



Africare

"Improving the quality of life in rural Africa through the development of water resources, increased food production and the delivery of health services."

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Amendment Request to USAID

Cooperative Agreement No. 620-A-00-4078-00

Training for Anambra, Rivers and Kano States

November 7, 1985

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I. SUMMARY

Africare is requesting an amendment to Cooperative Agreement No. 620-0062-A-00-4078-00, expanding the scope of work to address training needs recognized under the present work effort, and extending the period of work through June 30, 1987 while adding \$504,577 for training the proposed 252 to 282 participants.

Under its present terms the Agreement provides Africare \$334,613 from September 8, 1984 through September 7, 1986 to provide basic equipment and supplies and to assist the Federal Ministry of Health of Nigeria and State Ministries of Health to upgrade 60 specified clinics. The goal is to strengthen the integration of family planning (FP), oral rehydration therapy (ORT) and immunization (EPI) services as a part of primary health care under the Family Health Initiatives Program.

Africare has completed the surveying and equipping of 60 clinics in five states required under the Agreement well ahead of schedule, and fully expended the grant. As a result of cost-saving measures, Africare was able to in fact survey a total of 120 clinics in eleven states providing considerable added benefit.

Africare submitted a draft narrative report on survey findings and recommendations to USAID/Nigeria in July 1985, and an evaluation report on the supply effort in September. Africare is now completing the final financial and narrative report and will submit them by December 31, 1985.

During the surveys of the above 120 clinics in eleven states, and yet another 80 clinics in the remaining eight being assisted by Africare under a separate agreement, Africare recognized needs which training programs for service providers should more specifically address. The requested amendment will enable Africare to incorporate instructional units to address

these into the already existing curriculum at no curriculum development cost, and Africare would address them as part of six training cycles in three states (Anambra, Rivers and Kano) for 270 to 300 participants.

The first training cycle would be conducted in the early part of 1986 in Anambra State, the second in mid-1986 also in Anambra, the third and fourth in late 1986 simultaneously in Kano and Rivers States, and the fifth and sixth in early 1987 also in Kano and Rivers. Africare will provide one physician and one nurse-midwife from the United States for the first cycle, one U.S. physician for the second, a physician and nurse midwife from the U.S. for each the third and fourth cycles, and a physician for each the fifth and sixth cycles. Areas of special emphasis which Africare will incorporate into the existing curriculum fall under the general categories of improved management and on-the-job training, as elaborated below and discussed in further detail under the project description and design section.

Management needs to be stressed will include optimum use of physical facility, equipment, supplies and staff for delivery of family planning services in conjunction with ORT, EPI and other activities, preventive maintenance and simple repairs of equipment at the site and knowledge of how to arrange the repair of more complex equipment, commodity resupply and record keeping, consumer choice, and professionalism in counselling to divorce what is objectively offered and discussed with the patient from any possible counsellor biases.

In carrying out training, Africare will draw heavily on Nigerian professional resources. As noted above, during the second, fifth and sixth cycles the presence of U.S. hire Africare staff will be reduced to one per site. Nigerian M.D.'s and nurse-midwives who worked with them in the earlier cycles will become the principal trainers.

This approach to strengthening training is highly important and appropriate at this time, to benefit from observations it gained during the surveys and supply effort. At the same time, Africare will be able to draw heavily from the body of training material which already exists for the FP, ORT and EPI curriculum. Curriculum development workshops will not be needed.

The training sessions and number of persons to be trained will be as follows, resulting in a total of 468 to 498 person-weeks of training:

	<u>Persons Trained</u>		
	<u>Anambra</u>	<u>Kano</u>	<u>Rivers</u>
5-day Physician Family Planning Update	10-20	10-20	10-20
5-day Nurse Basic Competency Training	30	60	60
4-week Nurse Full Competency Training	24	24	24

The budget which Africare will require to accomplish to above is summarized as follows:

<u>Category</u>	<u>Amount</u>
PERSONNEL SALARIES/FRINGE	\$ 133,302
TRAVEL/ALLOWANCES	118,880
EQUIPMENT/SUPPLIES	13,575
TRAINEE FOOD/LODG/TRAVEL	132,580
OTHER DIRECT	4,150
ADMINISTRATIVE (INDIRECT)	101,751
TOTAL	\$ 504,577

A statement on Africare's experience as a development assistance organization and qualifications for the proposed work is contained in Annex I. Africare is prepared to begin work as soon as a decision is formalized on the requested amendment.

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II. PROJECT BACKGROUND AND NEED

A. GENERAL

Nigeria is the most populous country in sub-Saharan Africa. In mid-1982 its estimated population was 90.6 million, about one quarter of the entire population of Africa below the Sahara Desert. An estimated one-fifth of Nigeria's population is urban, with the rest residing in the rural areas.

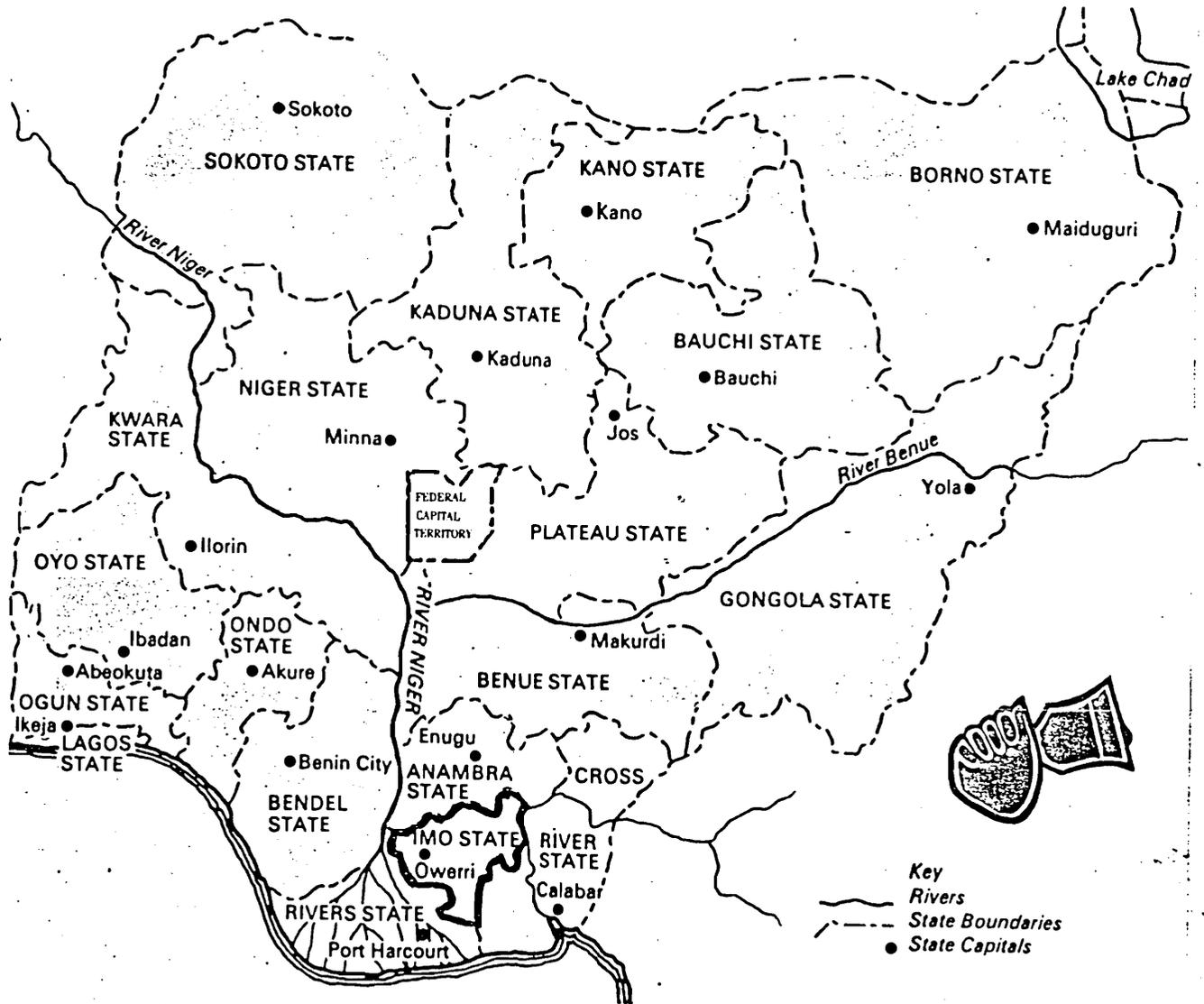
Nigeria is a land of great contrasts, both in physical attributes and in cultural patterns. Its economy is based principally upon agriculture, mineral commodities and petroleum.

