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Association
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**DEVELOPMENT OF PERMANENT
AND LONGTERM CONTRACEPTION
IN NIGERIA, 1986-1990**

**REPORT OF A CONFERENCE HELD AT THE DURBAR HOTEL,
KADUNA, NIGERIA
AUGUST 7-10, 1990**

Hosted by the Ahmadu Bello University Teaching Hospital (ABUTH)
and the Kaduna Ministry of Health

In collaboration with the
Association for Voluntary Surgical Contraception (AVSC)

And with sponsorship from the
United States Agency for International Development (USAID)

Acknowledgments

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The support of the Kaduna State Ministry of Health and Commissioner of Health were greatly appreciated. AVSC is also grateful for the sincere support and active participation brought to the conference by the Federal Ministry of Health Department of Population Activities and Department of Primary Health Care.

This conference owes its success most importantly to the enthusiasm and dedication of all its participants, who came from throughout the country and from neighboring Ghana. AVSC wishes to thank them for their commitment to sustaining and developing voluntary surgical contraception as a family planning option in Nigeria.

Special mention should be made of the participation of the State Family Planning Coordinators from Kaduna, Plateau, Oyo, Benue, Rivers, Akwa Ibom, Imo, Cross River, Sokoto, Ondo and Kwara states for their valuable contributions to this event.

We also wish to acknowledge with sincere appreciation the vital contributions that the VSC Zonal Leaders and their Deputies continue to make toward supporting and expanding voluntary surgical contraception services throughout Nigeria.

Finally, AVSC thanks the United States Agency for International Development for its financial support of the conference.

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I. EXECUTIVE SUMMARY

This four-day conference, hosted by Ahmadu Bello University and the Kaduna State Ministry of Health, brought together some ninety participants including officials of the federal and state ministries of health, faculty of the major teaching universities and medical centres providing voluntary surgical contraception (VSC), representatives of public and private sector agencies involved in family planning (FP), and direct service providers working at VSC facilities all over the country.

The principal aims of the conference were to review recent progress in surgical contraception in Nigeria and to develop practical strategies to ensure that Nigeria can continue to integrate and institutionalize voluntary surgical sterilization services, making them readily available to all women and men who desire to limit their fertility. To paraphrase the major recommendations,

1. Federal Ministry of Health (FMOH) should encourage state and local governments to use the newly-developed data reporting system, so as to allow for meaningful programme planning.
2. To reduce VSC costs to clients and increase access, FMOH should explore in-country manufacture of FP commodities and equipment. FMOH should also seek assistance from Nigerian corporate bodies and philanthropists.
3. All agencies--Nigerian, bilateral and multilateral--working in support of family planning should include VSC-related support in their assistance.
4. FMOH should continue and expand its laudable efforts in Information and Education for family planning, and should devote more attention to surgical methods.
5. FMOH and State ministries of health (SMOHs) should encourage more active communication between private and public sector FP agencies/providers.
6. To improve access, FMOH and SMOHs should make sure that general hospitals and comprehensive health centres are properly equipped, in both materials and personnel, to carry out VSC procedure. All FP counsellors should know how to counsel and refer potential VSC clients.

Another major conference objective was to discuss Norplant, a newer, long-acting contraceptive that is surgically inserted under the skin of a woman's upper arm. The government of Nigeria, following the lead of other countries, may approve Norplant for general use within the next one to two years. In anticipation of this possibility, the conferees developed ideas to help the Ministry of Health, the medical leadership and family planning service personnel introduce Norplant information, education and services to the Nigerian public. To cite the key recommendation,

1. FMOH should consider introducing Norplant as an approved family planning method in the country as soon as possible.

II. CONFERENCE THEMES AND OBJECTIVES

The growth of VSC in Nigeria

As recently as 1984 there was very little VSC activity in Nigeria. The past six years have witnessed tremendous growth, not only in the number of procedures provided but more importantly in the general acceptability among Nigerians of permanent contraception as a family planning option. Sterilization is now pulling into second place behind the IUCD for the greatest contribution to couple-years of protection. At the level of national government, the current Administration has enunciated a clear population policy; explicit support for family planning including permanent methods has been voiced at the highest levels and is now unequivocal.

Context and rationale for the 1990 Kaduna conference

The present conference, hosted by Ahmadu Bello University and the Kaduna Ministry of Health, has built upon two preceding meetings sponsored by AVSC and hosted by Nigerian institutions. In August of 1987, all the VSC providers in the country gathered in Jos to establish norms and guidelines for voluntary surgical contraception and to plan for the institutionalization of VSC services across the country. Conferees at that meeting developed a set of recommendations to assure the high quality of all VSC procedures performed in Nigeria and created the zonal system in which four university teaching hospitals serve as hubs for technical assistance and coordination in VSC.

In August of 1989 AVSC convened a follow-up conference in Benin City to discuss means to promote sustainability for VSC services in Nigeria. This meeting brought together officials of the federal and state Ministries of Health as well as representatives from family planning agencies working in Nigeria, along with the VSC zonal leaders and service providers from the public, university and private sectors. The purpose was two-fold: to increase the FP agencies' awareness of surgical contraception and to enhance collaboration and communication among agencies in both the public and private sectors. As before, this conference produced recommendations--many of which have already been implemented. For example, as was recommended at the 1989 conference, the Federal Ministry of Health has increased its budget to purchase contraceptive commodities for all public sector programs. The Ministry has also become more actively involved in training activities, reproductive health curricular revision and information & education (I&E) activities.

With the advent of this 1990 conference in Kaduna, an even broader range of participants, including planners and administrators, came together. It was anticipated that the sessions would offer a forum to explore practical ways to build upon the sound foundation already laid in Nigeria and make VSC sustainability a reality.

Conference themes and objectives

The specific objectives of this meeting were to:

1. review VSC programmes and progress nationally from 1986 through 1990;
2. forge a stronger link between federal- and state-level policy support for VSC and the commitment and work of service providers in the field;
3. develop practical recommendations to further integrate surgical contraception into all public and private sector maternal and child health/family planning (MCH/FP) programmes;
4. inform participants about other recent developments in longterm contraceptive methods and their potential for use in Nigeria: these sessions focused mainly on the Norplant (TM) implant.

The conference adopted a combined format of full plenary sessions and smaller working groups. The emphasis of the working groups was to use a "brainstorming" approach to generate and discuss workable solutions to commonly-felt problems and needs. Each group analyzed a case study addressing one of the following themes:

- I) Integration of Technical Assistance with Quality Assurance
- II) The Public Sector--Expansion of Services
- III) Gaining Acceptance for VSC through Information, Education and Communication (IE&C) efforts
- IV) The Private Sector--Increasing Coordination, Removing Barriers
- V) Access--Serving more Clients

In response to the case studies, all working group generated sets of recommendations that they presented to the plenary on Days Two and Three. These recommendations were distilled by a smaller sub-committee comprising representatives of the MOH, the Family Planning Coordinators, zonal leadership, AVSC and the private sector (membership listed in Appendix E). They are presented in the next section of this report.

