
	G.H.*	MCH	MD	Others**				
1 Ogun	27	96	1	119	(7x4)	28	271	2
2 Niger	7	5	43	187	(3x4)	12	254	2
3 Ondo	97	260	38	269	(7x4)	28	692	6
4 Sokoto	10		45	278	(4x4)	16	349	3
5 Oyo	35	210	6	220	(17x4)	68	539	5
6 Plateau	13	24	7	205	(13x4)	52	301	3
7 Anambra	71	43	59	78	(15x4)	60	311	3
8 Bendel	82	182	58	250	(11x4)	44	616	6
9 Kwara	33	42	27	198	(7x4)	28	328	3
10 Kano	27	12	13	301	(11x4)	44	397	4
11 Kaduna	23	91	14	176	(22x4)	88	431	4
12 Gongola	13	15	39	284	(4x4)	16	363	3
13 Cross River	26	60	119	125	(21x4)	84	414	4
14 Benue	13	31	29	118	(5x4)	20	211	2
15 Imo	90	53	52	88	(16x4)	64	347	3
16 Bauchi	8	50	58	250	(3x4)	12	378	3
17 Rivers	52	31	33	74	(6x4)	24	214	2
18 Borno	13	50	58	250	(4x4)	16	387	3
19 Lagos	55	33	8	90	(11x4)	44	230	2

* General Hospitals

** Clinics, Dispensaries

*** Nursing, Nurse/Midwifery, and Health Technology Schools --
4 participants per institution.

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TABLE IX

TOTAL NUMBER OF HEALTH PROFESSIONALS TRAINED PER YEAR

<u>YEAR 1</u>	TRAINERS	18	
	REFRESHER	10	
	IN-SCHOOL	500	528
<u>YEAR 2</u>	TRAINERS	42	
	REFRESHER	380	
	IN-SCHOOL	10185	10607
<u>YEAR 3</u>	TRAINERS	60	
	REFRESHER	1440	
	IN-SCHOOL	10185	11685
<u>YEAR 4</u>	TRAINERS	12	
	REFRESHER	2430	
	IN-SCHOOL	10185	12627
<u>YEAR 5</u>	TRAINERS		
	REFRESHER	2430	
	IN-SCHOOL	<u>10185</u>	12615
		Total	48062

30d

RETRAINING

Review and Updating
of skills
Patient Information
and Counseling
Management/Supervision
Record Keeping/Monitoring

TRAINING OF TRAINERS

Curriculum Development
Methodology
- clinical
- technical
Evaluation of Training
Post Training Follow-up

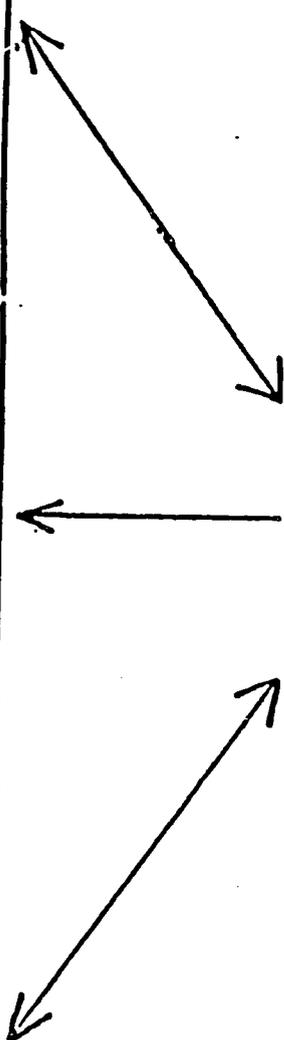
IN- SCHOOL TRAINING

Technical/Clinical
- theory
- practice
Management/Administration
Patient Information and
Counseling
Record Keeping and Monitoring

COMPREHENSIVE TRAINING PLAN

SERVICE DELIVERY

- . Motivation and Education
- . Patient Screening
- . Patient Counseling
- . Methods
- . Treatment
- . Follow-up
- . Resupply
- . Record Keeping
- . Evaluation



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Once these basic programs are well established and the Federal MOH is fully conversant with their use, the MOH should provide or arrange to train state personnel to use the same computer applications. Federal MOH personnel can then go on to develop or adapt more advanced programs for research and evaluation and subsequently train state researchers in their use.

While a computer can be of immense assistance in compiling and analyzing service statistics, it is recommended that the client card and the service statistics system be developed and that analysis be done manually before computerization. In this way, the system is more likely to be modified when necessary, and costly investments in programming can be postponed until the details of the system have been worked out.

Supplies and Distribution

An order for the supplies listed in Table XI should be placed immediately or as soon as an intermediary who will act as the supply agent has been selected. A special request should be made to have one-fourth of the requirement shipped immediately and by air, if possible. Even if all funding, procurement, and shipping procedures are expedited, it is unlikely that the commodities will be in the country in less than six months or by January 1984. Assuming the first shipment does arrive in January, the balance could be sent beginning in March 1984 on a bi-monthly basis.

If this schedule is followed, it should be possible to resupply the clinics and hospitals that now are operating with few or no supplies by March or April 1984 at the latest. First priority should be given to stocking all the clinics currently providing contraceptive services. Contraceptive preferences should be carefully monitored during the first year of the program, so that the contraceptive mix can be adjusted to avoid over- or under-supply in any of the methods included.

In the first year of the program, a single distribution facility should be established to supply all of Nigeria. This would simplify the development of a sound logistics management system. The necessary forms, reporting channels, and supervisory requirements could be more easily and effectively field-tested through a single distribution system than through several zonal distribution points. Once the mechanics of the system have been established, additional outlets or distribution centers could be established as necessary to handle the volume of commodities and equipment.

It should be the responsibility of the intermediary agent who supplies the commodities to work out the details of port clearance, transportation to the warehouse, and onward dispatch to hospitals, clinics, and primary health centers. First priority should be given to supplying programs currently in

TABLE X
POSSIBLE SERVICE DELIVERY POINTS

STATES	GENERAL HOSPITAL	MATERNITY HOSPITAL	MATERNITY HOMES	MCH CLINICS	MEDICAL HEALTH CENT.	OTHER
ANAMBRA	71	5	222	43	59	7
BAUCHI	8			50	22	25
BENDEL	82		67	182	58	25
BENUE	13		10	31	29	11
BORNO	23			29	75	13
CROSS RIVER	26	(260) *	37	60	119	12
GONGOLA	13		14	15	39	28
IMO	90		167	53	52	8
KADUNA	23	3	57	91	14	17
KANO	27			12	13	30
KWARA	33	2	56	42	27	13
LAGOS	55	1	81	33	8	9
NIGER	7		3	5	43	13
OGUN	27		27	96	1	11
ONDO	97	2	260	260	38	26
OYO	35			210	6	22
PLATEAU	13	1	7	24	7	20
RIVERS	52		13	31	33	-
SOKOTO	10			32	45	27
	705	14	1021	1299	688	344

Federal Ministry of Health, Medical Statistics Division

Health Establishments by States and Types in Nigeria as at September 1981.

* beds

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TABLE XI

INITIAL CONTRACEPTIVE SUPPLY

Initial supply for hospitals and clinics
assuming a 3-month resupply time lag.

<u>Contraceptive</u>	<u>Initial Supply</u>	
	<u>Per Hospital</u>	<u>Per Clinic</u>
Oral Contraceptive		
1-50 (cycles)	400	200
.50-35 (cycles)	600	300
Depo Provera (doses)	110	55
IUCD (units)	270	135
Condoms (pieces)	32,400	16,200
NeoSampoon (tablets)	5,400	2,700

This initial supply will provide contraceptive coverage for 18 hospital (total of 1080) and 9 clinic (540) patrons per day for three months.

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TABLE XII

INITIAL CLINICAL SUPPLIES

Initial supply for hospitals and clinics
assuming a 3-month resupply time lag

<u>CONTRACEPTIVE</u>	<u>PER HOSPITAL</u>	<u>PER CLINIC</u>
Oral Contraceptive		
1-50 (cycles)	500	300
.50-35 (cycles)	700	400
Depo Provera (doses)	110	55
IUD's (units)	320	190
Condoms (pieces)	4000	2000
NeoSampoon (tablets)	1400	700

This initial supply will provide contraceptive coverage for 18 hospital (total of 1080) and 9 clinic (540) patrons per day for three months.

operation, so they can service the clients they now have. The intermediary should also make arrangements with any new programs for meeting their commodity requirements.

A minimum initial supply of commodities should be distributed to MCH clinics affiliated with hospitals and clinics, as shown in Table XII. During the first six months, particular attention should be given to observing product movement in an effort to minimize the accumulation of "dead stock" in the storerooms or cupboards of overcrowded clinics. If any items should prove to be generally unpopular, immediate action should be taken to change the product-mix in future request to the contraceptive supplier.

The suggested initial supply is also the stock level to maintain following each delivery of new supplies. If the delivery time for resupply requests is more than three months, or if the draw-down against supplies is faster than projected in Table XII, the minimum level should be adjusted upward to accommodate for the time lapse in the supply chain.

Information and Education

The Information, Education and Communication Report has been prepared by the Population Communications Services of the Johns Hopkins University as noted above. A brief summary of the report's recommendations can be found on pages 21 to 22 of this report.

Accelerated State Programs

Shortly after the team began its field work, it became apparent that the scope of work mandated the development of four national systems: a national training system, a national medical logistics system, a standardized patient record and data system, and a standardized patient information system.

As plans were developed to expedite the FH/FP services, it became apparent that simultaneously implementing the four-fold system in all of the states of a country as large and complex as Nigeria would be impossible. Therefore, the team assessed each state visited with a view to selecting three for accelerated programs. On the team's return to Lagos, the acceleration plan was thoroughly discussed with Dr. Sulaiman. He readily agreed to the concept, stating that it would serve to work out the details of the program before nationwide implementation was undertaken. He further agreed with the team's choice of states for the accelerated program. This was very reassuring to the team, inasmuch as Dr. Sulaiman has an excellent grasp of the strengths and weaknesses of each state health system.

In making the final selection, the team considered the efforts already underway to develop an integrated FH/FP program, the quality of state leadership, the enthusiasm and experience of the staff, and the state's location.

After careful consideration, the team recommended Ondo, Niger, and Ogun (see Figure IV). Their combined population is 8.5 million. As noted above, these three states differ widely in climate, wealth, educational levels, and health care infrastructure. They are located, respectively, in the center, the north and the western regions. All three states have demonstrated a dedicated, practical, enthusiastic approach to undertaking an integrated family health/family planning program. In each instance, their leaders clearly involved members of their staff in policy discussions and decision-making.