In recent years, the depressed price of crude oil on the international market, the burden of a huge national debt, and the global recession have cut Nigeria's export trade and purchasing power. Government budgets and programs have been severely curtailed because there is not enough money to finance them. The cuts have had serious impact on health care programs.

The major prevalent diseases in Nigeria include malaria, measles, diarrhea, dysentery, whooping cough, malnutrition, parasitic infections, pneumonia, tuberculosis, other respiratory infections, and leprosy.

Government functions in Nigeria are organized at the Federal, State and Local level. The map on the following page shows the division of country into nineteen states. There is also a centrally located Federal Capital Territory to which the Federal Government intends to transfer. At the moment, however, the Federal Government remains based at the coastal city, Lagos. The country has a well developed internal road and airline system, however internal phone and telex communications are much less reliable.

Map 1



Map of Nigeria Showing States

B. HEALTH POLICY

Since 1960 when Nigeria gained independence, statements of national health policy have given priority to expanding the health system, particularly in the rural areas, developing health manpower and training capacity, and strengthening the delivery of preventive health services. However, the policies were not realized over the first two five-year plans, and by 1975 the expanded health manpower base led to pressures for improving the quality and sophistication of care, particularly at the hospital level, leading to a widening gap between those services available in major cities and those immediately available to the rest of the population.

An ambitious plan was mounted to construct over ten years about 285 Basic Health Units -- self-contained subsystems covering 150,000 to 200,000 people. At the apex of each unit would be a comprehensive health center providing tertiary care, supported by three to five primary health centers providing secondary level care, and each of these was in turn to be supported by three to five basic health clinics and a mobile health clinic providing primary level and community health care. From the start, this program was constrained by three factors: cuts in funding as a result of austerity measures required by Nigeria's deteriorating financial situation growing out of the drop in world oil prices; low commitment by most state governments to what was viewed as Federal Government's attempt to impose a duplicate and costly system; and the limited construction capacity at the state levels to meet building specifications. Implementation of the program varied greatly from state to state, and in one instance was never undertaken. It is estimated that fewer than 50% of all facilities constructed have been put into operation.

Following Nigeria's ratification of the 1979 Alma Ata Declaration on Primary Health Care, a specially formed Commission recommended greater involvement of State and Local governments and the community in developing health programs, full integration of existing facilities and health manpower in the desired health system, the development of less costly and more appropriate facility designs and equipment lists, and the adoption of explicit evaluation criteria. Adjustments were called for in the allocation of health responsibilities between the various levels. Increased emphasis was also placed on State Ministries of Health developing their planning, coordination and technical control functions, particularly with a view to the Local Government Authority operated dispensary system.

C. ORGANIZATION OF HEALTH SECTOR

Nigeria's constitution of 1979 specifies that health is a concurrent responsibility shared by the Federal and State Governments. The Federal Ministry of Health (FMOH) has overall responsibility for the sector. In each of the nineteen states, the State Ministry of Health (SMOH) is responsible for planning and implementing all health programs specific to the state and not of national character or common usage. Thus the SMOH is responsible for planning and coordinating the development of the health care system within the state, operating and maintaining all secondary and non-specialized tertiary level health facilities, implementing public health programs, training nursing, midwifery and auxiliary health personnel, and assisting the local governments with the management and operation of the network of primary level health facilities.

A Health Services Management Board (HSMB) in each state administers health care facilities at the state level, such as general hospitals, rural health centers and urban clinics, and coordinates health services delivered

by these facilities. Its primary functions are personnel administration and management of logistical support systems, including drugs, supplies, small equipment and maintenance. It is headed by a Chairman who reports to the State Commissioner of Health.

Also reporting to the Commissioner of Health is a Permanent Secretary who is the head of service, supervising the Chief Medical Officer who in turn oversees a number of technical and service units (e.g. nutrition, maternal and child health, family planning, immunization, etc.).

D. FAMILY PLANNING AS A PART OF HEALTH POLICY

The need for a wide availability of modern contraception has been officially recognized in Nigeria at least since the Second National Development Plan (1970-74) under which the government strengthened the Planned Parenthood Federation of Nigeria in its efforts to provide appropriate services for childspacing. In the current Fourth National Development Plan, the health sector includes family planning within primary health care services. Some State Ministries of Health and Local Government Authorities have begun to provide family planning services.

In 1984, when Nigeria participated in the International Population Conference in Mexico City, the Nigerian delegation presented a statement by the Head of State calling for a national population policy and increased services for childspacing. The Federal Government is now preparing a National Policy for Population and Development which is expected to be promulgated by late 1985, allowing for many of the conceptual ideas to be incorporated into the Fifth National Development Plan (1986-1990). The Federal Ministry of Health has developed a plan of action which calls for increased involvement of the FMOH in planning

and supporting a much more expansive State Ministry of Health and private sector family planning program.

As part of a worldwide effort, international organizations such as the United Nations Fund for Population Assistance, the World Bank, USAID and the International Planned Parenthood Federation are assisting Nigeria's family planning program.

E. HEALTH CARE AND FAMILY PLANNING SERVICE DELIVERY

Africare performed a clinic survey in all 19 states of Nigeria from November 1984 to September 1985. The survey (a) inventoried equipment and supplies, (b) noted the state of the physical plant and maintenance practices, (c) described services rendered and staffing patterns, (d) assessed the knowledge, attitudes and practices of health care providers regarding family health initiatives, and (e) during the last half of the survey also assessed the knowledge, attitudes and practices of 300 consumers regarding Family Health Initiatives. During the last half of the survey work, health care providers and consumers also were asked questions specifically aimed at obtaining better information of knowledge, attitudes and practices concerning voluntary surgical contraception. Africare found that health care providers were almost always invariably wrong in the prediction of consumer attitudes, and that they usually expressed surprise at consumer response. Africare also found other common characteristics at health care delivery facilities throughout Nigeria, whether university teaching hospitals or rural government dispensaries, which can be summarized as follows.

Personnel are hampered by lack of adequate physical plant, commodities and equipment. Frequently they lack the most essential drugs and supplies. Electricity may be lacking either because there is no available power source or because there are no funds available for the payment of utility bills. Backup generators, when present, may be non-functional due to need for repairs or lack of diesel fuel.

Family planning services may be unavailable due to lack of trained personnel or commodities. In many instances, trained personnel may be available but due to their perceptions of consumer needs or desires, they fail to offer a full array of services. In clinics where the provider feels that "Nigerian women" (meaning that particular clinic's patients) "would never use the diaphragm", this traditional wisdom becomes fact and that clinic will have no diaphragm users. This applies to the full array of family planning services, and particularly to surgical contraception.

Whether at the local government dispensary or the university teaching hospital, equipment maintenance was rarely carried out on a routine, preventive basis. Any number of minor defects created major needs. This is a problem which deserves special attention, and which can be easily incorporated as a topic to address in conjunction with other training.