Norplant: a promising long-term method for Nigeria

Participants devoted most of the fourth (and final) day to reviewing the experience to date in Nigeria with Norplant (TM) and discussing programmatic issues that may arise in connection with its generalized use. Norplant is a long-acting (up to 5 years), progestin-only (levonorgestrel) contraceptive that is delivered via six Silastic capsules surgically placed under the skin of a woman's upper arm. It appears likely that the federal government will approve Norplant for general use within the next one or two years. (Note: The United States granted approval to Norplant in late 1990.) With this eventuality in

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mind, four working groups addressed these themes as they relate to the special characteristics of the Norplant method:

- a) Counselling, client selection and client satisfaction
- b) The approval process, supply/distribution and medical quality assurance
- c) Follow-up and removal
- d) Integrating Norplant into the national FP programme.

Norplant-related issues are further discussed in the "Recommendations" and "Future Directions" sections of this report.

III. RECOMMENDATIONS FOR ACTION

One of the principal aims of the conference was to enable the participants to share experience and exchange ideas in smaller working groups. The smaller groups could tackle specific issues, "brainstorm" together and suggest solutions or strategies that the Nigerian government and other key organizations would find useful.

The working groups analyzed case studies that dealt with the following themes:

- I) Integration of Technical Assistance with Quality Assurance.
- II) The Public Sector--Expansion of Services
- III) Gaining Acceptance for VSC through Information, Education and Communication (IE&C) Efforts
- IV) The Private Sector--Increasing Coordination, Removing Barriers
- V) Access--Serving More Clients

Each group "dissected" the problems and issues brought out by its case study, then devised solutions and recommendations, specifying in each instance which individual(s) or organization(s) would have primary responsibility for carrying out the proposed actions. Later, a smaller subcommittee (membership listed in Appendix C) distilled all the groups' suggestions into the following set of recommendations for action.

Official Recommendations

Preamble: It has been observed that data collection and reporting in the country is poor and does not allow for meaningful planning.

Recommendation:

1. The Federal Ministry of Health (FMOH) should encourage state and local governments to monitor the family planning activities of public and private institutions, in keeping with the new reporting system developed by the federal government.

Preamble: To enable VSC and other family planning services to reach a wider segment of the Nigerian population, there is a need to make these services affordable to clients.

Recommendations:

1. As a means of reducing the cost of family planning to consumers, the FMOH should explore possibilities for setting up in-country manufacture of some FP commodities and equipment (e.g., operating tables and lamps, instrument trolleys, etc.).
2. The FMOH should seek assistance for FP service expansion from Nigerian philanthropists and corporate bodies.

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3. The time has come when all agencies (Nigerian, bilateral and multilateral) working in support of FP should include VSC-related support in their assistance.

Preamble: It is becoming obvious that the current growth in contraceptive prevalence can be largely credited to the information, education and communication (IE&C) efforts by federal government agencies.

Recommendation:

1. The FMOH should continue its commendable efforts in Information, Education and Communication (IE&C) for family planning, and should devote more attention to surgical methods.

Preamble: It has been observed that private sector facilities find it difficult to offer reasonably-priced FP services, especially in VSC, because of the high cost of commodities and expendable supplies.

Recommendations:

1. The FMOH should help to make the purchase of commodities and materials for VSC less expensive for private sector facilities, or make these facilities aware of more economical supply sources (such as FPIA). The Federal Ministry should also investigate ways to waive import tax and duties for all family planning commodities.
2. FMOH should alert the private sector to the need to communicate through the State and Federal Ministry on matters [i.e., present or intended activities] relating to health in general and FP in particular.
3. A more active referral pattern between the private and public sector should be encouraged.

Preamble: Despite increasing demand for VSC, accessibility to services has been hampered by shortage of sites, personnel and space.

Recommendations:

1. The Federal and State Ministries of Health (SMOH) should ensure that all general hospitals and comprehensive health centres are properly equipped, in both materials and personnel, to carry out VSC services.
2. Efforts should be made to strengthen the capabilities of all teaching hospitals in the country in the area of training and research.
3. Wherever FP services are rendered, counselling should include VSC as a method. (Counsellors at facilities not currently providing VSC should know where best to refer clients desiring permanent contraception.) Therefore, VSC counselling should be emphasized in the nationally-used curriculum for FP training.

4. It has been observed that staff trained in FP are not always deployed in FP service areas. Selection of staff to attend FP training should take into account the possibility for their appropriate deployment in FP service areas upon completion of training. Similarly, transfer of personnel should be made with due cognizance of their particular training.
5. Managerial training for clinic supervisors should be intensified.
6. Policymakers at federal, state and local government levels should be exposed to managerial courses in FP.

Norplant in Nigeria: Recommendations for action

One recommendation was directed specially at Norplant:

Preamble: During this conference, there was convincing evidence from papers presented that Norplant (TM) is well-accepted by most Nigerian women on whom it has been tried. It was also shown to be safe and very effective.

Recommendation:

1. The FMOH should consider introducing Norplant as an approved family planning method in the country as soon as possible.

As noted earlier, the fourth day of this meeting was dedicated entirely to the outcome of Norplant field trials in Nigeria supported by Family Health International and preliminary results of AVSC-supported studies on the acceptability of clinical methods including Norplant in Nigeria. Four small working groups produced recommendations for the future introduction of Norplant in Nigeria. Each group focused on one of four themes:

- I. Counselling, client selection and client satisfaction
- II. Medical quality assurance and training
- III. Follow-up and Removal
- IV. Integrating Norplant into the national Family Planning program.

The Counselling, client selection and client satisfaction group recommended that counselling should include husbands as much as possible, that all clients should receive counselling and that providers should make sure the Norplant client desires a longterm method. Counsellors must clearly explain both the benefits and the common side-effects of Norplant, so that women know what to expect and are prepared for the more likely side-effects such as bleeding irregularities. Counsellors should offer reassurance to anxious clients, as this has been found to enhance their continuation and satisfaction with the method.

The working group considering Medical quality assurance and training recommended that AVSC assist in expanding Norplant training to all four zonal centres. Training should include insertion; removal; orientation to special needs for follow-up and counselling. Members of this group were also asked to

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address the topic of obtaining official approval for programmatic introduction of Norplant in Nigeria. They recommended prompt action for approval because the government is favorably disposed toward family planning and warned that this receptive climate could change as the government moves toward state and national elections in 1991 and 1992, respectively. This group requested the assistance of AVSC and Leiras (the company that markets Norplant) to convene a small leadership group that will carry out continuous follow-up until approval is granted.