Ondo has developed a model plan which would involve the Ministries of Education and local government as well as the MOH in adding family planning information and client counselling skills to the health curricula of all teacher training colleges and technical training schools. It would also add population education to secondary and pre-secondary curricula. The team felt that this was one of the most significant breakthroughs they had observed. Dr. Sulaiman offered to expedite this effort at the national level with the Federal MOE.

Prior to the team's arrival, Niger had developed a FH/FP five-year plan (See Appendix C) to reach a 20% prevalence level. During the team's visit, joint meetings were held with the minister of education and other officials which made it clear that a fully integrated plan could be developed in Niger.

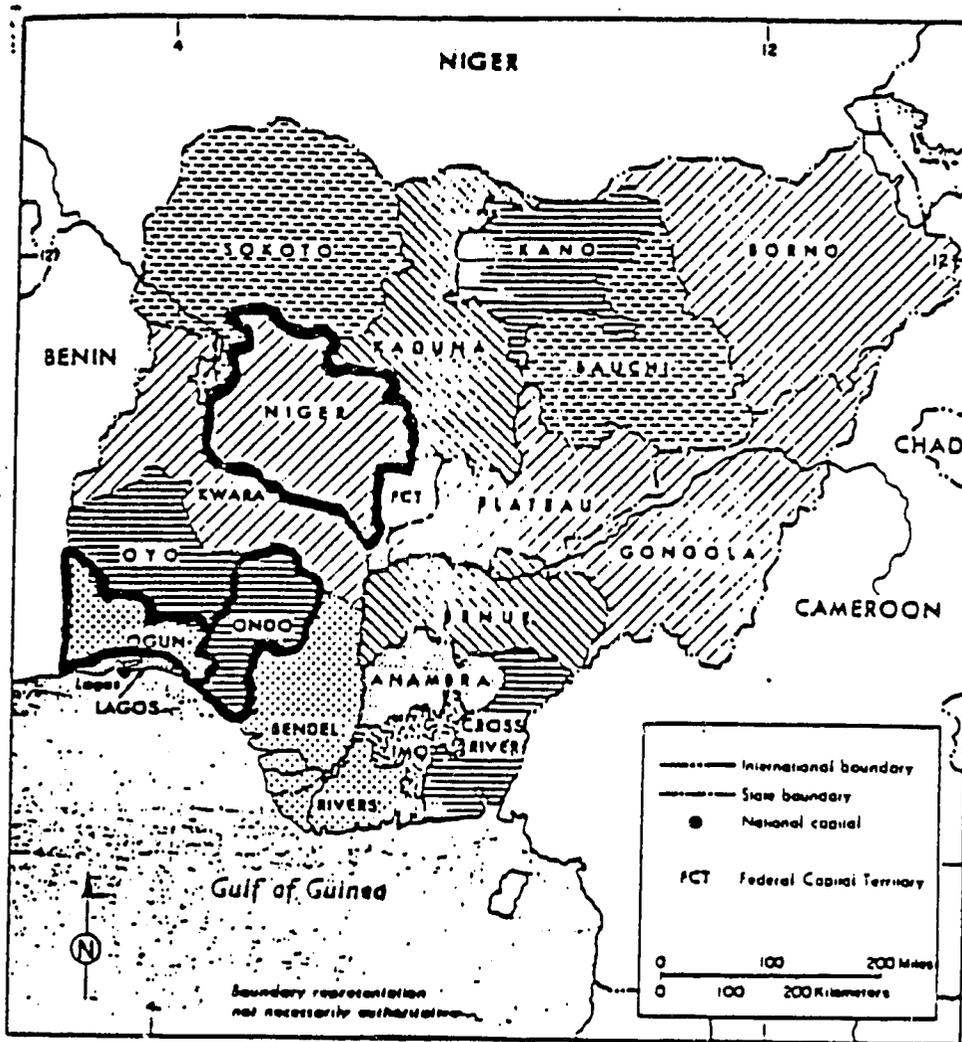
Ogun officials worked with Centers for Disease Control (CDC) team member, Michael Dalmat, to develop a state plan. They did not anticipate reaching a 20% prevalence rate, nor did they have any inputs from the MOE or local government. It was felt, however, that these two elements could be built into the plan in the future without much difficulty.

As the second step in working out the accelerated programs, the team developed a plan which would bring together 11 to 15 representatives from the three states chosen plus representatives from the Federal MOH and one or two representatives from states chosen as "back-up" states, should any of the pilot states face insurmountable implementation problems. This would also enable the representatives from the other states to learn about the program and be ready to implement it in their state when the time came. The 11 to 15 representatives would participate in a three-and-a-half week planning/technical assistance program in Atlanta, Washington, D. C., and Baltimore from September 26 to October 18, 1983.

FIGURE IV

STATES SELECTED FOR ACCELERATED PROGRAMS

(Niger, Ogun, Ondo)



Population Densities by State



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It is planned that the representatives will be given information on current and future contraceptive methods and allied topics in reproductive health care and on program design and development. They will be assisted to develop specific plans for their particular states. The overall purpose of this program is to provide the participants with

- . refresher training in fertility regulation, infertility, sexually transmitted diseases, etc.,
- . technical assistance in developing standard patient records forms, and logistical and commodities management plans,
- . an opportunity to learn what external resources are available from AID intermediaries and how these resources can be utilized in support of the pilot state programs, and
- . training and technical assistance in management and planning which will lead to the development of a plan of action for each state at the end of the program.

Representatives will spend the first week of the program at the Emory University School of Medicine. There they will be given an intensive review of the basic anatomy and physiology of reproduction, family planning methods, the diagnosis and treatment of sexually transmitted diseases, infertility, and other relevant medical conditions. They will also visit other clinical facilities and training institutions.

Following this segment, they will spend three days of training and technical assistance at the CDC in Atlanta where they will identify the basic elements of a successful FP program (policy, service delivery, logistical support, and evaluation), explore alternative strategies for providing services to high risk target populations, and become familiar with ways of assuring that the supply of commodities is reliable.

Following this review, they will attend the Second Annual Conference on Family Planning and Reproductive Health, October 6-7, 1983, sponsored by the Department of Gynecology and Obstetrics, Emory University School of Medicine. This meeting has a very distinguished group of experts as faculty members, (see the program, Appendix F), and the Nigerian attendees should benefit considerably by participating.

After the conference, the Centre for Development and Population Activities (CEDPA) in Washington, D.C., will hold a planning workshop at which the representatives will be given training in management and planning skills. This five-day session will focus on planning and management of state-level programs. The goal of the workshop is to help participants

understand the planning process. They will focus on functional areas, i.e., training, patient information, record keeping, evaluation, supplies and logistics, as they relate to the development of an overall strategy for an accelerated state program. Work includes developing a plan for each state represented. These plans will follow a format which includes justification, objectives, work plan, resources available, resources needed, strategy for implementation, and budget.

During this week, CEDPA will be assisted by the Pathfinder representative for Nigeria. In addition, representatives from Intrah and JHIEPGO will be present so that each state team will learn about the resources available for technical assistance and training.

Two additional days will be spent at JHIEPGO in Baltimore, during which participants will be involved in clinical demonstrations.

By the end of the program, the representatives from the three states selected for accelerated programs will have

- . increased their awareness of fertility regulation methods and teaching techniques,
- . developed a standard patient record-keeping format,
- . identified their need for patient information,
- . developed step-by-step action plans,
- . identified the local resources available to the project and decided how external resources will be utilized,
- . developed a logistics and supply plan which assures that commodities will be available as service delivery increases,
- . identified management practices that can improve clinic efficiency, and
- . developed methods of evaluation that respond to common program management concerns.

In summary the technical assistance and training program for the Nigerian representatives will enable the pilot states to receive the maximum input from U.S.-based organizations at the critical initiation phase of the accelerated plan. It will also guarantee that the state plans developed during this program will be focused on the four interventions agreed upon by the Federal Ministry. Furthermore, it is expected that in the future expansion of state plans throughout Nigeria, the three state plans developed during this program will be used as a model.

With this first phase accomplished, the second and third phases; implementation and expansion, can be more effectively implemented.

This program will also help those U.S. organizations that will be providing technical assistance and training to the pilot states to gain some insight into the program and assess what is needed. This should help shorten the time between project planning and initiation. Once the state teams have developed their plans of action, they can utilize internal and external resources more efficiently.

The total program should help the Nigerian state and federal planners to focus more clearly on simple, cost effective, and timely interventions. If these interventions are made concurrently at the state and federal levels, they will accelerate the delivery of family health services in the population. These planners will be the key to the implementation phase. It is, therefore, the overall goal of the program that they be assisted in planning realistic and effective programs that meet the local, cultural, economic, and social criteria for each of these diverse Nigerian states.

Finally, the team recommends that this entire training episode be carefully evaluated. The present plan is that the training episode will be repeated at periodic intervals until all of the states have developed their own plans. Therefore, it will be very important to assess the strengths and weaknesses of each part of the program in order to make necessary improvements for the succeeding groups.

BUDGET

TRAINING

Multiple training efforts must be undertaken in a number of areas for a variety of levels of workers. These include technical assistance, development of session plans, training of trainers, and training at the state level. The costs of these training activities for the next five years are indicated in Tables XIII - XVII.

B. Client Record Card and Service Statistics System

It is impossible to determine the cost of developing the uniform client record and instituting the service statistics system at the present time.

C. Supplies and Distribution

Cost for contraceptive commodities are also shown. Table XVIII shows the cost of the commodities by type of contraceptive. Some adjustment in the cost may have to be made among line items if there is a major change in the contraceptive preference once the program becomes operational and a full range of contraceptive choices are available in all outlets.

Cost projections for the five years of the program are presented in the Table XIX. It assumes that the requirements will remain constant for the second year of the program because start-up delays will leave an unused reserve in the commodity stockpile. The reserve should be drawn down during the second year of operation, leaving only a nominal reserve as a back-up against possible delays in the international supply chain. Thereafter, the projection assumes a 2% annual increase in commodities compounded annually at today's prices.

The 2% annual increase is the very least that can be tolerated since it is hardly adequate to maintain a constant acceptance rate. Arrangements should be made with the Futures Group to incorporate into the rapid model for the Apple II computer, now with the Population Commission, a projection of contraceptive requirement for future years. The model should use the contraceptive preference mix which emerges when the pipeline has been filled and spot shortages will not affect the overall choices, as is now the case. Such a projection should be made at least annually and take into account the changing age structure and size of the group of women in the reproductive ages, 15 to 44 years of age.

The exact costs and availability of additional clinical equipment and the total amount needed is not known at the present time.

D. Information and Education

The summary of the costs of the IEC Project as calculated by the Population Communication Services, is given in Table XIX.