Africare saw extremely dedicated and competent individuals who have implemented family planning clinics by their own tenacity, thwarted by commodity lack due to poor communication and/or inadequate record keeping or plan to justify replenishment.

Donor agencies have more support personnel than do Nigerian health care providers and sometimes require more documents than can be provided due to a large gap in training in administration, management and supervision.

Health care providers are also frequently unaware of potential sources for family planning commodities. At times the warehouses at the State Ministry of Health may be filled with contraceptives and a clinic may not have any, yet due to the unpredictability of communication and the lack of institutionalization of procedures this can happen repeatedly.

Within the framework of the project setting it should be noted that with few exceptions most work days tend to slow down at mid-day and there are usually at least four hours each week that could be devoted to on-the-job training.

Also, it has been Africare's experience that within health care delivery facilities there are ample opportunities for providers in settings other than family planning clinics, if adequately trained, to provide family planning counselling and to dispense contraceptives thus enabling consumers to receive services (a) pending insertion of an I.U.C.D., (b) while awaiting surgical contraception, and (c) in the anonymity of a clinic other than a family planning clinic.

It should be noted that the cost of family planning commodities in the private sector is out of the reach of most Nigerians (i.e. Depo-provera up to ₦ 15.00 per injection, I.U.C.D. @ ₦ 25.00 per insertion, pill cycle @ ₦ 10.00 per cycle). It should also be pointed out that the cost of surgical contraception even within the public sector is rarely less than ₦ 100.00 when one considers the cost of intermediate surgery, anesthetic agent, intravenous fluids, infusion set, diesel for the back-up generator, antiseptics, syringes, needles, antibiotics, gauze, dressings, adhesive tape, cotton balls, etc. The patient may have to pay for all

or any of these depending upon availability at the facility providing the procedure.

Another observation of the Africare team was that there is much unused equipment that could be well used if there was a program for its appropriate relocation.

F. HEALTH AND TRAINING NEEDS

As noted earlier, Nigeria contains about 25 percent of the sub-Saharan African population. Even by conservative extrapolation of the 1963 census, it is among the ten most populous countries of the world. If there is to be any significant contribution to improved quality of life for rural, sub-Saharan Africa, due attention must be given to Nigeria. Even though, by per capita income standards, Nigeria is not in the group of countries termed lesser developed, its higher per capita GDP (approx. \$550) is an artificial distinction which would disappear if the currency of the country (Naira) were to be devalued in line with IMF recommendations. The true value of the Naira is estimated to be less than one half of the official exchange rate established in Nigeria. In real terms, as evidenced by the cost of goods and services in Nigeria, the annual income of the average rural family and the lack of accessibility to basic health care are typical of if not lower standard than conditions found in other countries considered lesser developed.

In Nigeria, the Infant Mortality Rate is estimated by the World Bank to be 109, and the Maternal Mortality Rate to be 10, per 1000. Both are extremely high and reflect the general health condition.

In 1982, life expectancy at birth was 50 years. It should be noted that in a detailed review of mortality and morbidity statistics by Africare in one state (Imo), the figures varied greatly from one source to another. The universal wisdom regarding statistics in Nigeria is, as in many other countries, that they represent useful information rather than hard fact.

The population pyramid is broadly based with 45 percent of the population 15 years of age or younger.

Although exact numbers differ, the pervasive conclusions include high birth rate, high infant mortality and child death rates, high rate of natural growth, many deaths from infectious diseases including preventable diseases, lack of prenatal care, grand multiparity, extremely long periods of child bearing starting at very young ages, lack of attempts at spacing children, and child bearing in high risk situations (e.g. elderly grand multiparous, medically inadequate deliveries in a traditional manner without any semblance of sterile technique in mothers who are malnourished, anemic and may have concomitant disease).

Sexually transmitted diseases are a widespread problem. Malnutrition is estimated to be present in as many as 40 percent of the children in many states.

Africare's own survey indicated that in spite of tremendous health needs, many of the rural facilities were underused. This was attributed to lack of drugs and the general austerity so that fees were a constraint. It was pointed out that when drugs were available and fees were not charged, facilities were always busy. Urban facilities were usually very busy. Certainly there seemed to be more than enough rural clinics to meet needs, and large rural staffs.

Across the nineteen states, staff training was extremely uneven and sometimes inappropriate for the facilities intended to benefit. For the most part, staff needed training in diarrhea management and oral rehydration therapy. When EPI was in place, the staff had a good immunization program. Unfortunately, this was not true in most instances. Vaccine supply was spotty, the importance of the cold chain was not appreciated, and in many instances was not intact. Where EPI was operating, the response by the community was gratifying, evidencing that the service will be taken advantage of where properly introduced and implemented.

Although health care providers interviewed who had family planning training were reasonably knowledgeable, there was a breakdown in communication with the consumer since there were very few users of contraceptive materials and except in Association for Voluntary Sterilization contract facilities, it was rare to find anyone referred for elective surgical contraception.

In some instances there were policy decisions to deny the consumer access to information regarding surgical contraception for fear that this would jeopardize the use of any form of contraception.

As a result of Africare's field experience, it is obvious that there is a need for training in the prevention and treatment of diarrhea, the significance of the cold chain, the principles and methodology of immunization, the social, economic and family health benefits of a planned family, the methods of family planning including abstinence, breast feeding, rhythm, barrier, oral contraceptives, I.U.C.D.'s, and surgical contraception, including indications, contraindications, and relative effectiveness. Professionalism and fairness in communication with patients regarding family planning require special emphasis, with the service counsellor and provider

encouraged to interact with each patient in a way which allows and enables the patient to make the best personal choice based upon sound clinical advice and explanations, while allowing for the variety of attitudinal and motivational differences from one individual to another which also are a part of the individual's decision.

There is also a need for proper nutrition as part of training. This becomes apparent when one sees nutritional deprivation with readily available unused sources of nutritious substances.

Two other areas of need observed by Africare during the surveys have to do with on-the-job training, and use of clinic settings other than family planning clinics for providing family planning services.

Very few short-term workshops are available for clinic personnel on family planning, oral rehydration therapy and immunizations. There is therefore a need for more reinforcement or on-going, short period educational opportunities on the job, at the service facility during slack periods. On-the-job training is rarely implemented, yet it offers one of the better opportunities for obtaining a multiplier effect from the training investments being made by external donors and state health authorities.

The need for providers trained in family planning who work in settings other than family planning clinics has already been alluded to. Women in the child-bearing age group are present in large numbers at infant welfare clinics, post natal clinics and certainly the lying-in wards. The lying-in wards are locations where the provider may have the opportunity to encounter husbands in addition to mothers.

Joining the emphasis for on-the-job training with that of providing family planning services through other clinics should allow broader benefits from central training activities.

III - DESCRIPTION AND DESIGN

A. PROJECT DESCRIPTION

1. Goal and Purpose

The goal of work under the Cooperative Agreement will remain unchanged; it will be to strengthen the integration of family planning, oral rehydration and immunization activities as a part of primary health care under the Family Health Initiatives Program of the Government of Nigeria.

The purpose of the proposed training will be to present already developed family planning and health education curricula to participants, while drawing upon Africare's experience with clinic surveys and equipment supply in all nineteen states to incorporate and provide instruction addressing special management, maintenance, facility/equipment use, record keeping, communication and commodity supply needs, as well as regards on-the-job training and the increased use of host country professionals as trainers. It is expected that the approach will provide participants an ability to more rapidly and broadly introduce family health initiatives at their facilities.