The group that discussed Follow-up and Removal recommended a specific timetable for follow-up visits by Norplant users: clients would return one week after insertion, then at three months, 12 months, and thereafter annually for a routine exam including a reminder about the five-year removal guideline. This group recommended that nurses handle the routine revisits with referral to the doctors if a problem arose. Record-keeping should include a register of all Norplant users with specific contact information, including that of a relative or friend as a back-up contact. Counsellors would update this record whenever the client returned for follow-up care. Each client should also receive a clinic card clearly stating the insertion date and the fifth-year date to return for removal.

Integrating Norplant into the National Family Planning Programme was the theme discussed by the fourth group. This group in its recommendations stressed the need to mobilize two key groups: first, policymakers and leadership at the national level, and second, health providers at all levels throughout the country. The group recommended a variety of information and education activities for policymakers, traditional leaders, doctors, nurses, counsellors and community workers. The group also emphasized the need for curriculum development for pre-service and in-service training in the medical schools and schools of nursing and midwifery.

IV. QUALITY OF CARE

Presenters at the conference spoke on several of the essential contributors to quality of care in voluntary surgical contraception programmes.

Counselling's key role

Good counselling forms the backbone to quality VSC and other family planning services. A paper presented on behalf of Mrs. Bola Lana of the Pathfinder Fund cited these five guidelines that counsellors should always bear in mind:

- o show concern, maintain supportive attitude
- o seek to understand your client's problems and needs
- o develop empathy
- o assure your client's privacy
- o assure enough time

Mrs. Bose Ojobe of University College Hospital (UCH) emphasized the value of peer counselling for women who are considering sterilization. Being able to speak with a satisfied client is one of the most effective ways for potential VSC clients to dispel their fears and worries about the procedure. She also noted that programmes should begin training male counsellors to serve male clients.

During the question and answer period there was discussion about the nature of "good counselling." One participant asked whether advice can play any role in counselling: Indeed it can. There is nothing that should prevent a counsellor from offering advice or an opinion to his/her client, if the client so requests and after the counsellor has fully informed the client about the available options. Often clients will ask, "Counsellor, what do you think would be the best method for me to use?". A counsellor should respond to such questions by offering her/his honest opinion, while at the same time being careful not to impose her/his own biases or values on the client.

Beyond counselling per se, the way in which providers treat their clients can greatly influence the clients' satisfaction, noted Mrs. Grace Delano of UCH in her talk. Clients will stop patronizing FP centres where they encounter uncaring or harsh treatment, as studies at under-utilized FP sites have confirmed.

Medical monitoring and quality assurance

Effective monitoring and supervision are key to maintaining a quality VSC program. One of the most fundamental reasons for monitoring is to assure that medical safety standards are being met. As Professor Ekwempu of Ahmadu Bello University Teaching Hospital (ABUTH) reminded the assembly, nothing can destroy a programme more quickly than a death or severe complication among its clients. Professor Ekwempu summarized the major mechanisms for monitoring and supervision:

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Direct observation. Programme directors or trainers directly observe their providers and trainees in action, discussing and reviewing their performance with them either formally or informally. Site visits to outreach sites can reveal how well participants at a previous training or site staff perform.

Record keeping. With a good system of record keeping, programme managers can readily identify trends and directions in their programs. Reviewing record data from one site or several can reveal many things: for example, a drop-off in the number of clients served may suggest that something about the programme is putting them off. A higher-than-usual complication rate might point to problems in surgical technique or asepsis; similarly, records showing that a large volume of local anesthetic or heavy sedation was used during minilap procedures would raise a red flag: Is the surgeon appropriately trained and skilled in the latest methods? Are counsellors preparing clients well enough on what to expect during the operation?

Self-assessment. The speaker stressed that "Programme staff at whatever level should be encouraged to conduct a self assessment regularly...A good method of self assessment... is the newly-introduced Client-Oriented, Provider-Efficient (COPE)" package, which looks at "such things as client flow, clients' perception of services, service staff/management interactions, time and material utilization." (COPE is described below.)

Research. While supervision aims to bring the performance of service providers up to best known techniques and standards of practice, research endeavors, through generating new and more accurate knowledge, to improve upon those techniques and standards themselves. Much of the recent increase in acceptance of permanent and longterm contraception can be credited to changes in practice that grew out of research findings. Formerly, tubal ligations were done only under general anaesthesia, which carried a mortality rate four times that associated with minilap under local. The introduction of local anaesthesia for tubal ligation served to popularise it.

Client-Oriented, Provider-Efficient Services ("COPE")

Across the African continent, many family planning programme leaders have been facing similar issues and asking the same sorts of questions: why are services under-utilized? why don't more women and men come forward for family planning when all indications suggest that there is active interest in child-spacing and family size limitation? Or conversely, when clinics are well-used, even over-extended, how can the limited staff attend to all their clients? As the number of clients increases, sometimes dramatically, how can family planning providers modify the way they work so that they can satisfy the increased demand?

With these considerations in mind, AVSC launched the Client-Oriented, Provider-Efficient (COPE) project. The idea was that COPE would be a vehicle for clinic workers to take a detailed look at their own clinic organization and management as these relate to service delivery.

What exactly is the COPE exercise? It comprises two parts: a Client Flow Analysis (CFA) and a Self-Assessment Checklist. The Client Flow Analysis can reveal how long the average client has to wait to be seen, how long she actually is in contact with providers, and where the excessive delays occur. It can also show how much of the staff time is devoted to direct client care, possibly revealing inefficiencies in staff working patterns. The second part of COPE, the Self-Assessment Checklist, is a set of questions that provoke personnel to think about how their family planning facility operates and how it might run better. Administrators, surgeons, counsellors, theatre personnel, recordkeeping staff and outreach workers each complete a section of the checklist. For example, a counsellor would ask herself such questions as, Do the counselling sessions inform clients about all methods? Does the area for counselling offer enough privacy?

COPE is above all a participatory exercise. Staff at all levels are involved. Once a facility conducts the COPE exercise the first time, they can see how it works and will be able to use it again themselves from time to time. The process itself can be very useful for clinic staff, as it brings them all together for a common purpose. The results, too, have been encouraging. Examples of problems identified by COPE include:

- severe lack of waiting room space
- VSC-trained staff frequently transferred to other areas of the hospital
- clinic poorly marked, or signs too small for easy reading
- inadequate support, communication, or feedback from administrators on issues affecting the programme's success

What is the impact of COPE on quality of care? It is still early to know definitively. However, early follow-up has found that some sites have drastically cut their client waiting times. Some sites have devised ways to redistribute staff workload more equitably, allowing more time for breaks during slow periods of the day. Several locations have shown a noticeable increase in the number of VSC clients they serve each month.