TABLE XIII
BUDGET FOR TECHNICAL ASSISTANCE

	<u>Person Months</u>	<u>Trips</u>	<u>Per Diem</u>	
Year 1	8	2	80	
Cost	\$80,000	\$5,000	\$13,000	\$98,000
Year 2	6	2	80	
Cost	\$60,000	\$5,000	\$13,000	\$78,000
Year 3	3	2	40	
Cost	\$30,000	\$5,000	\$ 6,500	\$41,500
Year 4	2	1	20	
Cost	\$20,000	\$2,500	\$ 3,250	\$25,750
Year 5	---	---	---	----
			TOTAL	\$243,250

TABLE XIV

BUDGET FOR SESSION PLANS

<u>Recipients</u>	<u>Number of Copies</u>	<u>Cost *</u>
Training team members/state (6 X 19)	114	\$ 2,850
Educational institutions (187 X 1.0 copies)	1870	\$46,750
TOTALS	<u>1984</u>	<u>\$49,600</u>

* \$25 per copy

TABLE XV

BUDGET FOR STATE LEVEL TRAINING

<u>Year 1</u>	<u>Training Programs</u>	<u>Number of Participants</u>	<u>Cost *</u>
TT 1	1	10	\$3,200
<u>Year 2</u>			
TT 1	7	70	\$22,400
TT 2	6	60	\$19,200
TT 3	17	170	\$54,400
TT 4	4	40	\$12,800
TT 5	4	40	\$12,800
TOTALS	<u>38</u>	<u>380</u>	<u>\$121,600</u>
<u>Year 3</u>			
TT 1	7	70	\$22,400
TT 2	6	60	\$19,200
TT 3	17	170	\$54,400
TT 4	10	100	\$32,000
TT 5	16	160	\$51,200
TT 6	10	100	\$32,000
TT 7	10	100	\$32,000
TT 8	20	200	\$64,000
TT 9	10	100	\$32,000
TT 10	10	100	\$32,000
TT 11	10	100	\$32,000
TT 12	5	50	\$16,000
TT 13	5	50	\$16,000
TT 14	5	50	\$16,000
TT 15	1	10	\$ 3,200
TT 16	1	10	\$ 3,200
TT 17	1	10	\$ 3,200
TOTALS	<u>144</u>	<u>1440</u>	<u>\$460,800</u>

* Based on an average training course of 15 days at \$20 p/d
+ \$20 travel = \$320 per participant.

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<u>Year 4</u>	<u>Training Programs</u>	<u>Number of Participants</u>	<u>Cost *</u>
TT 1	7	70	\$22,400
TT 2	6	60	\$19,200
TT 3	17	170	\$54,400
TT 4	10	100	\$32,000
TT 5	16	160	\$51,200
TT 6	10	100	\$32,000
TT 7	10	100	\$32,000
TT 8	20	200	\$64,000
TT 9	10	100	\$32,000
TT 10	10	100	\$32,000
TT 11	15	150	\$48,000
TT 12	15	150	\$48,000
TT 13	7	70	\$22,400
TT 14	15	150	\$48,000
TT 15	15	150	\$48,000
TT 16	15	150	\$48,000
TT 17	15	150	\$48,000
TT 18	15	150	\$48,000
TT 19	15	150	\$48,000
TOTALS	<u>243</u>	<u>2,430.</u>	<u>\$777,600</u>

Year 5 AS ABOVE

243 2,430 \$777,600

GRAND TOTAL \$2,140,800

* Based on an average training course of 15 days at \$20 p/d
+ \$20 travel = \$320 per participant.

Handwritten initials

TABLE XVI

SUMMARY OF BUDGET FOR TRAINING

Year 1

Technical Assistance	\$98,000	
Training of Trainers	82,700	
State Training	3,200	
Session Plans	67,625	
Sub Total		\$251,525

Year 2

Technical Assistance	78,000	
Training of Trainers	214,300	
State Training	121,600	
Sub Total		\$414,900

Year 3

Technical Assistance	41,400	
Training of Trainers	264,000	
State Training	460,800	
Sub Total		\$766,200

Year 4

Technical Assistance	25,700	
Training of Trainers	49,800	
State Training	777,600	
Sub Total		\$853,100

Year 5

State Training	777,600	
Sub Total		\$777,600

TOTAL		\$3,062,325
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TABLE XVII

BUDGET FOR TRAINING OF TRAINERS (TOT)

Training Teams

Number of teams = 19

Number on team = 6

Total TOT = 114

Duration of training = 2 months

Costs

Tuition	= \$50 p/d x 40 days	= \$2,000
per diem	= \$50 p/d x 40 days	= \$2,000
travel	= \$150	= \$ 150
	Total per participant	\$4,150
Year 1	18 participants x \$4,150	\$74,700
	Equipment	\$ 5,000
	TA by TOT inst to 1 state	\$ 3,000
	Sub Total	\$82,000
Year 2	42 participants x \$4,150	\$174,300
	Equipment	\$ 10,000
	TOT at 1st Inst. for 2 ^{ed}	
	6 participants x \$5000	\$ 30,000
	Sub Total	\$214,300
Year 3	60 participants x \$4,150	\$249,000
	Equipment	\$ 15,000
	Sub Total	\$264,000
Year 4	12 participants x \$4,150	\$ 49,800
	Sub Total	\$ 49,800
Year 5	-----	-----

TABLE XVIII
BUDGET FOR CONTRACEPTIVES

(First Year)

<u>CONTRACEPTIVE</u>	<u>QUANTITY</u>	<u>UNIT PRICE \$</u>	<u>COST \$ (including shipping)</u>
Oral contraceptive	6,200,000	\$.150	\$1,023,000
Depo Provera	640,000	.900	633,600
IUD's	560,000	.850	523,600
Condoms	48,000,000	3.300/100	1,742,000
NeoSampooon	8,000,000	.065	<u>572,000</u>
		TOTAL	\$4,494,200

Contraceptives required for the first year of services in Nigeria under the assumption of 10% prevalence and costs at current contract prices plus international transportation costs.

TABLE XIX

SUPPLY REQUIREMENTS

<u>Contraceptive</u>	<u>Distribution of Users</u>		<u>Quantity Required for 1,000,000 WRA (10% prevalence)</u>	<u>Quantity Required for all of Nigeria 16,000,000 WRA (10% prevalence)</u>
	<u>Percent</u>	<u>Number</u>		
Oral contra- ceptives	30	30,000	390,000*	6,240,000*
Depo Provera	10	10,000	40,000	640,000
IUCDs	25	25,000	25,000	400,000
Condoms	30	30,000	3,000,000	48,000,000
NeoSampoo	5	5,000	500,000	8,000,000
TOTAL	100	100,000		

Estimated supply requirements for a population with one million women (ages 15-44), assuming coverage for 10% for one year as a start-up supply level.

* Recommended ratio of 40% = 1 + 50
60% = .50-35

Assuming that the low dose pill is the initial method issued to new users.

TABLE XX

Summary Of All IEC Project Budgets
(in thousands)

<u>National FH IEC Program (Federal Health Education Division)</u>	<u>Naira Budget</u>	<u>Dollar Budget</u>
--	---------------------	----------------------

FH film	N100	\$25
Videotape programming	200	50
FP print materials	1,130	100
Orientation workshops	270	
State collaboration	30	
	<u>Subtotal: N1,730</u>	<u>\$175</u>
	(\$2,595)	
	US Dollar Total:	<u>*\$2,770</u>

FP IEC Delivery Systems Program (PPFN)

Project for men	119	22
Satisfied users	80	
Pharmacists	235	
Billboards/signboards	107	
Evaluation and reproduction of past IEC materials	70	25
Administrative costs	139	
	<u>Subtotal: N750</u>	<u>\$47</u>
	(\$1,125)	
	US Dollar Total:	<u>*\$1,172</u>

Adolescent Fertility IEC Project (Family Life Education Association)

Magazine development and printing	110	
Pamphlet & poster development & printing	28	
TA		15
Administrative costs	10	
	<u>Subtotal: N148</u>	<u>\$15</u>
	(\$222)	
	US Dollar Total:	<u>*\$237</u>

Monitoring and Evaluation

10 site visits and reports		150
Materials evaluations		30
Projects evaluations		100
	<u>Subtotal:</u>	<u>\$280</u>
	U.S. Dollar Total:	<u>\$280</u>

US DOLLAR TOTAL: *\$4,459

*Assumes N1=\$1.50 (U.S.)

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APPENDIX A

MEETINGS

PRESENTATION TO NIGERIAN MINISTRY OF HEALTH

BY U.S. EMBASSY CONSULTANTS ON

FAMILY HEALTH

- INTRODUCTION KEYS MACMANUS, J.D.
- TRAINING
- A) FAMILY PLANNING ELIZABETH B. CONNELL, M.D.
- B) HEALTH PEGGY CURLIN, M.A.
- C) MANAGEMENT PEGGY CURLIN, M.A.
- LOGISTICS & PATIENT RECORDS HARALD PEDERSEN. PH.D.
- INFORMATION & EDUCATION STEVEN SMITH, M.A.
- ROCCO DE PIETRO, PH.D.
- COMMUNITY RESOURCES & SUPPORT MAY YACOOB, PH.D.
- SUMMARY & CONCLUSION KEYS MACMANUS, J.D.
- DISCUSSION CONSULTANTS
MINISTRY STAFF

ATTENDEES OF MEETING WITH ONDO STATE REPRESENTATIVES - 9 JUNE, 1981

MRS. B. OGUNODE	CHIEF INSPECTOR OF EDUCATION Ministry of Education Akure, Ondo State
DR. ROCCO DEPIETRO	ASSISTANT PROFESSOR Department of Health Behavior Health Education The University of Michigan Ann Arbor, Michigan
STEVEN C. SMITH	CONSULTANT Population Communication Services John Hopkins University Baltimore, Maryland
DR. ELIZABETH B. CONNELL	PROFESSOR Dept. of Gyn/OB Emory University CDC guest researcher Atlanta, GA, USA
DR. HOWARD J. TATUM	Dept. of GYN/OB Emory University School of Medicine CDC guest researcher Atlant, GA, USA
HARALD A. PEDERSEN	CONSULTANT formerly Chief FPSB Officer Population, AID/W
PEGGY CURLIN	VICE PRESIDENT The Center of Development and Population Activities Washington D.C.
MRS. C.I. IKUOMOLA	CHIEF HEALTH SISTER Ministry of Health Akure, Ondo State
J.A. AJAYI	S.A.S. Ministry of Health Akure, Ondo State