2. Intended Outputs

As a result of the amendment, it is expected that Africare in collaboration with host health authority trainers in three states (Anambra, Kano and River) will carry out review and training sessions for 270 to 300 physician, nurse and nurse-midwife participants as follows:

- a. 5-day Physician Family Planning Update 30-60 participants
- b. 5-day Nurse Basic Competency Training 150 participants
- c. 4-week Nurse-MW Full Competency Training 90 participants

3. Important Considerations

The combined experience of training organizations working with the Federal Government of Nigeria and the various State government is contained to a great extent in the training materials and curricula developed and used in past training sessions. Africare has reviewed some of these materials and curricula in Nigeria, and will rely upon USAID, other international agencies and the State governments to make available for Africare reference and use in conjunction with health authorities of Anamabra, Kano and River States the most useful of those materials.

Africare will provide additional lecture, demonstration, discussion and review units for use in conjunction with existing materials, in order to give emphasis to areas of special need. The newly provided materials, in addition to benefitting Anambra, Kano and River States will subsequently be available for sharing with the other organizations.

4. Project Inputs

The inputs which will be required to undertake the project can be summarized as follows:

* Personnel

Africare is posting a Country Representative to Nigeria, and that person will devote approximately 25% of his/her time to direct field support of the project. This will include helping to set up training site arrangements, transfer and accounting on use of funds, and the efficient logistics, programmatic and administrative support to the project.

Also, Africare is supplying short-term, full-time US hire trainers (one physician and one nurse-midwife for the first cycle of training at each State, and one physician for each State's second cycle). In addition, Africare is supplying one local hire physician and one local hire nurse-midwife for both cycles at each state.

Thirdly, Africare will hire local lecturers in some instances for the training, and where possible secure from the host agency local lecturers at no cost.

The Government of Nigeria will provide in clinic practical staff for trainees to work with in practical settings, at no cost to the grant. Also, the Government will supply the trainees at no cost for their services.

* Travel and Allowances

Africare will support the travel, food and lodging of all trainers, local hire lecturers if they come from locations out of state, and trainees.

* Equipment and Supplies

Since a large reservoir of materials already exists, this will be draw upon. There will be little requirement for curriculum development, and the cost of equipment and supplies will be minimized by utilizing resources already incountry.

* Other

Minor, normal costs will be incurred for postage, telex, etc.

5. Intended Beneficiaries

The beneficiaries of the project will include the most direct group (the 30-60 physicians and the 222 nurses and nurse-midwives to receive review materials and instruction), the intermediate group (the other staff at their facilities which on a modest multiplier of 3 to 1 would be another 756 to 846 health professionals), and the ultimate beneficiaries the patients to receive strengthened family planning, oral rehydration and immunization services with the Family Health Initiatives Program.

B. PROJECT DESIGN

1. Methodology - Physician Family Planning Update

Training will be provided to three categories of health professionals in each state.* The first of these categories is physicians, with the first cycle of training to be provided to physicians who have been practicing for some time in the system, and if arrangements can be made with the National Youth Service Corps a second cycle to be given to N.Y.S.C. physicians. We would try to have ten physicians in each cycle, and the length of the course, entitled Family Planning Update, would be five days. A tentative curriculum is given in Annex II. We would regard this as a peer group, therefore the size is restricted. Preference would be given to voluntary participants.

Traditional teaching methods would be used, however the emphasis would be on an attitudinal, motivational input. Statements regarding family planning on the national and state level would be discussed. The participants would be encouraged to share with their peers their own attitudes, misgivings and enthusiasm at the macro level. Hopefully the faculty member would be able to elicit from the participant response to misgivings at this level.

The results of the Consumer Survey performed by Africare in 1985 would be shared with the participants at the appropriate time. A Nigerian counterpart trainer would participate with the Africare trainer in this course so that he/she may conduct another similar course if N.Y.S.C. participants are to be involved.

There will be a discussion of currently used contraceptive methods describing those in use in Nigeria and those not available. Arrangements

* The three states are Anambra, Rivers and Kano.

will be made well in advance for those physicians who have not inserted an I.U.C.D. to do so after proper instruction and demonstration.

In addition to the macro benefits (national and state) of family planning, the social, economic and health benefits will be discussed. In addition to this the risk factor associated with unplanned short-interval, age-extreme pregnancies will also be covered.

Hopefully all physicians to complete the Family Planning Update will recognize the importance of family planning to the future of Nigeria, the state in which they are working, and the Nigerian mothers and families who can most directly benefit. They will know how to insert and I.U.C.D., when to insert, and the contraindications to all methods of of contraception that they will advise. They will know the relative effectiveness of each method. They will know how to integrate basic data into their current record keeping and that will assist trainers in evaluating and revising course content. They will be prepared to demonstrate to the evaluator their capabilities in a post-test and in a clinical setting some two months after course completion. They will have an understanding of the competence of nurse-midwives fully trained in family planning and health care providers who receive a brief course in family planning. They will be aware of commodity consumption, optimal and critical stock levels, and reordering procedures. They will have basic knowledge of equipment maintenance.

Additionally, the physician participants will know the indications for tubal ligations, appropriate times at which to perform tubal ligation, when the patient can be referred, what the cost will be, the preferred anesthetic, the period of disability, and in-patient/out-patient procedure. They should be able to answer most questions that a couple might have regarding surgical contraception, male or female.

2. Methodology - Nurse Basic Competency Curriculum

The short course for non-physician providers will follow the basic curriculum currently in use in Nigeria, with modifications. Following the existing curriculum, the participants will be provided knowledge on the available contraceptive methods, their indications, contraindications and method of use so that they can intelligently dispense condoms, foam, foaming tablets and oral contraceptives, and so they can also properly administer the long-acting progestational agents and discuss in advance in a non-threatening manner potential side effects and risk factors.

In addition, they will be sufficiently motivated so that they will initiate one-to-one discussions with mothers in settings of the ante-natal clinics, infant welfare clinics, immunization clinics or wherever they may work. They will be comfortable in discussing family planning and secure in their own knowledge of it. They will understand the fact that child bearing can be a conscious choice and even a women who has not yet been pregnant has the option of completing an education or working to accumulate some savings before she starts a family. They will be encouraged to discuss their own extent of practicing family planning.

Training will strive to instill a sense of responsibility in the provider so that he/she will be willing and able to teach his/her body of knowledge to peers while on-the-job. A module methodology with appropriate training aids will be provided to each participant and he/she will be encouraged to demonstrate the ability to use the training aids.

A motivational/attitudinal module will be included. Again, record keeping functions, maintenance and management will be stressed. The need for conscious advocacy of safe, healthy child-bearing within the health

care system will be stressed, this advocacy to be implemented at women's group meetings and on other occasions that are appropriate.

Here, too, we will share the results of our consumer survey. If time permits we will have participants observe and participate in counselling. Also, we will work with participants to provide them the perspective and knowledge to be comfortable and objective regarding surgical contraception, male and female.

The course will be taught with a Nigerian counterpart on the first cycle of 30 participants, so that the counterpart can conduct the second such cycle with the Africare trainer serving as a resource person and observer.

3. Methodology - Nurse-Midwife Full Competency Curriculum

The third category of trainees will be nurse-midwives trained for full competency in the family health initiatives. The curriculum will be drawn from that currently in use for family planning/ORT service delivery and health education courses, modified to stress the additional needs observed by Africare during the clinic surveys and supply effort.

It is inappropriate to discuss a modality with a patient, have her accept the modality, with the patient then unable to obtain the service for a number of reasons, e.g. none of the particular contraceptive in stock, no available provider, no knowledge of where a suitable provider can be seen, no appreciation of the cost involved, etc. These shortcomings have been observed in relation to nearly every method including surgical contraception. With particular reference to voluntary surgical contraception, it is important that the participants know where the service is provided, at what cost, the risks, the effectiveness, the period of disability, in-patient/out-patient procedure, anesthetic requirements, and post-partum or interval considerations.