V. SUSTAINABILITY: DIVERSIFYING RESOURCES FOR VSC

Recent growth and consolidation of family planning

The past five years have seen a major expansion in the public sector for family planning services. As Dr. Richard Sturgis noted, the number of individuals obtaining family planning for the first time has climbed steeply, from under 100,000 new requestors nationally in 1985 to over 400,000 in 1989. Southern states have shown annual growth rates of over 200 percent, while growth in the Northern zones has been more modest.

Integrating surgical contraception into all family planning programmes

According to FHS data, female sterilization now accounts for eight percent of all couple-years protection in Nigeria. For many individuals who have completed their families, surgical contraception is becoming the method of choice. Improving access to sterilization services--both at new sites and at already-established ones--will therefore be crucial in the coming years. More importantly, the time has come to stop isolating permanent contraception from temporary methods: VSC needs to be seen as part-and-parcel of the contraceptive spectrum, and all those who provide family planning services must be able either to provide VSC or to appropriately refer clients to the nearest site that provides it.

Conference participants agreed that AVSC (with an annual budget of only about \$450,000 to spend in Nigeria) cannot singlehandedly support all VSC-related activities. Nor would it be appropriate for one agency to assume responsibility for any single FP method. Rather, as the conferees recommended, any governmental or non-governmental body that supports family planning should incorporate support for VSC in its assistance. This guideline should apply equally to support for information and education, training and direct service.

Role of the Federal Ministry of Health

As the FMOH Division of Population Activities representative (Mrs. Afolabi) made clear in her speech, the official climate for family planning has improved radically in the last decade. Until as recently as 1984, all Nigerian governments had opposed family planning. The current administration fully endorses family planning and has clearly stated its platform in a formal population policy which it approved in February of 1988 and launched at the national level in April of 1989.

To speed the implementation of the new policy, the Minister of Health established a Population Working Group. This body, comprising representatives of ministries, parastatals and NGOs with population-related activities, pursues greater integration and sustainability of population programmes/FP services. In addition to developing a workplan that defines the roles of each organization in relation to specific objectives, sectors and projects, the Working Group has taken these actions in relation to VSC:

- o names the institutionalization of VSC as an official goal and formally promotes the establishment of new VSC service sites

- o endorses the release of health providers to attend training to enable them to implement a VSC programme
- o approves the VSC zonal system structure
- o has incorporated VSC into the national training curricula for midwives, community health workers, community health officers, community health extension workers and voluntary health workers
- o has also integrated VSC into the in-service curricula for three cadres of FP providers: clinical providers, community health educators and voluntary health workers
- o includes VSC as a reportable procedure in the MOH's recently-developed Monitoring Information System (MIS) manual. This system provides for data collection at all levels of health care provision

The FMOH also plans to begin to establish VSC service capability at Comprehensive Health Centres (CHCs), which are the highest level of primary health care facility. To start with, Ministry will equip one CHC in each of the four zones. The Federal Director of Primary Health Care noted in his speech that "The Ministry is also working with AVSC in ensuring that the [zonal] system fits into the FMOH zones so as to ensure proper integration of the [VSC] programme with other FMOH programmes. The PHC Zonal Coordinators have been linked with the VSC leaders and are now developing a good working relationship."

Role of the state Ministries of Health

The state MOH representative from Benue State, Dr. C. T. Izonzughul, reminded conference participants that the state Ministries of Health have a key role to play in assuring VSC sustainability. Since many VSC service sites are primary or secondary care centres (as opposed to tertiary teaching hospitals), they come under the jurisdiction of the SMOH. Private health facilities also lie within the domain of state-level governance. Therefore, the State Ministries want to develop their skills and institutional capacity to carry out needs assessments, programme planning, programme implementation, and monitoring and evaluation activities as related to permanent and temporary family planning services.

The present strength of the state-level MOH is good managerial capability. The speaker noted that SMOHs are handicapped foremost by limited funding, and he stressed that SMOHs must endeavor to secure funding--both from the FMOH and from appropriate donors.

Sustainability: Participation by other FP agencies

As noted above, it is evident that AVSC does not have the resources to support all VSC-related activities in Nigeria--nor would it be appropriate for AVSC to do so. Most of the other major Nigerian-based agencies working within family planning fall under the Family Health Services II (FHS-II) project, a multimillion dollar initiative funded by U.S. Agency for International Development. Targeted support from FHS-II agencies like the Pathfinder Fund, Family Planning International Assistance (FPIA) and Population Communication Services will help assure the integration and sustainability of VSC within the

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national Maternal and Child Health/Family Planning programme. As examples of the support already rendered by major FP agencies,

- o Pathfinder supported development of the FMOH's Management Information Systems manual that includes VSC among the reportable contraceptive methods
- o Population Council has funded VSC-related operations research
- o Population Communication Services will feature permanent as well as temporary contraception in its forthcoming I&E resources

Soliciting support from large international donors

In their quest for VSC support, family planning leaders should not overlook the major international health and development donors. Currently, the World Bank is providing major funding to construct and upgrade Ministry of Health surgical facilities. This sort of broad assistance provides an ideal opportunity for officials to make a special appeal for support of equipment and/or supplies for sterilization surgery.

The private sector scene: more opportunities for VSC integration

It is often hard to capture information about what is happening within the diverse and decentralized private sector--all of the private doctors' offices, clinics and hospitals, traditional birth attendants, community-based contraceptive distributors and so forth. However, Dr. Sturgis characterized the current scene as very lively. Some doctors working in the private sector have begun to promote and provide VSC services to their private patients on a fee-for-service basis. It was agreed that private sector services deserve to be encouraged; the FHS-II Project (FHS) has been very involved in developing family planning services within the private sector.

VI. IMPORTANT FUTURE DIRECTIONS

During the last two days of the meeting, attention turned toward addressing future directions for family planning in Nigeria. Professor Ladipo spoke about key issues that Nigeria will face in the nineties. Other speakers addressed innovative approaches and new family planning techniques that are expected to grow in importance.

Family planning themes for the nineties

In the coming decade, it will be critical to earn continued commitment to family planning from the civilian government that will take power in 1992. There will also be a continuing need to involve and mobilize "community-level leaders, traditional chiefs, Obas and thought leaders whose acceptance of the concept of family planning is essential to the success of village programmes." As the speaker reminded his audience, "although many of these leaders have little or no formal education, they are intelligent, extremely receptive, and committed to initiating any health programme that will improve quality of life."

