

000-372

000-12
3

**LESSONS LEARNED IN THE OYO STATE
COMMUNITY-BASED HEALTH AND FAMILY PLANNING PROJECT**

Gene Weiss

The Community-Based Delivery (CBD) Health and Family Planning Project was designed to demonstrate and test the effectiveness of providing low-cost rural health and family planning services through trained community volunteers who are directly supervised by health personnel from governmental facilities. This project is the first CBD effort established under government auspices and with direct government participation in Nigeria. Services were initiated in 1981 in an area just north of Ibadan with a population of about 85,000. In 1983, four additional areas in Oyo State were added as the State Health Council (Ministry of Health) joined University College Hospital (University of Ibadan) in sponsoring the project. The lessons learned in implementing the project are presented below.

Organizing CBD Operations Research Programs

- The CBD project has rapidly and significantly increased the health services rendered to the rural population.

Before CBD services were introduced, a Baseline Survey found that only 36% of the respondent's families had utilized any government health service in the last year.

In the first full year of operation (1982) the 170 CBD workers provided the following services to the 85,000 Akinyele residents:

Illness Treatments	33,788	The treatments were for:	
Prenatal Pill Disbursement	2,051	Malaria	37%
Contraceptive Disbursement	6,662	Cough	19%
Deliveries	575	Worms	12%
Health Talks	4,751	Diarrhea (ORT)	11%
		Wounds, First Aid	11%
		Anaemia	9%

- Very positive and practical benefits resulted from integrating family planning with basic health services.

From the perspective of Oyo State, there is tremendous value in integrating family planning with basic health services. Not only does this make the initiation of the topic of childspacing acceptable at the village level, but it allows family planning to be associated with a very much appreciated service -- bringing basic health care to the rural villages and hamlets. It allows the CBD workers to justify their promotion of family planning through an emphasis on its health benefits. At the Ministry of Health, and among Oyo State health personnel, the program is known as "CBD and Family Planning"; it is recognized that family planning is an integrated component of the community-based services.

- There were large political and program advantages in utilizing Traditional Birth Attendants in the CBD services.

It has been found in the Expanded Project that TBAs are not absolutely necessary for an effective MCH/FP CBD program-- non TBA female volunteers also work well. However, TBA involvement has a political overtone that makes the project more acceptable to many health and other government personnel. It also fits in with the federal government's policy and efforts to train TBAs. Even though TBAs may not deliver the majority of babies in Oyo State, (two-thirds of home deliveries are not assisted by a TBA), their influence on family planning acceptance is still likely to be significant.

- Dissemination of project information at the local level proceeds through a variety of channels, both formal and informal, and can have a major impact on project replication.

The interest of the Oyo State Health Council in expanding the project, and in other nearby states (such as Ogun) in starting a CBD project, was not due to a careful evaluation of the initial project and its impact. Rather, it was due to basically word-of-mouth communication among health professionals and other elites. This was facilitated by political feedback from the project area that the services were valuable and appreciated, and by television and radio coverage of graduation and launching ceremonies. A demand grew in other constituencies of Oyo State that they too should have such services.

- The local university played an important role in initiating the CBD project. However, there are drawbacks to running a project from a university hospital.

Effective supervision has remained a problem in the original project area. In particular, a number of the local government employed nurse/midwives have remained

somewhat aloof from the CBD project, and thus have not become effective supervisors. This has not been the case with the nurse/midwives in the expanded project areas, where they display enthusiasm and commitment. The likely explanation lies in the dominant role played by University College Hospital's staff in the original area, where they are still regarded as the key supervisory personnel by the CBD workers. This points out a serious disadvantage of a pilot program led by university or other outside personnel. However, UCH staff provided the dynamic and charismatic leadership that was needed to initiate an innovative project of this type.

The successful transfer of the pilot project was the result of a carefully planned "apprenticeship". State personnel first spent time in the Pilot area observing the functioning of the program. After Training-of-Trainers programs, they observed and assisted UCH staff in the initial steps of the Expanded Project, gradually taking over the training and other local program functions. Planning and overall project management are still currently jointly undertaken. The expanded project is both more replicable, and has better supervision, resulting from the government nurses having organized the local CBD program themselves.

Developing Effective Health Services Delivery Systems

- The community-based approach has changed the perception of health personnel from a concern with providing services to clients who come to a fixed site to providing services to all people living within a particular catchment area.

A significant result of the implementation of the CBD program, especially in the expansion areas where the government midwives have been the organizers, has been a new emphasis placed on serving the population at need. In the fixed clinic program the fact that typically only 25%-50% of the rural population utilized the facilities did not seem to be relevant to the rural nurse/midwife. In the CBD program, on the other hand, the supervising nurses make considerable efforts to see that all parts of their catchment area are served by the program, and that none are left out. As mentioned earlier, this also has political overtones, as no area should be seen as being denied the services of the program. In particular, supervisors now express concern that the more distant/isolated communities, who greatly rely on their CBD workers for the treatment of illness, are served. The workers from these areas appear to be very motivated.