Regardless of their personal biases we expect our students to demonstrate sufficient professionalism so that the consumer has the full complement of family planning options to choose from. Our course will emphasize freedom of choice for the consumer after a thorough explanation of all suitable options, relative effectiveness and risks, and medical contraindications.

Trainees in the four-week course will be expected to be nurse-midwives of demonstrated competency who have neither cultural nor religious constraints regarding counselling or practicing family planning service delivery, including inserting I.U.C.D.'s. We would like our trainees to have been in the health care system sufficiently long so that the probability of remaining in the system is high. In addition to demonstrated competence, we would like a sense of commitment to improving the system and a willingness to teach peers or subordinates. We would like our trainees to be comfortable as public speakers. They must be aware of their responsibility to initiate dialogue regarding family planning.

In depth instruction, demonstration and return demonstration regarding record keeping will be executed. Commodity availability and sources of commodities will be discussed. Mechanics of ordering, stock levels, inventories, and fiscal responsibilities will be emphasized.

As in the traditional family planning course they will graduate with the competence to completely administer a family planning clinic including patient counselling, dispensing contraceptive materials, and inserting I.U.C.D.'s. As previously implied, they will be able to supervise peers in family planning counselling, teach peers to insert I.U.C.D.'s, and institutionalize on-the-job training in family planning. They will know resource physician availability in case of emergency, and will be prepared

to discuss all questions a couple may have regarding surgical contraception which they will include in the array of family planning options.

The participants will demonstrate their skills in teaching peers, counselling patients, record keeping, administration and management. The relationship of family planning to religious beliefs will be discussed.

A counterpart relationship will be maintained so that the second session of the course in each state will be taught by Nigerians.

During the four-week course, each participant will draw up a proposed plan for implementation of family health initiatives to present to the chief health officer in charge or his/her facility being returned to upon completion of training. The plan will include specific recommendations for optimizing use of existing clinics to provide family planning services to a broader range of potential acceptors outside those who might attend the scheduled family planning clinics. The plan will also include a strategy for the-the-job training of peers, enabling participants to transfer to co-workers the skills they learn from the Africare-supported training.

Some two to four months following completion of the Africare-supported course, their performance in the field will be evaluated.

4. Job Descriptions

The five key positions to be staffed by Africare, and collaborating state health authorities, in each state, are as follows:

- a. Training Coordinator - assigned by state health authority to coordinate and administer training activities involving all three categories of participants.
- b. Africare Physician F.H.I. Consultant - assigned by Africare, Washington, to travel to Nigeria and serve as a principal resource person and trainer for the Physician Family Planning Update course, and the Nurse-Midwife Full Competency Training course in the first cycle. Serve as a principal resource person and backstopper to the Nigerian physician counterpart during the second cycle.
- c. Nigerian Counterpart F.H.I. Consultant - recruited in Nigeria by Africare and assigned to serve as counterpart resource person

and trainer during the first training cycles for physicians and nurse-midwives; principal trainer during second cycles.

- d. Africare Nurse-Midwife Consultant - assigned by Africare, Washington, to travel to Nigeria and serve as a principal resource person and trainer for the Nurse Basic Competency Training course and the Nurse-Midwife Full Competency Training course in the first cycles. Will not be present during the second cycles.
- e. Nigerian Counterpart Nurse-Midwife Consultant - recruited in Nigeria by Africare and assigned to serve as counterpart person and trainer during the first training cycles for nurses and nurse-midwives; principal trainer during second cycles.

Job descriptions for these positions are contained on the following pages.

In addition, Africare will provide direct support to the project for administrative and program purposes by devoting a part of its Program Manager's time to the needs of the project from its Washington office, and by posting a Country Representative to Nigeria to devote a portion of his/her time to incountry program/financial support needs.

JOB DESCRIPTION

TRAINING COORDINATOR

In each State where training will be done, the responsible health authority (Health Management Board or State Ministry of Health) will assign a senior administrator (e.g. State Family Planning Coordinator or Director) with adequate authority to coordinate and administer project activities, with respect to obtaining the local compliance and support required for training.

The principal responsibilities of the State Training Coordinator under the project will be as follows:

- a. Serve as the liaison between Africare and the state's Health Management Board and Ministry of Health.
- b. Be responsible for the management, disbursement and accountability of funds transferred by Africare to the collaborating host government agency(ies).
- c. Identify candidates meeting selection criteria for participation in training, and help to select trainees.
- d. Identify suitable alternative training sites for Africare review; assist in negotiation of terms for using sites and formalization of arrangements. The site selected must provide adequate space and facilities for training classrooms, lodging and meals.
- e. Arrange transport, communications, secretarial support, incidental training and office supplies, training equipment, flip charts, audio-aids, and other logistics support.
- f. Ensure the availability of adequate clinical activity for the demonstration and practical aspects of training; scheduling of patients to be available for family planning counselling, I.U.C.D. insertions, etc., at the times scheduled for demonstration and practical activities, allowing for personal and medical variables.
- g. Identify speaker and lecturer candidates for topics of various sessions as noted in the curriculum.
- h. Notify participants, guest speakers and lecturers of dates and arrangements, expedite their presence in view of any constraints under the control of health authorities, obtain their resumes, and disseminate information to appropriate parties regarding the project.
- i. Coordinate, facilitate and participate in followup evaluation.

JOB DESCRIPTION

FAMILY HEALTH INITIATIVES CONSULTANTS

NIGERIAN COUNTERPARTS

Africare will provide Family Health Initiatives Consultants to direct and help carry out teaching activities in each state in accordance with the plan and framework of this proposal.

In the first cycle of training in each state, these will be a physician and a nurse-midwife, who will present the training along with two Nigerian counterparts of the same qualifications. In the second cycle at each state, only the Africare physician will be present, and the role will be more supervisory and facilitative, with all principal responsibilities for course presentation being carried out by the Nigerian physician and nurse-midwife. With this shift to monitoring and critiquing in mind, the responsibilities of the Africare consultant working with counterpart will be:

- a. Review and tentative finalization of curriculum, logistics, scheduling of clinical activity and other instructional arrangements.
- b. Review of resumes of course participants to enhance teaching capabilities.
- c. Review of resumes of guest speakers, lecturers, demonstrators.
- d. Acquisition of relevant information regarding commodity sources and distribution, availability and cost of family planning services in a general sense throughout the state, cultural and religious factors vis-a-vis family planning, nutritional patterns and practices, statewide implementation of EPI and other immunization programs, role of private sector in family planning, and other pertinent matters to training.
- e. Presentation of training sessions, demonstration and supervision of practical work, monitoring and evaluation including followup site visit.
- f. Compilation of relevant data and completion of training report.
- g. Management of Africare disbursed funds, maintenance of adequate and appropriate financial and accounting records, submission of financial reports to Africare/Washington.

Qualifications of the Africare Consultants and Nigerian Counterparts

will be as follows:

- M.D. (also MSPH desired but not required), experienced in Nigeria or similar health care system/resources/needs; or R.N. with same.
- Knowledgeable and experienced in family planing and primary health care; experienced teacher capable of demonstrating enthusiasm and motivation; appreciative of operative constraints and priorities; awareness of shortfalls in current family planning practices; knowledgeable and experienced enough to adapt to individual needs of participants.
- Adminstrative and management skills and experience.

5. Project Implementation

The chart on the following page sets forth the tentative project implementation schedule. Based upon a final pretraining visit to all three states, to complete arrangements, minor adjustments may be made, however the entire training program will be completed within the period of January 1, 1986 through June 30, 1987.