High quality of care will remain as essential as ever. Family planning programme managers must endeavor to offer the broadest possible choice of methods, provide accurate information for all current and potential contraceptive users, and cultivate a cadre of responsive and technically competent service providers.

As young men and women continue to train as doctors, nurses and other types of health workers, schools and universities should strengthen the teaching of reproductive health and contraception, offering both didactic teaching and hands-on practical introduction to clinical skills

Professor Ladipo also spoke of the need for full access to counselling and contraceptives for adolescents. "We must support efforts to introduce reproductive education and information programmes in secondary schools. Appropriate contraceptives should be made available to sexually active adolescents free or at minimal cost." If approved, Norplant may well become a leading method among adolescents using contraception.

Finally, stressing the important role that researchers can play in mobilizing "political and financial commitment to the population programme," the speaker called for "studies that unquestionably demonstrate the [demographic, health, economic, environmental and social] consequences of high fertility and non-use of modern family planning methods."

Norplant: a promising longterm method for Africa

Norplant is a progestin-based, long-acting contraceptive in the form of six small silicone tubes filled with levonorgestrel. Surgically inserted under the skin of a woman's upper arm by a trained medical practitioner, Norplant remains highly effective for up to five years or until the tubes are removed. Dr. Adekunle of University College Hospital gave a description of Norplant's mechanism of action, indications and contraindications (for further detail, the

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reader is referred to publications by the Population Council, which has sponsored the research and development of this contraceptive since 1966).

Results of programmatic Norplant trials

AVSC has funded a five-site operations research study of Norplant in Nigeria, the results of which were summarized by Dr. Adekunle. The 759 Norplant users in the AVSC study, on average, are women in their late 20s or early 30s; they are generally married women with a mean of slightly over 4 children. Slightly over half desire more children in the future, while about a third of users say they want no more children; others are unsure. These data suggest that Norplant may meet an important contraceptive need among women who desire longterm protection but do not wish to end their fertility altogether. Feedback from participating women, along with a removal rate of only four percent overall, paint a very favorable picture of Norplant's acceptability. The most common reason for early removal has been menstrual irregularities, followed by desire to become pregnant. Experience suggests that most women do not mind the menstrual disruptions, as long as the FP counsellor has explained what to expect and has offered reassurance in this regard. When quizzed after six months of use, over a third of women cited "few side effects or problems" as what they liked best about the method, while another third mentioned Norplant's "convenience" and ease of use. Although about half of all users in the study experienced some side effect, over 90 percent would definitely recommend Norplant to a friend. To date there have been no method failures reported.

Similarly, a second multi-site study supported by Family Health International (FHI) has yielded promising results. Among 250 participating women, only one experienced complications linked to insertion (one woman reported a bruise (hematoma)). There was a very low incidence of reported problems during use, with the majority of complaints being related to bleeding pattern disturbances. However, these are most pronounced in the first few months of use, after which they tend to diminish or disappear. At two years post-insertion, the study found there were no statistically significant menstrual cycle changes. As found in the AVSC-supported study, Norplant has been 100 percent effective, with zero failures reported to date.

When asked if they would recommend Norplant to a friend, 98% of the women in this study said yes, indicating a high level of satisfaction with the method. Ninety percent said they would use Norplant again "next time."

Drs. J. Djan and T. Turkson from Kumasi, Ghana, presented similar results obtained in FHI-funded programmatic trials with 100 Ghanaian women to date. Notably, menstrual disruptions have been very well-tolerated, and most have subsided within one year. The study centre has been flooded with requests for insertion.

Planning Ahead for Broad Introduction of Norplant

If the findings of these studies are any indication, Norplant has the potential to become a highly popular contraceptive among Nigerian women and couples. However, if the Nigerian government gives its regulatory approval for

generalized use of Norplant, a number of programmatic concerns will have to be addressed in order to assure a smooth introduction of the method. For example it will be critical to develop:

- o **PROCUREMENT AND DISTRIBUTION MECHANISMS:** the Ministry of Health will have to take steps to assure an uninterrupted supply to meet potentially large increases in demand for the method. Introducing Norplant gradually through a centre by centre "phase-in" approach should keep supply requirements more manageable. The Ministry has already included Norplant in the Essential Drugs List for Nigeria.
- o **STRATEGY FOR TRAINING PROVIDERS** in insertion, removal and special Norplant-specific counselling issues. There must be an orderly plan and schedule for training (preferably in-service) that corresponds to the service introduction strategy. Training in removal technique should be scheduled once there is a sufficient number of women ready to have their Norplant taken out.
- o **PLANS FOR DISSEMINATING INFORMATION AND EDUCATION** among health professionals, potential users and the general public. Nigerians must have access to the facts about Norplant.
- o **ADEQUATE PROVISION TO ASSURE TIMELY REMOVAL AT THE END OF 5 YEARS.** Adopting a phase-in approach will help avoid a sudden surge in requests for removal that could overburden the limited number of facilities with staff trained in removal.

For further detail, the reader is referred to the "Recommendations" section of this report, where specific recommendations for action are to be found.

Increasing Male Involvement in Family Planning

There was a general sense at the conference that much more needs to be done to encourage men to take responsibility for contraception and safe sexuality, and to support their partners in doing so. Motivating men to become more active in contraceptive decision-making, providing services aimed specially at men: these themes will rank high on the programmatic agenda of the coming years.

Men play an important role

The Planned Parenthood Federation of Nigeria (PPFN) representative in his talk stressed the importance of encouraging greater involvement of men in family planning decisions, regardless of whether the method selected is a male-dependent method. Studies have revealed that contraceptive continuation rates are much higher among women whose husbands are supportive than among women whose husbands do not support their family planning practice.

What do men think about family planning?

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To be able to encourage men to assume a more positive role in family planning, we need to know what they themselves feel about their role. Dr. Adetunji of AVSC described the focus group research study that is being carried out with AVSC sponsorship at four Nigerian sites to learn more about men's attitudes toward family planning, including surgical methods. The "focus group" method employs a trained facilitator to lead informal discussion groups of men or women in which the participants air their views and feelings about a given topic. Some of the more general questions that it hoped the study will answer are: What are men thinking about family planning and their role in it? What do women want men to be thinking? How can we stimulate greater male involvement in family planning? How can male-directed FP services be made more attractive to prospective clients? How best can they be offered, publicised?