DR. MAY YACOOB	ASSISTANT PROFESSOR for African Studies and Research Center Howard University Washington D.C.
DR. A.A. ADETUNJI	SNR. CONSULTANT (PREV. MED.) and PRINCIPAL School of Health Technology Akure, Ondo State
MRS. P.M. AJAYI	CHIEF COMMUNITY DEV. OFFICER Ministry of Local Gov't. & C
A.M. ATTAH	Planned Parenthood Federation of Nigeria P.O. Box 1646 Akure, Ondo State
MRS. F.M. FALOMO	CHIEF HEALTH SISTER Health Management Board Akure, Ondo State
DR. A.O. OKUSANYA	SENIOR CONSULTANT Health Planning, Federal Ministry of Health
DR. A.B. SULAIMAN	DIRECTOR , N.H.P. Federal Ministry of Health
LADY D.O. JIBOWU	National Population Commission 67, Oyemekun Road, Akure Ondo State
DR. J.I.A. ADETOSOYE	PERMANENT SECRETARY Ministry of Health
KEYS MACMANUS J.D.	AID AFFAIRS OFFICER AMERICAN EMBASSY Lagos, Nigeria

APPENDIX B

INDIVIDUALS CONTACTED DURING TEAM VISIT

FEDERAL MINISTRY OF HEALTH

. A. B. Sulaiman	Director, National Health Planning and Research
. A. D. Kolawole	Chief Coordinator, Primary Health Care
. J. A. Laole	Assistant Director, Health Education
. O. A. Adelaja	Senior Consultant, Medical Statistics
. P. Y. Odunsi	Senior Consultant, Epidemiology
. A. O. Okusanya	Senior Consultant, National Health Planning
s. A. O. Payne	Deputy Chief Nursing Advisor
s. Oshuno	Nurse, Manpower and Training
ss O.A.S. Williams	Senior Pharmacist
s. D. R. Olatokunbo	Health Planning Officer
. R. O. Olaniyan	Principal Health Planning Officer
s. F. A. Henshaw	Assistant Chief Health Educator
. J. A. Ola	Principal Health Educator
ss A. O. Alabi	Senior Health Educator
s. A. A. Ogunbiade-Abu	Higher Health Educator
. L. O. Oke	Higher Graphic Artist

NATIONAL POPULATION COMMISSION

Chief Abdurrahman Okene	Chairman
ddy (Chief) Deborah Jibowu	Commissioner

ONDC STATE

Dr. J.I.A. Adetosoye

Permanent Secretary
Ministry of Health

Mrs. B. Ogunode

Chief Inspector
Ministry of Education

Dr. A.A. Adetunji

Senior Consultant and Principal
School of Health Technology

Mrs. P. M. Ajayi

Chief Community Development Officer
State Ministry of Local Government

Mrs. C. I. Ikuomolo

Chief Nurse Sister
Ministry of Health

OGUN STATE

Dr. Oni

Ministry of Health

Mrs. Grace Delano

Acting Project Director, Dept. of Ob-
University of Ibadan

OYO STATE

Mr. Toye Ogunyemi

Permanent Secretary
Ministry of Health

Dr. L. K. Windokun

Chief Medical Officer
Ministry of Health

Dr. Joshua D. Adeniyi

Director, African Regional Health
Education Center
University of Ibadan

Dr. Okun Ayangade

Senior Lecturer, Dept. of Ob-Gyn
University of IFE

Mrs. O. A. Akinola

Director, MCH Center
Ministry of Health

Mrs. Afolabi

Director for Policy/Administration
Ministry of Health

NIGER STATE

Mr. Adeyemi Adesegun Adelfulu

Minister of Health

Dr. M. O. Jibril

Permanent Secretary
Ministry of Health

Dr. Susan L. Saba

Director, Public Health and Planning
Ministry of Health

NIGER STATE (Continued)

Mrs. Jumai Mohammed	Senior Public Health Sister/MCH Ministry of Health
Mrs. Zainab T. Tako	Administrator/MCH Clinic Ministry of Health
Mrs. G. M. Guerrero	Health Educator Ministry of Health
Mrs. Antonia Pada	Permanent Secretary Ministry of Youth, Culture and Welfare
Mrs. Asamau Y. Usman	Principal Women's Teaching College (Minna)
Malam Mahmoud B. Ibrahim	Science Teacher Women's Teaching College (Minna)
Mr. Clement Stephen	Chief Inspector Ministry of Education

SOKOTO STATE

Alhaji Usman M. Bonza	Deputy Project Manager Basic Health Services Ministry of Health
Miss Mirium Rapp	Assistant Project Manager Basic Health Services Ministry of Health
Dr. M. Diri	Chief (Consultant Physician) Health Education Ministry of Health

KWARA STATE

Dr. David Olubaniyi	Chief Medical Officer Ministry of Health
Dr. O. O. Fakeye	Lecturer, Dept. of Ob-Gyn University of Ilorin

LAGOS STATE

Dr. M. Y. I. Salami	Chief Consultant Ministry of Health
Prof. Ransome-Kuti	Director, Institute of Child Health University of Lagos
Dr. Akin Agboola	Chairman, Dept. of Ob-Gyn University of Lagos
Dr. O.O.F. Giwa-Osagie	Senior Lecturer and Consultant Dept. of Ob-Gyn University of Lagos
Dr. Akinsanya	Director Lagos Island Maternity Hospital Ministry of Health
Mrs. A. Martins	Chief Nursing Officer Simpson Street Health Clinic Ministry of Health

PLANNED PARENTHOOD FEDERATION OF NIGERIA

Mr. A. Fajobi	Director
Mr. Marc A. Okunnu	Director for Programs
Mr. Olu Aleloiose	Senior Program Officer (IEC)
Chief A. M. Attah	Executive Secretary for Ondo

PATHFINDER

Dr. Diedre Strachen	Chief, Fertility Services Division
Dr. Ayorinde Ajayi	Project Officer, Africa
Ms. Gail Callahan	Project Officer, Africa

FAMILY PLANNING INTERNATIONAL ASSISTANCE

Mr. Reuben Johnson	Regional Officer, Africa
Mr. Gaigi Bendon	Project Officer, Africa

UNITED NATIONS FUND FOR POPULATION ACTIVITIES

Mr. Gary R. Gleason	Project Support Communications Officer
---------------------	---

JOHNS HOPKINS UNIVERSITY

Mr. Wilbur Wallace	Chief, Africa Region JHPIEGO
Mr. Steven Smith	Project Officers for Anglophone Africa PCS
Dr. Rocco de Pietro	Consultant for PCS

FORD FOUNDATION/LAGOS
Ms. Deborah Prindle

Project Officer

OTHERS

Dr. Bolaji Kuti

Ob-Gyn Clinician
Lagos

Dr. Howard Tatum

Professor, Dept. of Ob-Gyn
Emory University
Atlanta, Georgia

NOT LISTED:

All of the many helpful people in the American Embassy, Lagos,
The Department of State, and AID/Washington

APPENDIX C

FAMILY PLANNING ONDO STATE OF NIGERIA

1. Ondo State has a total land area of 14,400 sq. kilometre (K^2) with an estimated 1983 total population 74,032,235 projected from the 1963 census. At current estimated growth rate of 2.5% per year the population by the year 2000 will be 6,382,351 thus raising the population density from the current 287/ k^2 to 443/ k^2 in just 17 years. There are 17 Local Government areas with estimated population as shown in annexure I.

2(i) Relevant data already published about Nigeria *(applicable to Ondo State) include:

Crude birth rate	- 50 per 1000
Crude death rate	- 18 per 1000
Rate of Natural Increase	- 3.2% per annum
No. of years to double population	- 22 years
Infant mortality	- 157 per 1000 live births per year
Total fertility Rate	- 6.9
Population over 15 years	- 47% of Total population
Population over 64 years	- 2% of Total population
Life expectancy at birth	- 48 years
Urban population	- 20% of Total population
G.N.P. per capita	- U.S. \$670

(ii) The population is predominantly Yoruba with a preponderance of peasant farmers. Religious practices include various Christian sects which form the majority of the population, Islam and other traditional religions. Among the Christians, there is a noticeable small Roman Catholic group.

(iii) At present family planning is not widely accepted and practised. Every available evidence points to the fact that this may remain so until family planning service is completely integrated with other health programmes particularly fertility management and Maternal and Child Health (MCH) services.

3. Current Status of F.P. Service in Ondo State:

(i) Family Planning Service in Ondo State is currently being rendered by the State branch of the Planned Parenthood Federation of Nigeria (P.P.F.N.) which provides non-professional staff, contraceptive devices, some clinical equipment and pays some pittance as honorarium (session fees) to professional staff.

(ii) The service is however already heavily subsidized by the State Government. Clinics take place in government institutions.

OUTLINE FOR CLINICAL TRAINING

I Embryology and Fetal Development

- A - Male
- B - Female

II Anatomy of Reproductive Tract

- A - Male
- B. - Female

III Reproductive Physiology

- A - Male
 - 1 - childhood
 - 2 - puberty
 - 3 - adult
 - a - hormonal cycle
 - b - sexual function

-
- B - Female
 - 1 - childhood
 - 2 - puberty
 - 3 - adult
 - a - hormonal cycle
 - b - menstrual cycle
 - c - pregnancy
 - 1) fertilization
 - 2) implantation
 - 3) fetal growth
 - 4) complications
 - 5) mortality

IV Contraception - reversible

- A - Ideal: definition
- B - Current Methods
 - 1 - oral contraceptives
 - a - combined
 - 1) high dose
 - 2) low dose

- 2 - injectables
- 3 - intrauterine devices
 - a - non-medicated
 - 1) Lippes loop
 - 2) Saf-T-coil
 - b - medicated
 - 1) Cu-7
 - 2) Tatum-T
 - 3) Progestasert
- 4 - barrier methods
 - a - male
 - b - female
 - 1) diaphragm
 - 2) cervical cap
 - 3) spermicidal agents
 - 4) sponge
- 5 - Periodic abstinence
 - a - calendar
 - b - temperature
 - c - ovulation detection
 - d - symptothermal
- 6 - Traditional
 - a - withdrawal
 - b - douche
 - c - lactation
 - d - abstinence
- C - Considerations
 - 1 - general
 - a - parity
 - b - age
 - c - motivation
 - d - spacing/terminating
 - e - health factors

- 2 - method - specific
 - a - effectiveness
 - 1) method
 - 2) use
 - 3) extended use
 - b - advantages
 - c - disadvantages
 - d - indications
 - e - contraindications
 - 1) absolute
 - 2) relative
 - f - side effects - adverse
 - 1) short term
 - 2) long term
 - g - health benefits
 - h - acceptability
 - i - continuation rates

v Contraception - permanent

A - Methods

- 1 - male
- 2 - female

B - Considerations

- 1 - general
 - a - parity
 - b - age
 - c - health factors
 - d - personal factors

2 - method - specific

- a - effectiveness
- b - advantages
- c - disadvantages
- d - indications
- e - contraindications
- f - adverse side effects
 - 1) immediate
 - 2) long term

- g - acceptability

VI Infertility

A - Causes

- 1 - male
- 2 - female

B - Treatment

- 1 - medical
- 2 - surgical

VII Sexually Transmitted Diseases

A - Classification

B - Diagnosis

C - Treatment

D - Complications

VIII Health Education

A - Diarrheal Disease Control

- 1 - rehydration theory
- 2 - rehydration formulae
- 3 - patient care

B - Immunization

- 1 - mother/child
- 2 - administration
- 3 - cold chain

C - Family Planning

- 1 - methods - general
- 2 - method - specific
- 3 - follow-up

APPENDIX E

REFERENCES USED IN PREPARATION OF REPORT

A. BACKGROUND DOCUMENTS.

1. Rural Infrastructures in Nigeria: Basic Needs of the Rural Majority. Vol.2: State Annexes, by F.S. Idachaba, C.E. Umebese I.O. Akingbade, and A. Adeniyi. Federal Department of Rural development. October 1981.
2. Rural Infrastructures in Nigeria: Basic Needs of the Rural Majority. Vol.1: Main Report, by F.S. Idachaba, C.E. Umebese, I.O. Akingbade, and A. Adeniyi. Federal Department of Rural Development. October 1981.
3. Mid-Year Population Projections by States 1963-2000. National Population Bureau. January 1978.