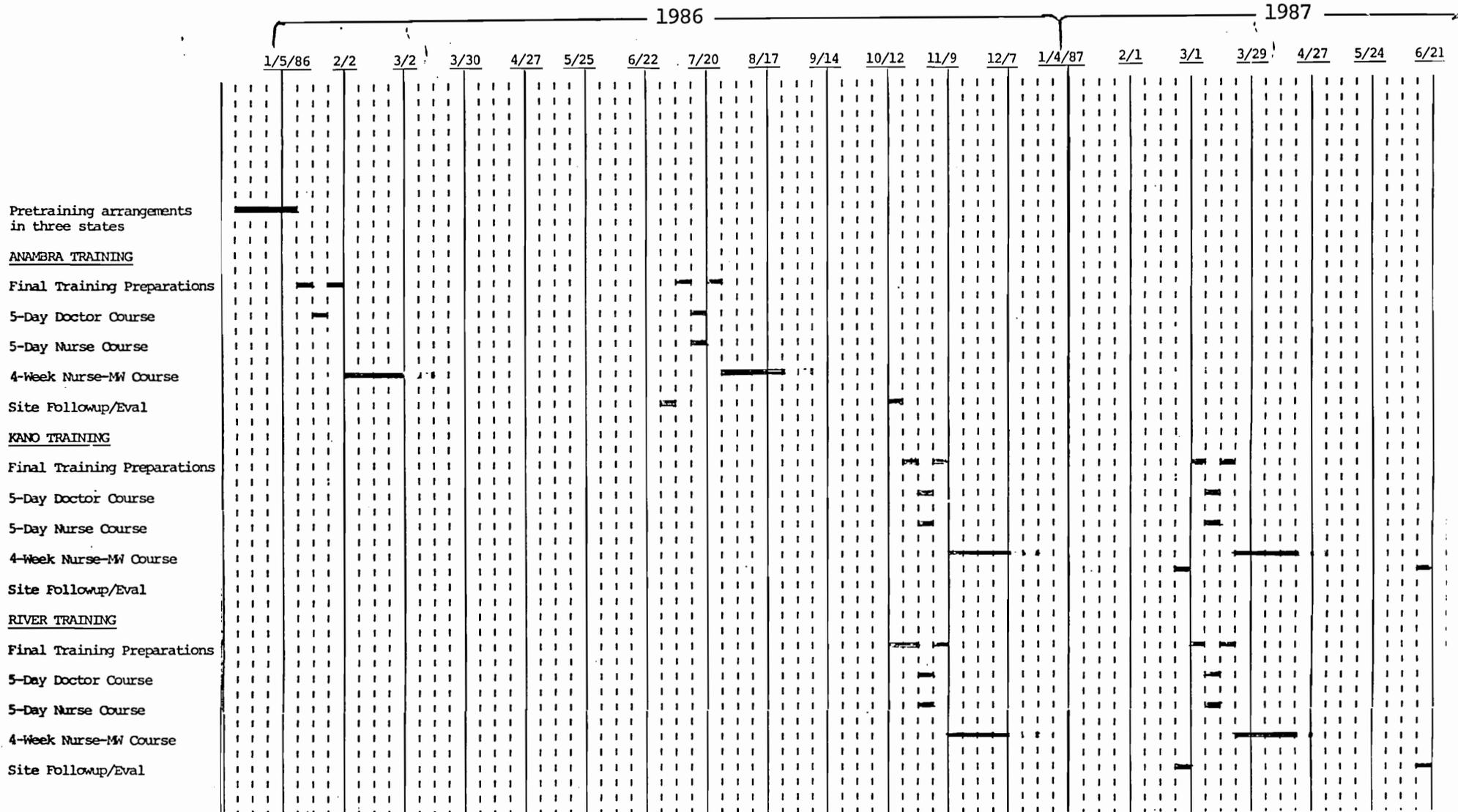
The pretraining visit will be accomplished to identify a site in each state which has suitable housing for participants and training staff, and appropriate facilities for training.

During the pretraining visit Africare will meet with the individual to serve as state training coordinator for training at the locale, to agree on selection criteria for the three participant categories. Also, meetings will be held at the national level to arrange, if possible, for National Youth Service Corps physician participation.

The criteria for training participant selection will include considerations on the candidates themselves such as prior experience, commitment, capability of being retained and current responsibilities, as well as considerations on the facilities where they will be practicing after training, such as location, geographic need for family planning, oral rehydration therapy and immunizations services, physical plant, staffing, types of clinics and patient volume.

A review of existing training materials and equipment, and additional needs, will be conducted jointly by the Africare consultant and the state health authority counterpart. The two will also review the local availability of teachers, trainers and support staff such as typists and drivers. They will identify office space, materials and equipment arrangements and formalize these, and will establish banking and financial arrangements for transfer of funds, payments, and accountability.

PROJECT IMPLEMENTATION SCHEDULE (TENTATIVE)



The Africare consultant and host agency counterpart will schedule the actual dates and place for training, identify the administrative chain of command for obtaining needed actions, draft the letters of notification for candidates, and define the training roles for Africare and host country staff. They will finalize the curriculum, identify local teachers and speakers, and firm up the commitments from host country managers, health management boards, and the State Ministry of Health for carrying out training and receiving the needed support (including vehicles and arrangements for practical experience) under the project.

The training visit will also allow the initiation of dialogue in infant welfare clinics, ante-natal clinics, post partum wards and other settings concerning the introduction of family planning services.

The site selected for the courses will be near to or in an urban center. Prior to the pretraining visit a letter will be sent to the State Commissioner of Health providing the date, duration and purpose of the visit, general criteria for site, staff and participant selection, and the need for patients interested in receiving family planning counselling and services including I.U.C.D. insertions for the practical aspects of the program.

The site will be centrally enough located so that accessibility to practical teaching situations (family planning clinics, ante-natal clinics) will not be a problem. There will be ample opportunity for participants in the full competency program to spend two afternoons a week at varied family planning clinics. There they will observe the insertion of I.U.C.D.'s and accomplish these under supervision. To enable this to be accomplished in groups of three participants, there should be at least four such suitable facilities with ample patient load within an

easily covered radius. One aspect of training support needed from the family planning service delivery and related equipment/supply program in Nigeria will be an adequate number of insertion kits and I.U.C.D.'s so that four to six insertions per clinic twice weekly, for four weeks in each of four clinics, can be completed.

The centres being visited will also serve as a laboratory to observe counselling in action and participate as a counsellor.

By the time the expanded Africare team reaches the first state, Anambra (and subsequently before the launching of training at other sites) we would like to receive the resumes of the participating physicians, and of the nurse-midwives attending the four week course. These will be used to tailor training if needed and possible.

The implementation schedule on page 30 presents in sequential fashion the timing of specific preparations for each training cycle, the duration of the cycle, and the timing of followup activities.

Africare will prepare and submit narrative progress report and financial reports quarterly, one month following the quarters covered ending March 31st, June 30th, September 30th and December 31st. A final progress and financial report will be completed and submitted one month following the project termination date of June 30, 1987. Reports of training cycles, new curriculum units developed and other materials of interest developed under the project will also be made available.

6. Project Monitoring and Evaluation

Pre-testing and post-testing will form an important aspect of the coursework with participants. There are criteria enumerated for each segment of training, for the purpose of evaluation on a day by day basis. There will be constant dialogue and feedback. The termination of the course will be associated with filling out an evaluation form regarding the course content, presentation and relevance. The participants will be requested to provide recommendations for course modification.

During the 4-week full competency cycle, nurse midwives will each formulate a family health initiatives strategy for their respective facilities, to include how they will approach attempting to institutionalize on-the-job training. The extent to which the strategy is initiated and implemented will be assessed during a subsequent followup site visit by a team comprised of an Africare training consultant and Nigerian counterpart.

The actual success of the course will be determined at the site visits approximately two to four months after the course. At that time if there are active family planning programs throughout the facility, if there is institutionalized on-the-job training, and if there is a definitive change in referral patterns for voluntary surgical contraception, the course will be considered successful.