- Non-professional rural health personnel have made a major contribution to the CBD program.

After the project began, it was discovered that some of the wardmaids, locally trained assistants to the nurse midwives, spent more time with the CBD workers than did the nurses. In addition, the wardmaids were always available at the maternity center, and did not commute like the nurses. Following the special training that was organized for them, they have played an effective role in supervision and family planning education, and are now a standard element of the program. For example, at one of the Pilot maternities, Alade, a ward maid ran the CBD project for six months when the nurse midwife was transferred and a replacement had not come. At Iroko maternity, the ward maid conducted 18 CBD supervision visits to villages during a recent 9-month period.

- A major value of CBD workers has been the linking/referral functions they have served with the government health services.

A recorded referral in the CBD program means that the CBD worker personally accompanies his client to the maternity center, hospital, or other clinic. In the Oyo (Expanded Project) area, where careful records have been kept, 142 referrals were made to the Primary Health Center of Ilora in nine months by the 100 CBD workers. Of course, many "verbal" referrals to clinics or maternities are made by the CBD workers where they did not personally accompany their client. An example would be a referral for an IUD insertion. In addition to referrals, agents have also played an important role in assisting health workers to follow-up patients in the villages.

- Individual monetary incentives are not necessarily needed in order to have motivated CBD workers.

A very significant finding is that in the new areas, volunteers have been found to carry out the CBD program without resort to a monthly financial supplement (such as 10 naira). One might hypothesize that effective community organization and participation may be an alternative to the giving of monthly stipends. On the other hand, once incentives are given, they create difficulties when they are stopped, as they were in the Pilot Area. Though Self-Help projects were initiated as a replacement, the workers have asked for a reinstatement of the monthly payments.

- Small service fees are an acceptable part of the CBD program, though it is unlikely they can ever totally support the costs of the program.

While the original project has been able to collect small service fees (33-67 US cents) from the clients, it is clear that this is not on a strictly commercial basis. Most CBD workers do not collect fees from their relatives--a significant portion of their clients. It is hoped that a mechanism in which fees collected are used directly for the purchase of drugs can be developed. Currently, each group of CBD workers has its own bank account where its leader deposits the money collected each month, currently about 60% of the cost of drug resupply. The program in the Expanded Areas has recently introduced fees as the government has given up the policy of "Free Health Care."

- Field studies have verified that illiterate villagers can properly treat malaria and other common illnesses. In addition, they can also be taught to recognize their limitations.

Two separate field studies (1982, 1984) each questioned a sample of approximately 30 CBD workers to determine how well they knew the presenting symptoms and appropriate treatment (by age of client) for the illnesses they treated. Both concluded that over 90% of the mainly illiterate villagers had been taught to effectively diagnose and treat a few common illnesses. The use of pictographs for instruction and labels help to ensure the correct disbursement of treatments. Color, odor and taste are also used to distinguish the different drugs. However, the fear that the CBD workers would become self proclaimed "doctors" has not materialized due to the strong emphasis on the referral of clients, and the status that is conferred upon the CBD workers by their close association with the health centers.

Promoting Family Planning Acceptance

- About half of the married women in the project area in the reproductive ages are not sexually active at any one time, practicing abstinence for the purpose of ensuring the health of the nursing child.

Postpartum sexual abstinence is universally practiced in Nigeria, typically for one to three years in the rural Yoruba communities. The project's Baseline Survey found the median period of abstinence to be 24 months, with 58% of mothers with a child under five, to have not yet resumed relations since the last birth. The median length of breastfeeding is 22 months. Due to education and other modernizing factors, there is a desire and some pressure to reduce the period of abstinence. Most family planning acceptance is essentially the use of a modern contraceptive in place of the tradition of abstinence.

- Because of its relationship with the postpartum nursing/abstention taboo, contraception is not a topic easily talked about in the rural communities.

Open and cross-sex (male-female) communication about family planning is very difficult. Thus, it is important to have both male and female community agents to introduce and promote modern contraceptives in the rural areas. The number of family planning acceptors per CBD worker (in the Pilot Area) does not differ much between the sexes:

Average No. Contraceptive Disbursements, 1983

Male (VHW):	61
Female (TBA):	69

In addition, it appears that any use of contraception by the TBA or VHW his or herself greatly increases the ability of the CBD worker to influence others. A current study of the process and impact of CBD educational efforts will attempt to document this hypothesis.

- Male interest in family planning in the project area as well as the use of condoms have proven greater than was anticipated.