B. HEALTH INFORMATION.

1. Federal Republic of Nigeria Health Profile 1981/82, by Dr. Babalola A.A. Dada, Federal Ministry of Health, Lagos November 1982.
2. Annual Report on Maternal Child Health and Tradition Birth Attendants Activities in Sokoto State from Jan.-Dec. 1982. by M.K. Rapp, Principal Health Sister.
3. Major Causes of Deaths from Notifiable Diseases in Nigeria, 1977-1981. Prepared by Medical Statistics Division, Federal Ministry of Health. July, 1982.
4. Health Establishments by States and Types in Nigeria as at 31st December 1980. Medical Statistics Division, Federal Ministry of Health.
5. Health Establishments by States and Types in Nigeria as at December 1981. Medical Statistics Division, Federal Ministry of Health.
6. List of Registered Health Establishments as at 31st December 1979. Medical Statistics Division, Federal Ministry of Health.
7. Health Care Facilities and Supporting Institutions, Federal Ministry of Health 1980

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C. TRAINING DOCUMENTS.

1. Session Plan for Community Health Officers, National Basic Health Services Scheme. Federal Ministry of Health Basic Health Services Scheme Coordinating Unit. August 1980.
2. Curriculum for Community Health Officers/Supervisors, National Basic Health Services Scheme. Federal Ministry of Health Basic Health Services Scheme Coordinating Unit. May
3. National Community Health Practical Examination for Community Health Officers. June 1981. Papers I,II,III.
4. Session Plan for Community Health Aides, National Basic Health Services Scheme. Federal Ministry of Health Basic Health Services Scheme Coordinating Unit. October 1979.
5. Curriculum for Community Health Aides, National Basic Health Services Scheme. Federal Ministry of Health Basic Health Services Scheme Coordinating Unit. May 1979.
6. Session Plan for Community Health Assistants, Vol.1 (Block I-II), National Basic Health Services Scheme. Federal Ministry of Health Basic Health Services Scheme Coordinating Unit. February 1980.
7. Session Plan for Community Health Assistants, Vol.2 (Block III-IV), National Basic Health Services Scheme. Federal Ministry of Health Basic Health Services Scheme Coordinating Unit. February 1980.
8. Session Plan for Community Health Assistants, Vol.3 (Block V-VI), National Basic Health Services Scheme. Federal Ministry of Health Basic Health Services Scheme Coordinating Unit. February 1980.
9. Curriculum for Community Health Assistants, National Basic Health Services Scheme. Federal Ministry of Health Basic Health Services Scheme Coordinating Unit. May 1979.
10. Community Health Officers, Supervisors and Assistants Standing Orders, National Basic Health Services Scheme. Federal Ministry of Health Basic Health Services Scheme Coordinating Unit. December 1980.
11. A Textbook of Midwifery, by Victoria Ajayi. Macmillan Tropical Nursing and Health Sciences Series. 1981.
12. A Training Manual for Child-Spacing, by Barbara Adams, Consultant to the Institute of Child Health, Lagos, for National Basic Health Services Scheme. 1978.

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13. Training of Family Planning Trainers and Supervisors, Minna, Niger State, Jan 31-Feb 25 1983, by B. Major and N. Wilson for International Training in Health, University of North Carolina/Chapel Hill.
14. Developing a Curriculum for an MPH Degree in Health Education for Africa, How Suitable are the U.S. Models? by Joshua D. Adeniyi and William R. Brieger. International Journal of Health Education. Supplement to Vol. XXI 1980 ?

D. PLANNED PARENTHOOD FEDERATION OF NIGERIA DOCUMENTS.

1. Operational Guidelines No.3, Sessional Clinic Programme, by Marc A. Okunnu, Programme Development Department. June 1982.
2. Operational Guidelines No.4, Planned Parenthood Federation of Nigeria Fieldwork Program, by Marc A. Okunnu. November 1982.
3. Annual Report 1981 of Planned Parenthood Federation of Nigeria, by Mr. Abayomi Fajobi, Executive Director.
4. Annual Report 1982 of Planned Parenthood Federation of Nigeria, by Mr. Abayomi Fajobi, Executive Director.

E. HEALTH CARE DOCUMENTS.

1. Report of the Nursing Assessment Team, U.S. -Nigeria Cooperative Agreement on Health. April 1982.
2. Space Your Children For a Brighter Tomorrow, by Mrs. G.M. Guerrero, Niger State. 1983.
3. Report of the National Council on Health Committee for the Review of the Basic Health Services Scheme, Lagos. March 1981.
4. Guidelines on Development of Nutrition Programmes Based on Primary Health Care.
5. Guidelines on Development of Health Programmes Based on Primary Health Care for the Water and Sanitation Component of PHC, prepared by the Environmental and Occupational Health Division, Federal Ministry of Health.
6. Highlights on Health Care Delivery in Kwara State, compiled by Dr. D. Olubaniyi, Chief Health Officer, Ilorin, November 1982.
7. Guidelines on Development of Health Education Programmes Based on Primary Health Care. 63

8. Guidelines for Primary Health Care Support Group on Maternal and Child Health Care Including Family Planning, Primary Health Care Coordinating Unit, Lagos, March 1983.
9. Report on Primary Health Care Status in Selected States in Nigeria: an exercise carried out by multidisciplinary groups. Primary Health Care Coordinating Unit, Lagos.

F. MISCELLANEOUS DOCUMENTS.

1. Oral Rehydration Therapy (ORT) for Childhood Diarrhea. Population Reports, Series L, Number 2, Nov-Dec 1980. Population Information Program, Johns Hopkins University.
2. Annual Report of the Health Education and Nutrition Unit, Ministry of Health, Minna, Niger State: by G.M. Guerrero March 1983.
3. Technical Support Groups Workshop on P.H.C.
4. Population Education in Schools, by Chief (Lady) D.O. Jibowu, Commissioner National Population Commission, Ondo State, December 1982.
5. Diarrhea Persists as Scourge of the Third World, by William K. Stevens, The New York Times, May 3, 1983.
6. Use Salt, Sugar and Water to Cure Diarrhoea, by Professor O. Ransome-Kuti, Daily Times of Nigeria, May 31, 1983.

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 Department of Gynecology and Obstetrics

Family Planning and Reproductive Health

October 6-7, 1983
 WESTIN PEACHTREE PLAZA
 ATLANTA, GEORGIA



SCHOOL OF MEDICINE
 WOODRUFF MEDICAL CENTER
 EMORY UNIVERSITY

Non Profit Organization
 U S POSTAGE
 PAID
 Atlanta, Georgia 30303
 Permit No. 2

EMORY FACULTY

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JOHN D. THOMPSON, M.D.
 Professor and Chairman
 Department of Gynecology and Obstetrics

CENTERS FOR DISEASE CONTROL FACULTY

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 Director
 Division of Venereal Disease Control

DAVID A. GRIMES, M.D.
 Chief, Abortion Surveillance Branch
 Family Planning Evaluation Division

NANCY C. LEE, M.D.
 Medical Epidemiologist
 Division of Reproductive Health

GUEST FACULTY

RUDI ANSBACHER, M.D., M.S.
 Professor and Assistant Chairman
 Department of Obstetrics and Gynecology
 University of Michigan
 Ann Arbor, Michigan

RICHARD BLACKWELL, M.D.
 Associate Professor
 Department of Obstetrics and Gynecology
 The University of Alabama in Birmingham
 Birmingham, Alabama

FREDERICK DeFURIA
 County Judge
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RICHARD DERMAN, M.D.
 Clinical Assistant Professor
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MARGIE PITTS HAMES
 Attorney
 Margie Pitts Hames, P.C.
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CHARLES B. HAMMOND, M.D.
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 Department of Obstetrics and Gynecology
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 Associate Professor
 Departments of Medicine and Preventive Medicine
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 Professor, Department of Pathology
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WILLIAM N. SPELLACY, M.D.
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LOUISE B. TYRER, M.D.
 Vice President for Medical Affairs
 Planned Parenthood Federation of America
 New York, New York

A. ALBERT YUZPE, M.D.
 Professor of Obstetrics and Gynecology
 The University of Western Ontario
 London, Ontario, Canada

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FAMILY PLANNING AND REPRODUCTIVE HEALTH PROGRAM

WEDNESDAY, OCTOBER 5, 1983

7:00 am Registration

THURSDAY, OCTOBER 6, 1983

7:00 am Optional Workshops
 7:30 CREDENCE - E. B. Connell, MD
 8:15 INTRODUCTION - E. B. Connell, MD

SEXUALLY TRANSMITTED DISEASES

Moderator: E. B. Connell, MD
 8:30 DOES SEX LEAD TO GONORRHOEA? - E. B. Connell, MD
 9:00 CHEMICAL AND MECHANICAL BARRIERS TO HERPES AND CHLAMYDIA - E. B. Connell, MD
 9:30 FAMILY PLANNING AND STDs: STRANGE OR NATURAL BEDFELLOWS? - E. B. Connell, MD
 10:00 Discussion
 10:30 COFFEE BREAK

BARRIER CONTRACEPTION

Moderator: E. B. Connell, MD
 11:00 THE CHANGING ROLE OF FEMALE BARRIER METHODS - E. B. Connell, MD
 11:30 SPERMICIDAL ACTIVITY OF MEDICATED CONDOMS - E. B. Connell, MD
 11:30 Discussion
 12:00-12:30 THE SUPREME COURT DECISION: A DECADE OF CONTROVERSY - E. B. Connell, MD

ORAL CONTRACEPTION

Moderator: R. A. Hatcher, MD, MPH
 1:00 pm SYSTEMIC EFFECTS OF ORAL CONTRACEPTIVES - A. Yuzpe, MD
 2:00 PROS AND CONS OF PURE PROGESTIN THERAPY - E. B. Connell, MD
 2:30 Discussion
 3:00 COFFEE BREAK