At the time of the visit, the clinical skills of the participants and others they have trained on the job will be observed and critiqued, and in turn the participants will again be asked to critique the course to obtain further feedback for curriculum improvements. Also, observations will be made if preventive maintenance and simple repair of equipment is being done, and if more complex repairs are being externally accomplished.

IV. DETAILED BUDGET

<u>Description</u>	<u>Cycle 1</u>	<u>Cycle 2</u>	<u>Cycle 3</u>	<u>Cycle 4</u>	<u>Cycle 5</u>	<u>Cycle 6</u>	<u>Total</u>
A. PERSONNEL SALARIES/FRINGE							
Country Rep (25%), Prog Mgr (10%) and Secretarial Support part-time	7,688	7,688	3,844	3,844	3,844	3,844	30,752
US Hire Trainers (Phys & N-Midwives)	11,700	6,750	10,800	10,800	6,750	6,750	53,550
Local Hire Trainers (Phys, N-M, Lect)	6,700	6,300	6,300	6,300	6,300	6,300	38,200
Training Site Support Staff	1,800	1,800	1,800	1,800	1,800	1,800	10,800
	\$ 27,880	\$ 22,538	\$ 22,744	\$ 22,744	\$ 18,694	\$ 18,694	\$ 133,302
B. TRAVEL/ALLOWANCES							
Portion (25%) Country Rep Costs	8,890	2,290	1,690	1,690	1,690	1,690	17,940
Program Mgr (2 visits)	3,390					3,840	7,230
US Hire Trainers (Air Fares/P.Diem)	17,880	6,440	12,880	12,880	6,440	6,440	62,960
Local Trainers (Air Fares/P.Diem)	4,725	4,725	4,725	4,725	4,725	4,725	28,350
Local Transport/Taxis	400	400	400	400	400	400	2,400
	\$ 35,285	\$ 13,855	\$ 19,695	\$ 19,695	\$ 13,255	\$ 17,095	\$ 118,880
C. TRAINEE SUPPORT/TRAVEL							
Food/Lodging (\$40/day/trainee)	16,480	22,480	22,480	22,480	22,480	22,480	128,880
Travel Reimbursements (\$.10/mile)	450	650	650	650	650	650	3,700
	\$ 16,930	\$ 23,130	\$ 23,130	\$ 23,130	\$ 23,130	\$ 23,130	\$ 132,580
D. EQUIPMENT/SUPPLIES							
Training Materials/Supplies	1,400	2,000	2,000	2,000	2,000	2,000	11,400
Photocopy Equipment/Supplies	825	150	150	150	150	150	1,575
Other Office Supplies	100	100	100	100	100	100	600
	\$ 2,325	\$ 2,250	\$ 2,250	\$ 2,250	\$ 2,250	\$ 2,250	\$ 13,575
E. OTHER DIRECT COSTS							
Office Utilities	100	100	50	50	50	50	400
Telephone/Telex	750	400	200	200	200	200	1,550
Freight (Project Supplies)	1,000						1,000
Postage	200	200	200	200	200	200	1,200
	\$ 2,050	\$ 700	\$ 450	\$ 450	\$ 450	\$ 450	\$ 4,150
F. AFRICARE INDIRECT							
Level I, 25.8% of Categories A,B,C,E 0.258 x \$388,912							\$ 100,339
Level II, 12.9% of Category D 0.129 x \$13,575							1,751
							\$ 101,751
G. TOTAL BUDGET FOR REQUESTED AMENDMENT							\$ 504,577

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ANNEX I

Africare Qualifications

Background

Africare History

Africare is a private, non-profit organization working to improve the quality of life in rural Africa. It conducts self-help programs in the broad areas of food, water, health, literacy, reforestation and refugee assistance.

Africare was founded in 1971 in the District of Columbia, and since that time has worked in some 19 African countries. It maintains field offices in the nations of Chad, Ethiopia, Mali, Niger, Rwanda, Senegal, Somalia, Burkina, Zambia, and Zimbabwe, and is currently operating about 100 programs throughout Africa, ranging in budget from \$1,000 to \$5.9 million. It receives funding from private foundations, corporations, small businesses, churches and national denominational organizations, other private voluntary organizations, the Agency for International Development, the U.N. High Commissioner for Refugees, foreign organizations, and many thousands of individuals.

At the time of Africare's founding, West Africa was experiencing one of the worst droughts in its history. Africare has undertaken both short and long-term programs designed to protect against further encroachment of the Sahara and to restore the physical vitality and human dignity of millions of people affected by the drought. Short-term assistance has been in the form of foodstuffs, medical supplies, small equipment, wells, and nutrition recuperation centers. Long-range projects include water resource development (wells, dams, and irrigations systems), food production, range management, maternal and child health programs, paramedical training, and the construction of rural dispensaries and rural health department buildings.

Africare's Capabilities in Health-Related Activities

Africare's experience in health service activities falls into three major categories: management and distribution of pharmaceuticals, delivery of primary health care, and procurement and shipment of medical equipment and supplies. This experience has been on national and international levels and in collaboration with national governments, rural citizens, and multinational organizations.

1. Management and Distribution of Pharmaceuticals

A major hindrance to effective health care in developing countries occurs in the overall systems for planning, procuring, and distributing pharmaceuticals. Inefficiency in these systems leads to budget shortages and a poor correlation between needs and supplies. Africare has had significant experience in this domain in both Gambia and Sierra Leone where, after identifying problem areas and evaluating the situation, new systems were established.

2. Primary Health Care Delivery

Africare's assistance in the area of primary health care delivery addresses two basic deficiencies in the health care systems of developing nations: the lack of adequate equipment and facilities and the lack of qualified medical personnel. Once again, working with rural citizens and national ministries of health, Africare has designed village self-help projects for the construction and equipping of rural dispensaries and maternities and has helped to extend the proficiency of health service networks.

Maternity/health activities have been incorporated as part of a larger community development projects which involve the local population and lead to a greater awareness of community health needs. They strengthen national infrastructure because their location and management are determined through existing government services and they are staffed by service personnel.

In 1978, Africare launched the Health Support Program in which donations of "packaged hospital units" from states and localities in the U.S. -- once part of a national civil defense plan -- are integrated into existing African health care networks. A complete "packaged hospital" consists of essential medical equipment and supplies capable of equipping a 200-bed hospital or several rural clinics. Africare has shipped units to Egypt, Ethiopia, The Gambia, Rwanda, Somalia, Upper Volta, Guinea, Mali, Nigeria, Senegal, Sudan, Uganda, and Zambia, and where needed, and has provided technical assistance in setting up the equipment and training for host nationals in its repair and maintenance.

Africare has also worked closely with the Governments of Niger and Upper Volta to remedy the lack of qualified medical personnel and expand their health care networks through the organization of Village Health Teams (VHT's). Each VHT is composed of several local volunteers who have been trained to treat simple illnesses, educate their neighbors about disease prevention and proper nutrition, organize vaccination programs, and generally served as the liaison between their village and the regional medical center. Africare has trained and equipped some 30 VHT's as part of the integrated rural development project in Upper Volta's Seghenega Sector.

Africare has also helped establish a rural health care delivery system in Niger's Diffa Department, now functioning and serving some 145,000 people. Growing out of this assistance, Africare was contracted by the Nigerian government to provide technicians to the current Rural Health Improvement Project, a nationwide medical outreach program funded by USAID. Africare has provided a Public Health Physician, two Sanitary Engineers, two Medical Equipment Technician/Trainers, three Auto Mechanic/Trainers and an Administrative Officer, all of whom work closely with Nigerian officials to foster more efficient organizational procedures and to train technicians and the general public in health care.