Strategy for increasing men's involvement

The PPFN speaker stressed that as a starting point, programme planners need to overcome whatever stereotyped images they may themselves have of men as "macho" and unwilling to participate in contraception. Programme efforts should focus on encouraging men to

- o increase their own knowledge about all FP methods--not just "male methods"
- o take more responsibility for contraceptive decisions and actions
- o encourage their wives to practice family planning

PPFN currently has several male-targeted activities. In IE&C, in addition to giving talks and lectures, PPFN has produced a number of pamphlets, posters, radio jingles and TV films promoting men's participation in family planning. One strategy the Federation wants to pursue is targeting men in younger age groups, who are typically more receptive to adopting new attitudes and behaviours. The Federation also sponsors male motivation projects in 14 states. Most of these take the form of industry-based programmes targeting male factory workers. After PPFN has engendered a receptive climate by offering talks and IE&C materials, a factory worker is selected and trained to serve as a "male motivation agent." The trained motivation agent sells PPFN-supplied condoms and foaming tablets to his co-workers, keeping 25 percent of his sales income as a commission and returning the balance to the PPFN programme assistant who periodically brings him new stock. In Oyo and Benue states, PPFN has also piloted commercial service outlet projects. With this strategy, non-prescription methods are distributed through non-traditional outlets such as barber shops, petrol stations and taxi cabs. Agents in the outlets are also trained to advise and refer clients to FP clinics for other methods.

VSC for Nigerian men: new initiatives

Vasectomy--an effective and safe procedure that is simpler to perform than tubal ligation--still meets with skepticism in many African communities. However, based on the growing demand for male VSC in other regions of the world, programme planners expect that with increased information and education efforts, interest in vasectomy will gradually gather momentum here in Africa as well.

Undoubtedly the single most important key to unlocking interest in male surgical contraception is a clearer understanding of what Nigerian men and women

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currently think and feel about this method. The focus group research described above promises to yield new insights into the prevailing knowledge and attitudes--including any myths and misconceptions--that men and women have about male VSC. Then, education and outreach can be appropriately designed to respond to specific misunderstandings or fears that may be fueling unfounded resistance to male VSC.

To make an impact, IE&C efforts must be complemented by steps to make vasectomy services readily available. A recent article in Alternatives (Population Council: March 1990) observes that in Latin America, "a few projects have demonstrated that a combination of good facilities, quality services, and an information strategy can significantly affect the demand for vasectomy." (p.1) The same article also notes that most male clients don't mind talking about their vasectomy--and they usually recommend it to others. Experience with minilap services both here and elsewhere has shown that satisfied clients themselves are among the most effective educators and promoters for surgical contraception.

Once men are informed about vasectomy, how can they be encouraged to seek out services? This year, PPFN and AVSC have launched a joint venture to create the first "male only" FP clinic, which will offer vasectomy as one of its services. A major objective of the clinic project is to learn by experience how FP services can be tailored to attract and appeal specifically to male clients.

Post-partum Insertion of the IUCD: Experience in Other Countries

Immediate post-partum insertion (defined as within 48 hours of delivery) offers a way to extend service to women who desire contraception but who may have few contacts with health services. Though little-known and still viewed as experimental in Africa, post-partum insertion is very widely practiced in countries of Latin America, having become the most popular contraceptive choice among Mexican women. It is done after either vaginal or Cesarean delivery, or following a miscarriage.

Dr. Kelly O'Hanley, a consultant experienced with this method, reviewed some of the medical and service delivery-related issues of providing the IUCD during the post-partum period. Important advantages of post-partum insertion are that

- o the actual procedure is simpler than an interval insertion
- o non-pregnancy of the woman is assured
- o women express fewer complaints related to bleeding, probably because post-partum bleeding is experienced as "normal" and not attributed to the placement of the IUCD
- o the risk of uterine perforation is lower than with interval insertion.
- o failure rates are low: compare favorably with interval insertions
- o the client is already at the health facility and does not have to make a special trip

- o when performed immediately after delivery it represents a more cost-efficient use of clinic resources and staff time than interval insertion

Disadvantages may include a slightly higher expulsion rate than that associated with interval insertion, depending on the skill-level of the person who inserts the device, and a slightly lower continuation rate. However, contrary to fears expressed by some in the medical community, the risk of infection is not increased by post-partum insertion by well-trained providers.

Technical Update on Sterilization Reversal Surgery

The aim of counselling is to emphasize the permanent nature of surgical contraception and to ensure that clients make a free and fully-informed choice of this method. Even though effective counselling should minimize the incidence of regret following sterilization, a small fraction of clients may experience unpredictable life-altering events--such as remarriage or the death of a child--that lead them to desire a procedure that would reverse their sterilization. Programme personnel need to know how to react sensitively and appropriately to such requests.

Surgeons in some developed countries have achieved a measure of success in restoring fertility to men and women who had undergone vasectomy or tubal occlusion. In female patients, factors that have been found to affect the likelihood of successful reversal include:

- o the surgeon's skill
- o availability of optimal tools and equipment, particularly micro-surgical instruments
- o type of sterilization procedure that was used
- o length of intact fallopian tube left

Nevertheless, it cannot be over-stressed that a client opting for surgical contraception should always consider the method permanent.

VII. Appendices

Appendix A:

LIST OF CONFERENCE PARTICIPANTS AND THEIR AFFILIATIONS

FAMILY HEALTH SERVICES

1. Dr. Richard Sturgis - Nigeria FHS-II Project
2. Dr. V. Oluyemi - The Pathfinder Fund
3. Mrs. Olumburmi Dosumu - Family Planning Int'l Assistance

FEDERAL MINISTRY OF HEALTH

4. Dr. A. Dada - (represented Dr. O.E.K. Kuteyi)
Population Activities
5. Dr. (Mrs.) A. Afolabi - Population Activities
6. Mrs. A. Omolaja - (represented Dr. A.O.O. Sorungbe)
Primary Health Care/FHU
7. Mrs. F.F. Gbadamosi - (represented Dr. P. Okungbowa)
Primary Health Care/FHU

UNFPA

8. Alhaji Bebeji - Representative

ZONAL LEADERS/DEPUTIES

9. Prof. C.C. Ekwempu - Northwest Zone
10. Dr. I.S. Ejeh - Northwest Zone
11. Prof. J.A M. Otubu - Northeast Zone
12. Dr. I.A.O. Ujah - Northeast Zone
13. Prof. W.O. Chukudebelu - Southeast Zone
14. Dr. Peter C. Gini - Southeast Zone
15. Dr. A.O. Adekunle - Southwest Zone