STERILIZATION

Moderator: R. A. Hatcher, MD, MPH
 3:45 FEMALE STERILIZATION AND REVERSIBILITY - A. Yuzpe, MD
 4:15 IS VASECTOMY SAFE? - R. A. Hatcher, MD, MPH
 4:45 Discussion
 5:15 Adjournment
 6:30 Evening at Cyclorama

FRIDAY, OCTOBER 7, 1983

7:00 am Optional Workshops
 7:30 OPENING REMARKS - E. B. Connell, MD

HORMONAL AND IMMUNOLOGIC ASPECTS OF FERTILITY

Moderator: E. B. Connell, MD
 8:00 HORMONAL AGENTS AND FERTILITY REGULATION - E. B. Connell, MD
 8:30 THE ROLE OF IMMUNOLOGY IN FAMILY PLANNING - R. A. Hatcher, MD, MPH
 9:00 THE EFFECTS OF PROLACTIN ON THE REPRODUCTIVE CYCLE - W. H. Shubert, MD
 9:30 Discussion
 10:00 COFFEE BREAK

INTRAUTERINE CONTRACEPTION

Moderator: R. A. Hatcher, MD, MPH
 10:30 THE TALE OF THE DALTON SHIELD - E. J. Latham, MD, PhD
 10:50 A NEW PERSPECTIVE ON AN OLD PROBLEM - R. C. Lee, MD
 11:10 WHO IS A CANDIDATE FOR AN IUD? - E. B. Tyler, MD
 11:30 Discussion
 12:00-12:30 LUNCH: ADOLESCENTS AND THE LEGAL SYSTEM - E. DeFuria

CURRENT TRENDS

Moderator: W. Cates, Jr., MD
 1:30 pm PAPANICOLAOU SMEARS: WHEN AND WHY? - R. M. Bickman, MD
 2:00 PENDING LEGISLATION AND THE NURSE PRACTITIONER - J. King, RN
 2:20 CONTRACEPTION OR STERILIZATION? - A. Yuzpe, MD
 2:30 Discussion
 3:00 COFFEE BREAK

CURRENT CONTROVERSIES

Moderator: N. C. Lee, MD
 3:30 IS THERE A G SPOT? - M. G. Freeman, MD
 3:50 CHANGING PATTERNS IN THE DIAGNOSIS OF ECTOPIC PREGNANCY - R. DeGruen, MD
 4:10 TRENDS IN PREGNANCY TERMINATION - D. A. Grimes, MD
 4:30 THE FUTURE OF FAMILY PLANNING - R. A. Hatcher, MD, MPH
 4:50 Discussion
 5:15 CLOSING REMARKS - E. B. Connell, MD
 5:30 Adjournment

CONFERENCE DESCRIPTION . . .

The following topics will be covered during the course of the conference:

- Oral Contraceptives
- Intrauterine Devices
- Barrier Contraceptives
- Male and Female Sterilization
- Pregnancy Termination
- Current Trends in Contraceptive Research
- Medical Aspects of Gynecologic and Obstetric Practice
- Sexually Transmitted Diseases

PHYSICAL ASSESSMENT WORKSHOPS . . .

Four additional workshops will be offered. Each will include a film, the use of training models, and a slide and audiotape presentation. Each workshop has been approved for one hour additional credit. REGISTRATION LIMITED.

ACCOMODATIONS . . .

A block of rooms has been reserved at the Westin Peachtree Plaza for your convenience. The special rates are \$65.00 single and \$110.00 double. A hotel reservation card will be sent with your letter of confirmation of attendance. Reservation cards must be received by the hotel no later than September 13, 1982. You may also make reservations by calling the hotel at 404-659-1400; please indicate that you are a registrant for this conference.

LOCATION . . .

The conference will be held at the spectacular Westin Peachtree Plaza, designed by architect John Portman. The Plaza, the tallest hotel in this country, is located in Peachtree Center, Peachtree at International Boulevard. It provides a year-round pool, health club and numerous places to eat and drink, including a revolving cocktail lounge at the very top. The hotel, being located in Peachtree Center, makes it readily accessible to shops, restaurants, entertainment, galleries and the merchandise apparel malls. The Plaza is easily reached by taxi and airport limousine. Valet parking with in and out privileges will be provided by the hotel at \$3.50/day (regular charge, \$7.50). Above all, Atlanta is a very beautiful city in the fall of the year. The mornings are cool, days are warm and the evenings are delightful.

CONTINUING EDUCATION CREDITS . . .

The Emory University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. This continuing medical education actively meets the requirement for 16 credit hours in Category I toward the Physician's Recognition Award of the American Medical Association. This activity is approved by the American College of Obstetricians and Gynecologists for 15 CME credits. Contact hours for nurses have been approved by the Emory University School of Nursing.

EVENING AT CYCLORAMA . . .

Arrangements have been made for the Conference Participants to have the exclusive use of the Grant Park Pavilion and Cyclorama facilities on the evening of October 6th, including a private viewing of the spectacular Battle of Atlanta. Following this, there will be a traditional Southern Barbeque. Bus transportation will be provided.

REGISTRATION FORM

Emory University School of Medicine Presents

FAMILY PLANNING AND REPRODUCTIVE HEALTH

October 6-7, 1983

Westin Peachtree Plaza • Atlanta, Georgia

	Advance	At The Door
Fee: <input type="checkbox"/> Physicians:	\$325.00	\$350.00
<input type="checkbox"/> Non Physicians:	85.00	95.00
	(Residents, Interns, Nurses and Students, etc.)	

Cancellations: Cancellations received 30 days preceding the conference will be refunded less a \$25.00 administrative fee. No refunds will be made on cancellations received after that time.

Lunch: October 6th \$12.50
 October 7th \$12.50

Cyclorama: October 6th \$25.00

October 6th, 7:00-8:00 a.m.

Assessment of the Female Pelvis

Assessment of the Male Genitalia

October 7th, 7:00-8:00 a.m.

Assessment of the Female Pelvis

Assessment of the Pregnant Patient

Name _____

Address _____

City/State/Zip _____

Office Phone _____

Home Phone _____

Checks should accompany the registration form and be made payable to Emory University.

Please return to:

Continuing Medical Education
 Emory University School of Medicine
 109 WMCAB, 1440 Clifton Road, N.E.
 Atlanta, Georgia 30322

FOR FURTHER INFORMATION . . .

Write or Call: Emory University School of Medicine
 Department of Gynecology and Obstetrics
 Family Planning Program
 69 Butler Street, S.E.
 Atlanta, Georgia 30303
 Attention: Dr. Connell 404-588-3706

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 AID 6/29.83
 ECON:CENORRIS
 AAO:EKMACMANUS:AM
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 AAO-2 ECON AMB, DCM CHRON
 AMEMBASSY LAGOS
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 INFO AMEMBASSY ABIDJAN
 AMEMBASSY NAIROBI

EEN
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 JAF

AIDAC

DEPT FOR AID/W - PLEASE ALSO PASS TO CDC, ATLANTA, MR. DALMAT

E.O. 12356: NA

TAGS: NA

SUBJECT: POPULATION - NATIONAL PLANNING

REF: (A) LAGOS 07118 (B) LAGOS 07203

1. SUMMARY: AT FINAL MEETING WITH DR. SULAIMAN, IT WAS AGREED THAT THREE STATES, ONDO, NIGER AND OGUN, WOULD SERVE AS ACCELERATION GROUP. THE CONCERNED STATE MINISTRIES OF HEALTH HAVE ALSO AGREED TO THIS. PATHFINDER PROJECT OFFICER, AJAYI HAS AGREED IN PRINCIPLE. FOLLOWING DR. SULAIMAN'S MEETING, APHA/CDC TEAM MET WITH AAO AND DEVELOPED FOLLOWING TRAINING/PLANNING PROGRAM AS NEXT STEP IN ACCELERATION PROGRAM. END OF SUMMARY.

2. SELECTED TEAM MEMBERS FROM THREE STATES WOULD PARTICIPATE AS UNIT IN FOLLOWING PROGRAMS:

-- A) SEPTEMBER 28, 29, 30 EMORY UNIVERSITY, DEPT. OF OB/GYN, FACULTY OF MEDICINE, ATLANTA, GEORGIA. COMPLETE CLINICAL UPDATING IN CONTRACEPTIVE AND INFERTILITY TECHNOLOGY AND TEACHING METHODS. EMORY CONTACT DR. E.B. CONNELL.

-- B) OCTOBER 3, 4, 5 US CENTERS FOR DISEASE CONTROL ATLANTA, GEORGIA- OBSERVATION, DISCUSSION AND DEMONSTRATION OF EVALUATION, PATIENT RECORD KEEPING, LOGISTICS, MANAGEMENT, PATIENT DATA SYSTEMS AND ANALYSIS. CDC CONTACT- DR. MICHAEL DALMAT.

-- C) OCTOBER 6, 7, ATTENDANCE OF GROUP AT SECOND ANNUAL CONFERENCE ON FAMILY PLANNING AND FAMILY HEALTH, ALSO TO BE HELD IN ATLANTA.

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-- THIS CONFERENCE IS CERTIFIED FOR CREDIT FOR LICENSURE OF U.S. PHYSICIANS AND NURSES. CONFERENCE IS WELL ATTENDED BY BOTH HEALTH CATEGORIES AS WELL AS BY INTERNATIONAL ATTENDEES BECAUSE OF ITS EMPHASIS ON HEALTH ASPECTS OF CONTRACEPTION.

-- D) DURING ATLANTA STAY, GROUP WILL BE HOUSED AT INTERNATIONAL HOUSE. CONTACT CONNELL/DALMAT.

-- E) OCTOBER 10 THROUGH 14 AT CENTER FOR DEVELOPMENT AND POPULATION ACTIVITIES (CEDPA), WASHINGTON, D.C. CEDPA IN CONJUNCTION WITH PATHFINDER WOULD CONFER WITH ACCELERATION GROUP ON PROGRAM MANAGEMENT PRINCIPLES AND BY END OF WEEK WOULD HAVE DEVELOPED FIVE YEAR PLANS FOR INTEGRATED PROGRAM IN FAMILY PLANNING SERVICES AND TRAINING IN ORAL REHYDRATION, FAMILY PLANNING AND IMMUNIZATIONS. EACH STATE HAS PROGRESSED SOMEWHAT IN THIS TASK, ESPECIALLY ONDO WHOSE PLAN IS ATTACHED AS AN APPENDIX TO APHA REPORT. THERE IS A NEED, HOWEVER, FOR GREATER UNIFORMITY IN PLAN DESIGN TO MEET FEDERAL MOH REQUIREMENTS AND TO MEET PATHFINDER FUNDING REQUIREMENTS. IN ORDER TO KEEP NURSE/MIDWIFERY TRAINING, TO BE SUPPORTED BY BOTH PATHFINDER AND JHPIEGO, ALONG THE SAME TRACK, IT WOULD BE USEFUL FOR CONNIE HUSMAN, RN JHPIEGO TO PARTICIPATE IN CEDPA WEEK. CONTACT PERSON: PEGGY CURLIN, V.P., CEDPA

-- F) ACCELERATION GROUP SHOULD BE BOOKED AT QUALITY INN, 1310, 16TH STREET, N.W., WASHINGTON, D.C. CEDPA CAN GET SPECIAL RATE.