Both of these projects have sought to strengthen existing health service infrastructures and to stretch fiscal resources through increased efficiency. These goals were achieved both by improving procurement and delivery systems and by providing a data base which can be used to plan and monitor drug distribution relative to regional data profiles of disease prevalence and health care. All key decisions and full management responsibility rest with the respective governments. Africare's role has been advisory and supportive in nature through the fielding of technical assistance personnel, the delivery of donated items, and the monitoring and assessment of project progress.

3. Procurement and Shipment of Medical Equipment and Supplies

Although projects in the above areas must also address the problems of procurement and shipping, they have primarily dealt with the internal problems of national health care systems. In regard to externally-oriented concerns, Africare has also worked in collaboration with WHO, UNICEF, and African Member States to explore the possibility of a pool procurement scheme for essential drugs. This would allow Member States to secure more dependable and affordable supplies of quality drugs on better delivery terms as a result of pooling orders.

Africare was to study the financial, legal, operations, managerial, and cost-effectiveness aspects of the scheme. A Summary Report and Recommendations (May 1983) was prepared and submitted by Africare based on a visit to AFRO in March 1983, and in accordance with its recommendations, a five-week Africare-led mission was made to Zambia and Niger in July and August of 1983 to examine program considerations from those Member States' perspectives. The approach in each country was multi-sectoral, involving all principal ministries and agencies.

These studies culminated in a report submitted by Africare to the WHO African Regional Office in September 1983, which incorporated findings and recommendations in an implementation framework that set forth the roles of participating entities, alternative payment and financing mechanisms, the operation and management of the program, and a timeframe for its implementation. The program now awaits action by AFRO, UNICEF, Individual Member States, and international financing institutions.

The above examples illustrate Africare's direct experience in the field of the health care. Of course, all projects, whether they be wells for clean water or vegetable gardens for an improved food supply, have bearing upon a community's health.

4. Africare's Work in Nigeria

Africare's work in Nigeria has been, and will continue to be directed at improving the rural health delivery system, particularly as regards family health services. At the same time, Africare is exploring and preparing to provide assistance to food production, water resource development and other related projects.

Africare began its work in Nigeria in the late 1970's by supplying a complete packaged hospital, minus the roof and walls, to a non-profit group establishing and inpatient care facility at Owerri, in Imo State. The equipment and supplies were sufficient for a 200-bed unit, and the unit included set ups for four operating rooms, a clinical laboratory, facilities for X-Ray, pharmacology and other needs.

In 1984 Africare entered into the present Cooperative Agreement with USAID, in collaboration with the Federal Ministry of Health and State Ministries of Health, to conduct surveys of basic needs at 60 clinics in five states; this was however expanded with USAID concurrence, due to cost savings, to cover 120 clinics in eleven states. Also, Africare purchased, delivered and arranged for the incountry distribution of basic equipment and supplies for 63 clinics.

Subsequently, under a sub-Agreement with the Association for Voluntary Sterilization (AVS), Africare surveyed another 80 clinics in the remaining eight states, and is purchasing, shipping and distributing 120 more sets of equipment. Under the sub-Agreement, an evaluation was conducted on the earlier supply effort.

In July 1985, Africare secured as a donation for Merck & Co. a quantity of measles vaccine (400,000 doses) and shipped the vaccine as a contribution to the health program of the Imo State Ministry, for the childhood immunization program. To the extent possible, Africare will continue to seek measles vaccine contributions in support of needs not being met by UNICEF support, and not covered by State Ministry of Health budgets, particularly in the states where training is proposed under this requested amendment.

Annex II - Tentative Training Curriculum for Physicians

"Family Planning Update"

CURRICULUM - PHYSICIAN FAMILY PLANNING UPDATE

Day 1

<u>Time</u>	<u>Topic</u>	<u>Method</u>	<u>Materials</u>	<u>Evaluation</u>
8:00	INTRODUCTION	- Faculty present purpose of course and their qualifications. - Participants talk about their background and expectations	Dialogue	Free expression, non-threatening atmosphere
10:30	BREAK			
11:00	WHERE ARE WE NOW?	- Pretest	Pen, exam booklet	Performance assessment
12:00	WHERE DO WE GO FROM HERE?	- Discussion of pretest questions	Dialogue	curric concensus/modify
12:45	LUNCH			
2:00	NATIONAL POPULATION STRATEGY, GOALS AND OBJECTIVES	- Guest Speaker	Lecture, questions/answers	positive attitude/motiv.
2:45	STATE GOALS & OBJECTIVES, PLANS AND RESOURCES	- Guest Speaker	Lecture, questions/answers	positive response
2:30	BREAK			
4:00	PANEL ON MACRO ISSUES	- Prior guests and two other designates	Questions/answers	nature of interaction

CURRICULUM - PHYSICIAN FAMILY PLANNING UPDATE

Day 2

<u>Time</u>	<u>Topic</u>	<u>Method</u>	<u>Materials</u>	<u>Evaluation</u>
8:00	REVIEW MACRO ISSUES	Questions/answers, Faculty & Part	Dialogue	Responsiveness
8:30	FAMILY ISSUES AND FAM PLANNING	Question/answers, Faculty & Part	Dialogue	Nature of quest/answers
10:30	Social/Economic/Health/Religious BREAK			
11:00	FAM ISSUES AND FAM PLAN CONT'D	" " " "		" " "
1:00	LUNCH			
2:00	EQUIPMENT MAINTENANCE	Guest speaker/demonstrations	I.U.C.D. insertion kit	Return demonstrations
5:00	BREAK THEN SUPPER		sphygmomanometers salter scales adult scales stethoscopes	

CURRICULUM - PHYSICIAN FAMILY PLANNING UPDATE

Day 3

<u>Time</u>	<u>Topic</u>	<u>Method</u>	<u>Materials</u>	<u>Evaluation</u>
8:00	I.U.C.D. INSERTION	Demonstration and return demonstration, Divide into three to four groups and meet a three to four clinics.	Three to four clinics with OBGYN staff demonstrating with patients.	Return demonstration Discussion
1:00	LUNCH			
2:00	REVIEW OF CONTRACEPTIVE MEASURES INCLUDING VOLUNTARY SURGICAL CONTRACEPTION	Presentations/demonstrations Discuss indications, contraindications, side effects, counselling techniques.	Patients, contraceptives, charts, etc.	same

CURRICULUM - PHYSICIAN FAMILY PLANNING UPDATE

Day 4

<u>Time</u>	<u>Topic</u>	<u>Method</u>	<u>Materials</u>	<u>Evaluation</u>
8:00	To be finalized in consultation with host counterparts Will repeat I.U.C.D. insertion demonstration and practice if needed.			
1:00	LUNCH			
2:00	MANAGEMENT/ADMINISTRATION	Lecture and Demonstration on <ul style="list-style-type: none">- stock levels- proper family planning records- communications- resource channels- optimum use of facilities	Demonstration records. case studies/problems	Return Demonstration & problem solving

CURRICULUM - PHYSICIAN FAMILY PLANNING UPDATE

Day 5

<u>Time</u>	<u>Topic</u>	<u>Method</u>	<u>Materials</u>	<u>Evaluation</u>
8:00	ROLES OF NON-PHYSICIAN PROVIDERS, COUNSELLING IN CONTRACEPTION INCLUDING VOLUNTARY SURGICAL CONTRACEPTION/ON-THE-JOB TRAINING.	Patient interviews in F.P. Clinics, observations and performance of non-physician providers	OBGYN MD's, nurses, nurse-midwives, patients	Substance and atmosphere of interview
12:30	LUNCH			
2:00	COURSE REVIEW	Dialogue and demonstration	Discussion	Demonstrated competence
3:30	BREAK			
4:00	WHAT HAVE WE COVERED	Post-test	Pen, exam booklet	"