SELECTED VSC PROJECT DIRECTORS/COORDINATORS/COUNSELORS

16. Prof. O.A. Ladipo - UCH, Ibadan
17. Dr. S.A. Onadeko - UCH, Ibadan
18. Mrs. G.E. Delano - UCH, Ibadan
19. Mrs. O.A. Ojobe - UCH, Ibadan
20. Dr. S. Franklin - Adeoyo Hospital, Ibadan
21. Dr. (Mrs.) I.M. Olusanmi - Oyo State MOH, Ibadan
22. Mrs. O. Fasoro - Oyo State MOH, Ibadan
23. Prof. O.F. Giwa-Osagie - LUTH, Lagos
24. Mrs. C.A. Usifoh - LUTH, Lagos
25. Lt. Col. J.N. Ulasi - Military Hospital, Yaba

- | | |
|---------------------------------|---|
| 26. Dr. C. Igweike | - Central Hospital, Benin City |
| 27. Mrs. C.D. Aitonje | - Central Hospital, Benin City |
| 28. Dr. Alex Omu | - UBTH, Benin City |
| 29. Mrs. Cecilia Anumba | - UNTH, Enugu |
| 30. Mrs. P. Nzegwu | - UNTH, Enugu |
| 31. Dr. B.A. Akinola | - Ogun State MOH, Abeokuta |
| 32. Mrs. A.A. Aborisade | - Ogun State MOH, Abeokuta |
| 33. Dr. T.A. Fakoya | - Ogun State Univ. Teaching Hospital, Shagamu |
| 34. Dr. A.R. Iwatt | - UCTH, Calabar |
| 35. Dr. E.I. Archibong | - UCTH, Calabar |
| 36. Mrs. Elizabeth Eyo | - UCTH, Calabar |
| 37. Dr. N.D. Briggs | - UPTH, Port Harcourt |
| 38. Mrs. Otonye Dakoru | - UPTH, Port Harcourt |
| 39. Dr. O.O. Adetoro | - UITH, Ilorin |
| 40. Mrs. B.F.T. Akeju | - UITH, Ilorin |
| 41. Mrs. J.A. Ojo | - ABUTH, Zaria |
| 42. Mrs. B.E. Nnabugwu-Otesanya | - ABUTH, Zaria |
| 43. Dr. A. Yusuf | - General Hospital, Kaduna |
| 44. Dr. T.B. Dawodu | - General Hospital, Kaduna |
| 45. Dr. Y. Madaki | - Kaduna State MOH |
| 46. Ms. S.Y. Madaki | - Kaduna State MOH |
| 47. Mrs. H.K. Zubair | - Kaduna State MOH |
| 48. Mrs. Asabe Balami | - Kaduna State MOH |
| 49. Mrs. M.A. Bitiyong | - Military Hospital, Kaduna |
| 50. Mrs. S. Serki | - JUTH, Jos |
| 51. Mrs. Ruth Da'or | - JUTH, Jos |
| 52. Mrs. E.U. Obi | - Owerri General Hospital |
| 53. Dr. O. Kyari | - UMTH, Maiduguri |
| 54. Mrs. V.M.P. Noku | - UMTH, Maiduguri |
| 55. Mrs. Jummai Mbaya | - Maiduguri Nursing Home |
| 56. Dr. C.T. Ityonzughul | - Benue State MOH, Owerri |
| 57. Dr. O.A. Boyo | - NKST Mkar, Benue State |
| 58. Dr. (Mrs.) F.A. Akanni | - NKST Mkar, Benue State |
| 59. Mrs. L. Vanger | - NKST Mkar, Benue State |
| 60. Mrs. V.N. Acka'a | - Viewpoint Medical Center, Makurdi |
| 61. Dr. E.M. Umana | - Federal Capital Territory, Abuja |
| 62. Dr. Nuhu Maksha | - Gongola State MOH, Yola |
| 63. Mrs. Patrinah Ahmadu | - Gongola State MOH, Yola |
| 64. Mr. J. Olomajeye | - PPFN Headquarter, Lagos |
| 65. Dr. Ayo Olofin | - Glory-N-Heritage Medical Centre, Lagos |
| 66. Ms. Comfort U. Ufon | - Akwa Ibom State MOH |
| 67. Mrs. A. Henshaw | - Cross River State MOH, Calabar |
| 68. Dr. T. Esho | - Lagos State MOH |
| 69. Dr. D.O. Agboola | - Baptist Hospital, Ogbomoso |

STATE FP COORDINATORS

- | | |
|----------------------|----------------------------|
| 70. Mrs. Rhoda Laah | - Kaduna State MOH, Kaduna |
| 71. Mrs. Susan Ayina | - Plateau State MOH, Jos |

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| 72. Mrs. M.O. Olugbode | - Oyo State MOH, Ibadan |
| 73. Mrs. Justina S. Abeda | - Benue State MOH, Makurdi |
| 74. Mrs. Gloria A. Urombo | - Rivers State MOH, Port Harcourt |
| 75. Mrs. Jessie A. Nkanga | - Akwa Ibom State MOH, Uyo |
| 76. Mrs. C.A. Ukadike | - Imo State MOH, Owerri |
| 77. Mrs. M.A.H. Akpabio | - Cross River State MOH, Calabar |
| 78. Mrs. Assibi Kwaki | - Sokoto State MOH |
| 79. Mrs. M. Pariola | - Ondo State MOH, Akure |
| 80. Mrs. F.A. Tolushe | - Kwara State MOH, Ilorin |

GHANAIAN VSC/NORPLANT LEADERS

- | | |
|----------------------|---|
| 81. Dr. J.O. Djan | - Komfo Anokye Teaching Hospital,
Kumasi |
| 82. Dr. T.O. Turkson | - Komfo Anokye Teaching Hospital,
Kumasi |

AVSC

- | | |
|---------------------------|--------------|
| 83. Dr. K.O'Hanley | - Consultant |
| 84. Mr. Joseph Dwyer | - AVSC/AFRO |
| 85. Mrs. Grace Wambwa | - AVSC/AFRO |
| 86. Ms. Pamela Bolton | - AVSC/NYC |
| 87. Dr. Ademola Adetunji | - AVSC/WASRO |
| 88. Ms. Mofoluke Babawale | - AVSC/WASRO |
| 89. Mrs. Juliana Thompson | - AVSC/WASRO |
| 90. Mrs. Victoria Obadare | - AVSC/WASRO |
| 91. Mr. Mukky Onifade | - AVSC/WASRO |
| 92. Mr. Sunday Adekoga | - AVSC/WASRO |

SECRETARIAL SUPPORT

- | | |
|--------------------|----------|
| Mr. T.A. Oseni | - Kaduna |
| Mrs. Esther Ishaku | - Kaduna |

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Appendix B

CONFERENCE AGENDA

Monday, August 6 (pre-conference):

- O Zonal Leaders meeting

Tuesday, August 7 (Day 1):

MORNING:

CHAIRPERSON - PROF. C.C. EKWEMPU

- O The Environment of AVSC'S work in Nigeria; Introduction to the Workshop - Mr. J. Dwyer.
- O Review of VSC Programs in Nigeria 1986 - 1990 - Dr. A.A. Adetunji.
- O Implementation of the National Population Policy; The Place of Permanent and Long Term Contraception - given on behalf of Dr. A. O. O. Sorungbe by Mrs. F. F. Gbadamosi.
- O Perspectives on the Nigerian Family Planning Scene - Dr. R. Sturgis.
- O Experiences with Postpartum IUCD Insertion - Dr. K. O'Hanley.