3. RECOMMENDED TEAM MEMBERS ARE:

-- A) ONDO STATE

- 1. J.I.A. ADETOSOYE, M.D. PERMANENT SECRETARY, MOH
- 2. A.A. ADETUNJI, M.D. PRINCIPAL, SCHOOL OF HEALTH TECHNOLOGY

-- B) NIGER STATE

- 1. SUSAN SABA, M.D. DIRECTOR OF PUBLIC HEALTH AND PLANNING
- 2. JUMAI MOHAMMED, R.N., CHIEF MCH SERVICES

-- C) OGUN STATE

- 1. DR. ONI, CHIEF MEDICAL, HEALTH MANAGEMENT BOARD
- 2. A. MAKO, NURSING SISTER.
- 3. CHECK WITH MICHAEL DALMAT FOR FULL NAMES AND TITLES.

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-- D) FEDERAL MINISTRY OF HEALTH.
-- DR. J.A. LAOLE, ASSISTANT DIRECTOR, HEALTH EDUCATION.

-- MRS. A.O. PAYNE, DEPUTY CHIEF NURSING ADVISER.

-- E) OTHER STATES

-- 1. ALHAJI ARAF, M.D., PLATEAU STATE, PERMANENT SECRETARY FOR HEALTH.

-- 2. ALHAJI M. BONZA, SOKOTO STATE, DEPUTY BASIC HEALTH SERVICES.

-- 3. M.Y.I. SALAMI, M.D., MEDICAL OFFICER, LAGOS MINISTRY OF HEALTH.

4. ALTHOUGH PLATEAU STATE, SOKOTO AND LAGOS ARE NOT A PART OF THE INITIAL ACCELERATION STATES, WE BELIEVE THAT THROUGH HAVING REPRESENTATIVES AT THE OCTOBER MEETINGS, THESE THREE STATES WOULD LEARN THE FIVE YEAR PLANNING PROCESS WITHOUT HAVING TO SEND STATE TEAMS TO THE U.S. ALL OF THESE REPRESENTATIVES ARE KNOWN TO AAO AND ALL BUT LAGOS REPRESENTATIVES TO PATHFINDER STAFF. ALL VERY ENERGETIC AND INTERESTED IN FURTHERING F.P. ACTIVITIES. IF THREE CANNOT BE ACCOMODATED, ORDER OF PREFERENCE IS PLATEAU, SOKOTO, LAGOS.

5. IF POSSIBLE, THIS TRAINING FOR POPULATION, EDUCATION AND TRADITIONAL BIRTH ATTENDENT SESSION PLANS SHOULD BE COORDINATED WITH FPIA PROGRAM IN WASHINGTON FOR LADY DEBORAH J. JIBOWU, COMMISSIONER FOR POPULATION, ONDO STATE, MRS. A.O. PAYNE, DEPUTY, CHIEF NURSING ADVISER, FEDERAL MOE, AND MRS. B. OGUNODE, CHIEF INSPECTOR, MOE.

6. RECOMMENDED THAT DR. AJAYI, PARTICIPATE IN FULL PROGRAM AS SHOULD AID/W COORDINATOR FOR THIS EFFORT.

7. NAIROBI - PLEASE PASS TO DR. AJAYI, PATHFINDER AND MS. NANCY HARRIS, FPIA. PICKERING###

8. PLEASE ADVISE SOONEST PATHFINDER, FPIA AND AID/W SUPPORT AND REACTION. PICKERING##

5. DAY EIGHT WAS SPENT IN IBADAN (OYO STATE). THE PERMANENT SECRETARY FOR HEALTH THERE SAID HE WOULD WELCOME HELP IN TRAINING, SUPPLIES AND INFORMATION/EDUCATION. HE PARTICULARLY NOTED THE LARGE NUMBERS OF ADOLESCENT WHO NEEDED COUNSELING AND SERVICES. LATER WE VISITED DR. WINDOKUN'S IMPRESSIVE MODEL ADOLESCENT CLINIC AND THE IBADAN UNIVERSITY HEALTH EDUCATION CENTER.

6. DAY NINE, TEN, AND ELEVEN WERE SPENT IN THE REMOTE STATE OF NIGER (SMALLEST IN AREA, POPULATION AND PER CAPITA INCOME). THE PEOPLE OF NIGER ARE DIVIDED INTO THREE ETHNIC GROUPS. THE TEAM WAS ENTHUSIASTICALLY RECEIVED BY THE STATE MINISTER OF HEALTH, THE PERMANENT SECRETARY OF HEALTH, THE DIRECTOR OF PUBLIC HEALTH AND PLANNING AND THE PUBLIC HEALTH NURSE IN CHARGE OF MCH. IN THE ABSENCE OF CONTRACEPTIVE SUPPLIES, THE STATE HAS WISELY REFRAINED FROM ESTABLISHING F.P. CLINICS, BUT THROUGH INTRAHEALTH HAS TRAINED EIGHTEEN PEOPLE INCLUDING THREE DOCTORS, TWO HEALTH EDUCATORS AND THIRTEEN NURSE/MIDWIVES. IN ANTICIPATION OF OUR VISIT, THE STATE HAD DRAWN UP A FIVE YEAR PLAN WHICH UNLIKE THE ONDO PLAN, WAS LIMITED TO HEALTH PERSONNEL. NIGER HEALTH OFFICIALS, HOWEVER, INTRODUCED THE TEAM TO OFFICIALS OF THE STATE MINISTRIES OF EDUCATION AND LOCAL GOVERNMENT, BOTH OF WHICH WERE ENTHUSIASTIC ABOUT THE PROSPECT OF ADDING F.P. TO THEIR FAMILY HEALTH ACTIVITIES. NIGER STATE OFFICIALS RECOMMENDED THAT CONTRACEPTIVE METHOD SPECIFIC INFORMATION AS WELL AS POPULATION EDUCATION MATERIALS BE INCLUDED IN SESSION PLANS. WHETHER THIS TYPE OF FRANK MESSAGE WILL BE APPROVED AT THE FEDERAL LEVEL HAS NOT BEEN DETERMINED. WHAT IS CLEAR NOW IS THAT ALMOST NOTHING IS BEING TAUGHT BECAUSE THE INSTRUCTORS HAVE NOT BEEN TRAINED IN THE TEACHING OF POPULATION EDUCATION OR FAMILY PLANNING.

7. WHILE REST TEAM WAS IN IBADAN AND NIGER, MICHAEL DALMAT (CDC) MADE IN DEPTH REVIEW OF COLUMBIA/PATHFINDER CES PROJECT AND WORKED WITH DR. AYORINDE AJAYI (PATHFINDER) AND HEALTH OFFICIALS IN OGUN TO DEVELOP ACCELERATED PROGRAM FOR THAT STATE.

8. DAYS TWELVE THROUGH SIXTEEN WERE SPENT IN LAGOS

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AJAYI AT PATREFINDER. GEIPER

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CLASS: UNCLASSIFIED
 CERGE: AID 6/22/83
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 DISTR: AAO-2 ECON AME
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DEPT FOR AID/W

L.O. 12356: NA

TAGS: NA

SUBJECT: POPULATION: VISIT OF DR. SULAIMAN, MOH

REF: STATE 159863

1. AT CONCLUSION OF JUNE CONSULTANTS DEBRIEFING OF DR. SULAIMAN, AAO RAISED TIMING OF HIS VISIT TO WASHINGTON. HE SAID THAT HE WOULD BE ABLE TO BE IN WASHINGTON FOR CONSULTATIONS AUGUST THREE, FOUR AND FIVE AND IN NEW YORK ON AUGUST 8 FOR ADDITIONAL MEETINGS. ON AUGUST 9, DR. SULAIMAN WOULD DEPART FOR NIGERIA.

2. SUGGEST FOLLOWING AGENDA:

- - A) AAO WILL GO TO BILL BAIRS OFFICE AT 8:30 ON AUGUST THREE.
- - B) MEET WITH APPROPRIATE AID/W STAFF FOR ONE HOUR.
- - C) AFTER THIRTY MINUTE COFFEE BREAK, STATE, AID/W, AAO AND JUNE CONSULTANTS WOULD MEET FOR TWO HOURS.
- - D) AFTER ONE HOUR LUNCE BREAK, SAME GROUP WOULD MEET WITH DR. SULAIMAN AND AID/W CENTRALLY FUNDED ORGANIZATIONS TO DISCUSS STRATEGY FOR INTEGRATED FAMILY HEALTH/FAMILY PLANNING PROGRAM IN NIGERIA.
- - E) SAME GROUP WOULD MEET MORNING OF AUGUST FOUR, TO COMPLETE DISCUSSION AFTER WHICH JUNE CONSULTANTS COULD RETURN TO RESPECTIVE INSTITUTIONS.
- - F) AFTERNOON SESSION WOULD INCLUDE REPRESENTATIVES OF FAMN AND UNFPA, IF POSSIBLE, PLUS STATE OFFICIALS AND AID/W.
- - G) EVENING OF AUGUST FOUR, MACMANUS WILL HOST SMALL DINNER FOR NIGERIAN AMBASSADOR, CHIEF EKE, AMBASSADOR BENEDICT, AND DIRECTOR FOR HEALTH AND POPULATION (ST/HP), DR. GEORGE CURLIN AND DR. STEVEN SINDING TO HONOR DR. SULAIMAN. MACMANUS WILL SEND INVITATIONS.
- - H) EARLY MORNING OF AUGUST FIVE, DR. SULAIMAN SHOULD MEET WITH DR. CURLIN AND DR. JOE DAVIS AND OTHER AF/TR/E OFFICIALS IF APPROPRIATE.
- - I) REMAINDER OF DAY SHOULD BE LEFT FOR DR. SULAIMAN TO MEET WORLD BANK OFFICIALS.
- - J) DURING HIS AUGUST EIGHT VISIT TO NEW YORK, IT WOULD

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BE USEFUL FOR DR. SULAIMAN TO MEET WITH DR. LOUISE
 TYRER, MEDICAL AFFAIRS, PPPA AND DR. DAN WEINTRAUF,
 DIRECTOR, FPIA. UNDERSTAND FORMER WILL VISIT
 NIGERIA IN SEPTEMBER. REMAINDER OF DAY WILL PROB-
 ABLY BE SPENT WITH UNEPA STAFF.