While females practice 2-3 years postpartum abstinence, no such requirement is placed upon the male. Some (perhaps 30-40%) of the men are polygamous and extra-marital relationships are common. One male reported that the use of contraception allowed him to remain faithful to his wife: they could have sexual relations but, by not allowing conception, they would not break the taboo on the wife becoming pregnant before her child was weaned from the breast. On the other hand, some men may be using contraception to prevent pregnancies from arising out of the extra-marital relations. CBD workers report that an important reason for husbands objecting to their wives' use of contraception is the fear of their wives becoming "promiscuous". It is apparently felt that the susceptibility of pregnancy will keep a wife "true" to her husband, as an extra-maritally conceived pregnancy would be discovered, and the wife punished.

- While initial family planning acceptance was slow, indications are that ever use of a modern method has increased from 2% to 25%.

While the CBD system does not allow the collection of detailed (or any, for that matter) client data, estimates of use have been made from the number of disbursement and the amount of contraceptives

distributed. During 1982-1983 (12 months), the number of Pill, condom, and foam tablet acceptors was estimated at 2,460, 830, and 605, respectively. Given the approximately 16,000 women of reproductive age, about 25% have used modern contraception. Current use, however, is estimated at about 10% due to the relatively short periods of usage.

Conducting Operations Research

- Controlled quasi-experimental studies are extremely difficult to carry out in typical rural settings in Nigeria.

Both the original project proposal and the expansion proposal were unrealistic in asking for controlled variations in details of project services. Such control over project components is simply not likely in a Nigerian context in any large-scale endeavor. Managerial control over and feedback from field operations is usually fairly weak. In addition, there is a very strong bias for implementing the same program in all areas of a project. A more fruitful approach is to follow-up the naturally occurring variations in the program. For example, in two of the new areas, one zone was to utilize only TBAs, while another was to use only non-TBA female volunteers. This plan was not implemented. Instead, in both areas, through no particular plan, a mixture of the two types of CBD workers were selected. By investigating the comparative performance of the two types of workers in the same social environment, an even better assessment of the difference is possible. This particular lead will be followed up with both statistical analysis of tally sheet records as well as field interviews.

- The utilization of the portable microcomputer, though only in the first stages, will significantly alter our ability to obtain timely survey results and to, therefore provide feedback to the program managers. In addition, the cost of data analysis will be reduced while the accuracy will be improved. Key punching, editing, and basic results now typically take two-three months, instead of 12-24.
- The development of a mechanism to record the activities of the CBD workers, most of whom are illiterate, has been a notable achievement.

A pictograph-based sheet, turned in once a month, has been developed. It is simple, usable by illiterates, and records the type of service and the type of patient. A series of mini-studies has assisted in the evaluation and consequent improvement of this "tally sheet." While the CBD workers can appropriately record the type of client and service rendered, they have much

()ulty in distinguishing between "old" and "new" clients, and in recording a disbursement to one client as one event, and not marking down the number of drugs or contraceptives handed out.

name

aba
village

ile ibimọ
maternity

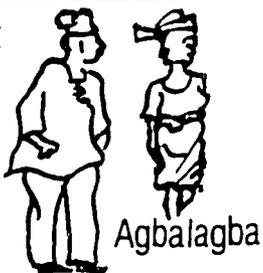
ti o fi iwe re si le
date turned in

agbegbe
zone

Treatment (Itoju)

Field work Reports Of **TBA**s & **VHW**s (Circle One)

Adult



School
Child



Infants & Under
Five



Malaria

Iba



Cough

Iko



Diarrhoea

Igbe
Gbuuru



Worms

Aran



Anaemia
Eje Koto
Lara



Dressing

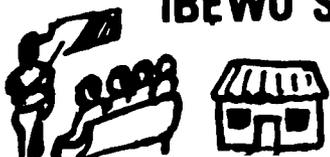
Egbo



Others
Awon
Arun
Yoku



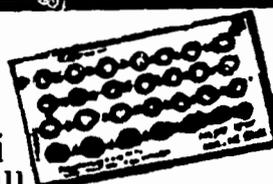
HOME VISIT (without treatment) but Health Talk
IBEWỌ SI ILE (Lai fun ni Logun) sugbọngbigba ni ni 'yanju nipa Ilera



'H REPORT

	<p>New Case (1st Visit) Ibewo Akoko tabi Alakowa</p> 	<p>Old Case (Follow Up) Alatunri Ti ki Ise Alakowa</p> 
<p>Antenatal Aboyun</p> 		
<p>Delivery Igebi</p> 		<p>Postnatal Care: Itoju lehin Igebi</p>

FAMILY PLANNING FETO SI QMO BIBI

	<p>New Case (1st Visit) Alakowa</p> 	<p>Old Case (Follow Up) Ti ki Ise Alakowa</p> 
<p>Oral pill Tabuleti Feto si omo bibi oni mumu</p> 		
<p>Condom Fetosii Oni Ruba ti Okunrin</p> 		
<p>Foam Tablets Tabuleti ifofo oni titi bo oju ara</p> 		
<p>Other methods Awon eroja feto si yoku</p>		