AFTERNOON:

CHAIRPERSON - PROF. W.O. CHUKUDEBELU

- O Family Planning Issues and Challenges of the Nineties - Prof. O.A. Ladipo.
- O Case Presentations on Dropping Barriers/Increasing Demand - Mrs. M.O. Olugbode.
- O Discussion.
- O Report on outcomes of the 1989 VSC Sustainability Meeting - Mrs. M.O. Olugbode.

Wednesday, August 8 (Day 2):

MORNING:

CHAIRPERSON - DR. A.O. ADEKUNLE
QUALITY ASSURANCE

- 0 Fundamental Elements of Quality Care - Mrs. G.E. Delano.
- 0 Client Satisfaction/Implication for Acceptance of FP Services Presented on behalf of Mrs. B. Lana
- 0 Client Oriented Provider Efficient Service (COPE) - Ms. M. Babawale
- 0 Developing In-Country Capacity for ML/LA Training: The Nigerian Experience in NE Zone - Dr. I. Ujah
- 0 Support for VSC Counselors - Impact on VSC Programme at UCH/Ibadan 1986-1990 - Mrs. B. Ojobe
- 0 Medical Monitoring and Supervision - Prof. C.C. Ekwempu.
- 0 Medical Quality Assurance - Prof. W.O. Chukudebelu.

AFTERNCON:

CHAIRPERSON - MAJOR I. S. EJEH

- 0 Introduction to Case Studies for Small Group Work
- 0 Small Group Work.
- 0 Reports to the Plenary from Small Group Work:
 - Group A): Integration of Technical Assistance and Quality Assurance.
 - Group B): Public Sector - Expansion of Services.
 - Group C): IEC - Gaining Acceptance.
- 0 Discussion of groups' presentations & recommendations

Thursday, August 9 (Day 3):

MORNING:

CHAIRPERSON - MS. M.O. BABAWALE

- 0 Small Group presentations to the Plenary, cont'd
Group D): Private Sector - Removing Barriers
Group E): Assessibility - Serving More Clients
- 0 Additional discussion of Small Groups' presentations & recommendations

CHAIRPERSON - DR. PETER C. GINI
SUSTAINABILITY AND FUTURE DIRECTIONS

- 0 Maintaining Sustainable VSC Services in Nigeria - Role of:
 - a) FMOH - Dr. (Mrs.) A.O. Afolabi.
 - b) SMOH - Dr. C.T. Ityonzughul, Benue State MOH.
- 0 Discussion.
- 0 TOUR OF VSC FACILITY AT MILITARY HOSPITAL, KADUNA

AFTERNOON:

SUSTAINABILITY AND FUTURE DIRECTIONS (cont'd)

- 0 UCH Experience with Filshie Clip - Dr. A.O. Adekunle.
- 0 Developing a Strategy for Male FP - Mr. J. Olomajoye
- 0 VSC Attitudes Focus Group Study - Dr. A.A. Adetunji.
- 0 Discussion.
- 0 Update on Sterilization Reversal - Dr. N.D. Briggs.
- 0 Norplant: A method for the future - Dr. A.O. Adekunle.
- 0 Discussion.

Friday, August 10 (Day 4):

MORNING:

CHAIRPERSON - DR. S.O. TURKSON
NORPLANT

- 0 FHI Norplant Activities in Nigeria - Prof. O.A. Ladipo.
- 0 AVSC Norplant Activities in Nigeria - Dr. A.O. Adekunle.
- 0 FHI Norplant Activities in Ghana - Dr. J.O. Djan.
- 0 Programme issues for Expanding Norplant and Discussion - Mr. J. Dwyer.
- 0 Small Working Groups - Planning for Norplant:
 - Counseling, Client selection and Client Satisfaction - Mrs. G. Wambwa/Prof. C. Ekwempu.
 - Medical Quality Assurance/training, approval process, and supply issues - Dr. A. Adetunji/Dr. A. O. Adekunle.
 - Follow-up and removal - Dr. J. Djan/Mr. J. Dwyer/Dr. I. Ujah
 - Integrating Norplant into national programme (if approval received) - Prof. A. Ladipo/Ms. Babawale

AFTERNOON:

CHAIRPERSON - DR. J.O. DJAN

- 0 Small Groups' report to Plenary
- 0 Discussion of Norplant presentations and recommendations

EVENING:

- 0 Dinner/Closing Ceremony.

Appendix C

MEMBERSHIP OF THE RECOMMENDATIONS SUBCOMMITTEE

Mrs. F. F. Gbadamosi -
Federal Ministry of Health, Department of Primary Health Care

Dr. (Mrs.) A. Afolabi -
Federal Ministry of Health, Department of Population Activities

Mrs. M. O. Olugbode -
Oyo State Ministry of Health, Family Planning Coordinator

Dr. Y. Madaki -
Kaduna State Ministry of Health

Professor C. C. Ekwempu -
Northwest Zonal Leader; Head of Ob/Gyn, Ahmadu Bello Univ. Teaching Hosp.

Dr. O. A. Boyo -
NKST Mkar, Benue State (representing private sector)

Dr. Alex Omu -
Univ. of Benin Teaching Hospital

Appendix D

KEY DEMOGRAPHIC INDICATORS IN NIGERIA Excerpted from Professor Ladipo's speech

Current national population (est.)	115 million persons (1 in 4 Africans is a Nigerian)
Projected (2000) population	163 million persons
Annual population growth rate	3.0 percent (National goal is to reduce figure to 2.0 percent by the year 2000)
Population doubling time	23 years
Population under 15 years	47.4 percent of the total population
Major demographic trend	Rural-to-urban migration
Per capita annual income (1987)	\$370 (down from \$680 in 1980)
Life expectancy at birth (1989)	51 years (up from 36 yrs. in 1950)
Crude death rate	17/1000 (down from 27/1000 in 1950)
Under-five mortality rate	160 per 1,000 live births
Crude birth rate	46/1000
Total fertility rate	6.3 births per woman (national goal is to reduce figure to 4 by year 2000)
Avg. age at first marriage (women)	16.3 years
Proportion of marital unions that are polygamous	42.6 percent