4) AAC WILL BE ON LEAVE ON FRIDAY AUGUST FIVE, BUT
 COULD ACCOMPANY DR. SULAIMAN TO FPIA ON AUGUST
 EIGHT.

5) AAC WOULD RETURN TO AID/W FOR FULL DAY OF
 MEETINGS ON AUGUST NINE. WOULD LIKE TO MEET WITH
 DONNELLY AND STAFF, CEOU, WILEY, TROTT, ROTHE AND
 BACKSTOPS FOR CONTRACEPTIVE PREVALANCE, RAPID,
 AND INTRAF. THESE MEETINGS SHOULD BE GROUPED OR
 INDIVIDUAL ACCORDING TO YOUR JUDGMENT.
 IF FICHER IS BACKSTOPPING NIGERIA, REQUEST THAT HE
 ATTEND ALL SESSIONS. REGRET THAT PAIR AND SEIMES
 WILL NOT BE IN WASHINGTON.

6. UNLESS THERE ARE PROBLEMS WITH ABOVE SCHEDULE, REQUEST
 THAT AT/TP/P COORDINATE MEETING ROOMS AND MAKE ALL
 APPOINTMENTS IN WASHINGTON AND NEW YORK FOR SULAIMAN AND
 AAC. PLEASE ADVISE IMMEDIATE NAME AND TELEPHONE OF
 COORDINATOR IN CASE AAC NEEDS TO CALL BEFORE HER DEPARTURE
 FOR ENGLAND ON JULY ONE. ALSO REQUEST RESERVATIONS FOR
 SULAIMAN AT QUALITY INN 1310 15TH STREET. CEDPA (CURLIN)
 CAN SECURE A SPECIAL RATE FOR HIM. HOTEL RESERVATIONS IN
 NEW YORK FOR DR. SULAIMAN, AUGUST SIX, SEVEN AND EIGHT
 SHOULD ALSO BE MADE. PERHAPS FPIA OR UNEPA CAN SUGGEST
 CONVENIENT HOTEL.

7. PATHFINDER SHOULD PROVIDE PREPAID TICKET FOR DR.
 SULAIMAN LAGOS/WASHINGTON/NEW YORK/LAGOS TO COINCIDE WITH
 THESE DATES. NO ESCORT IS REQUIRED. PLEASE ADVISE AAC
 OR MRS. SHITTA WHERE AND WHEN TICKET IS TO BE PICKED UP IN
 LAGOS AND HOW PER DIEM IS TO BE PROVIDED TO DR. SULAIMAN.

8. ABIDJAN - MACMANUS IS SELF FINANCING INTERNATIONAL
 TRAVEL COSTS OF TRIP FROM LAGOS/ WASHINGTON/LAGOS.
 REQUEST FUNDING CITATION FOR LOCAL TRAVEL AND PER DIEM
 NOT TO EXCEED SIX DAYS.

9. REGRET BURDEN THIS MESSAGE PLACES ON SHORT STAFFED
 OFFICES, BUT BELIEVE THIS MINI DONOR MEETING WILL BE

*Highly useful in terms of moving Nigerian program into
 Action phase*

LAGOS 7118 1/2

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 INFO RUEHAF/AMEMBASSY ABIDJAN 1479
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 DRFTD: AAO:EKMACMANI
 CLEAR: ECON:JAFORPE
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REPT FOR AID/W

F.O. 12356: NA

TAGS: NA

SUBJECT: POPULATION: JUNE CONSULTANTS (APHA)

1. SUMMARY. THE SEVEN POPULATION CONSULTANTS HAVE COMPLETED THEIR DRAFT REPORTS FOLLOWING FIELDWORK INCLUDING VISITS TO SIX OF THE NINETEEN STATES. ALTHOUGH LEVELS OF ENTHUSIASM AND PROGRAM SOPHISTICATION VARIED, A POSITIVE IMPRESSION WAS ENCOUNTERED IN EVERY STATE VISITED.

AAO MACMANUS ACCOMPANIED TEAM THROUGHOUT VISIT EXCEPT FOR BAIKAT'S (CTC) VISIT TO OGUN STATE. ALL OF TEAM HAVE DEPARTED EXCEPT CONNELL WHO IS INTEGRATING VARIOUS SECTIONS INTO FINAL REPORT AS WELL AS MEETING WITH KEY F.P. FIGURES IN LAGOS. SEPTELS FOLLOW ON SULAIMAN'S TRAVEL AND NEED FOR NIGERIAN PARTICIPATION IN PROPOSAL DEVELOPMENT IN THREE STATES. END SUMMARY.

2. THANKS TO SUPERP AID/W COORDINATION, APHA CONSULTANTS PEDERSEN, CURLIN, YACOOB, AND HOPKINS CONSULTANTS SMITE AND DE PIETRO ARRIVED ON JUNE ONE. ON FOLLOWING MORNING THEY MET WITH DR. SULAIMAN AND APPROPRIATE MEMBERS OF FEDERAL MOF. DISCUSSION WERE EXTREMELY POSITIVE AND FRANK. FOLLOWING DAY WAS SPENT IN SMALL GROUP MEETINGS WITH MOF STAFF, PPFA, AND LAGOS STATE MOE. DAY THREE AND FOUR WERE DEVOTED TO REVIEWING ENORMOUS AMOUNTS OF MATERIAL AND DATA GATHERED DURING INITIAL DAYS.

3. DAYS FIVE AND SIX WERE SPENT IN SOKOTO STATE WHERE MINISTRY WAS GENERALLY POSITIVE, BUT NOT AS CAPABLE OF USING U.S. TECHNICAL ASSISTANT AS OTHER STATES VISITED LATER BY THE TEAM. UNFORTUNATELY CHIEF NURSING OFFICER WAS IN LAGOS DURING TEAM VISIT. CONSULTANT CONNELL ARRIVED ON DAY SIX.

4. DAY SEVEN, WHICH WAS SPENT WITH ONDO OFFICIALS, WAS EXTREMELY PRODUCTIVE. IN ANTICIPATION OF ARRIVAL OF JUNE CONSULTANTS, ONDO OFFICIALS FROM THE STATE POPULATION COMMISSION, THE STATE MINISTRIES OF HEALTH, EDUCATION LOCAL GOVERNMENT AND THE LOCAL PPFM DIRECTOR HAD DEVELOPED A FIFTEEN PAGE INTEGRATED FIVE YEAR PLAN. THIS OUTLINED STATE STAFF AND INFRASTRUCTURE RESOURCES AND LISTED TRAINING NEEDS AND SUPPLY REQUIREMENTS.

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AREA WHERE MEETINGS WERE HELD WITH PPHN AND UNIVERSITY AND STATE LEVEL HEALTH OFFICIALS.

9. WORKING AS AN INTEGRATED TEAM, THE CONSULTANTS PREPARED A TEN PAGE DEBRIEFING REPORT FOR THEIR EXIST INTERVIEW WITH DR. SULAIMAN AND HIS SENIOR STAFF ON JUNE 17. DR. SULAIMAN ALSO INVITED TWO UNICEF STAFF MEMBERS TO ATTEND. THE TEAM MEMBERS MADE PRESENTATIONS OF FINDINGS AND RECOMMENDATIONS IN THE FOLLOWING AREAS:

- A) TRAINING NEEDS
- B) LOGISTICS AND SUPPLIES REQUIREMENTS
- C) PATIENT RECORD CARD AND DATA SYSTEMS
- D) PATIENT EDUCATION, INFORMATION AND MOTIVATION
- E) MODEL STATE PROGRAMS FOR ONDO, NIGER AND OGUN.

10. DR. SULAIMAN SAID THAT HE FOUND THE DEBRIEFING REPORT TO BE PRACTICAL, HIGHLY USEFUL AND BEAUTIFULLY PREPARED. HE SAID THAT THE MOH WOULD WORK WITH THE MOE ON THE INCLUSION OF A FAMILY PLANNING MODULE WITHIN THE TEACHERS-COLLEGES FAMILY HEALTH COURSE. HE AND HIS STAFF EAGERLY SUPPORTED RECOMMENDATION THAT SESSION PLANS BE DEVELOPED TO BE USED BY THE VARIOUS INSTRUCTORS IN THE FUTURE TRAINING OF STAFF. SESSION PLANS FOR ORAL REHYDRATION WOULD ALSO BE DEVELOPED. FORTUNATELY, THESE SESSION PLANS CAN BE INCORPORATED INTO THE CURRENT CURRICULUM AND THEREFORE WILL NOT ENCOUNTER THE BUREAUCRATIC DELAYS A CURRICULUM REVISION WOULD ENTAIL.

11. DR. SULAIMAN ALSO APPROVED THE TEAM RECOMMENDATION THAT THE PROGRAM BE INSTITUTED ON AN ACCELERATED BASIS IN THE THREE STATES, NIGER, ONDO AND OGUN WHERE LINES COULD BE WORKED OUT BEFORE FULL NATIONWIDE IMPLEMENTATION IS UNDERTAKEN.

12. SEPTTEL FOLLOWS ON PROPOSED PLANNING SESSION FOR THREE STATES IN OCTOBER AND ON DR. SULAIMAN'S VISIT IN AUGUST.

13. EXCEPT TEAM LEADER CONNELL, JUNE CONSULTANTS HAVE DEPARTED. IN ADDITION TO MEETING WITH FEDERAL AND STATE OFFICIALS, CONNELL IS COMPLETING FINAL DRAFT APHA REPORT AND WILL POST IT TO APHA THE WEEK OF JUNE 27. SHE WILL SEND COPIES OF THE REPORT TO THE OTHER THREE APHA CONSULTANTS AND TO MICHAEL DALMAT. SEPTTEL FOLLOWS ON JOHN HOPKINS I AND E REPORT.

14. WE WOULD APPRECIATE YOUR ADVISING APHA THAT WE WERE EXTREMELY PLEASED WITH JUNE CONSULTANTS WHO PROVED TO BE ENTHUSIASTIC, DEDICATED, ENERGETIC, FLEXIBLE AND HEALTHY, AS REQUESTED. WE WOULD LIKE ALSO TO SINGLE OUT EXCELLENT WORK OF DR. DALMAT (CDC) AND DR. AJAYI (PATHFINDER) FOR THE KEY ROLES THEY PLAYED IN THE DEVELOPMENT OF THE FINAL RECOMMENDATIONS.

15. PAO LOOKS FORWARD TO DISCUSSING FINAL REPORT IN AID/1 IN AUGUST.

16. FOR NAIROBI PLEASE PASS TO NANCY HARRIS FPIA AND

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