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**A FIELD STUDY OF WORKER PERFORMANCE
IN A COMMUNITY-BASED HEALTH AND
FAMILY PLANNING PROJECT,
OYO STATE, NIGERIA**

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INTRODUCTION

The Community-Based Delivery (CBD) Operations Research Project in Oyo State, Nigeria, was designed to demonstrate and test the effectiveness of providing low-cost rural health and family planning services through trained community volunteers. These community-based activities serve as an adjunct to existing governmental facility-based services and the volunteer health workers are directly supervised by health personnel. The project was implemented by University College Hospital (UCH), Ibadan, with assistance from the Center for Population and Family Health of Columbia University and The Pathfinder Fund.

A number of small community-based programs have been developed in Nigeria by private or sectarian institutions, but this project is the first CBD effort established under government auspices and with direct government participation. Oyo State interest in this rural health services delivery model is so strong that the Project was expanded at the government's request during the past year to serve a population of 235,000 in four additional areas. A total of 465 health agents have been trained, two-thirds of whom are female (many are Traditional Birth Attendants, or TBAs), while one-third are male Voluntary Health Workers (VHWs). They were selected by their local communities in consultation with the supervisory staff and received one month's training at their local health center.

This paper gives results from a recent (March, 1984) field study of CBD worker performance. The study was conducted as part of a broader effort to document the program and the insights

gained to date and to develop project staff capability in operations research. The field interviews, of both health agents and their clients, primarily addressed factors thought to influence agent performance. Specific performance features included treatment of general ailments, referral, family planning services, use of oral rehydration therapy (ORT), home visiting, and the recording of all these services. Additionally, the study attempted to elicit the agents' perceptions of their work, their interactions with other agents, and the response of the communities.

METHODOLOGY

A. Research Plan and Sample Selection

It was decided that three of the eight maternity center areas in the Pilot Zone (Akinyele) and three of the six in the Oyo Zone of the Expanded Project Area would serve the purpose of the study.

1. Pilot Zone: (Akinyele). One selection criterion was based on the past performance of the areas, rated subjectively by UCH staff as relatively "good" or "weak." Selections within the two groups were then made on the basis of an imminent UCH supervisory visit which would be used to meet agents and make appointments. Aroro and Ijaiye were chosen as relatively "good" areas and Iroko as a "weak" performer.

The researchers selected CBD agents for interviews based upon their service statistics for the previous two months; they were to include agents of both "active" and "least active" status in family planning and general treatments. Clients were to be selected from those indicated on the agent's current tally sheet,

with an aim of five clients per worker.

2. Expanded Area (Oyo Zone). Field research here was to be combined with observations of an ongoing CBD worker training program in family planning. Selection of center areas for study was determined by the Zone Supervisor based on logistical expediency, since all were said to be performing equally well. The Awe, Akinmorin, and Farm Settlement areas were chosen. Agents in these areas were selected as a convenience sample during interviewers' visits to villages with the supervisors. Clients were selected at the time of the agent interviews.

Modifications were made in the research plans to reflect the field situation, including, for example, some substitution of agents and the use of group rather than individual interviews in some cases. Table 1 indicates the number of interviews and the type of respondents in each location.

B. Field Interview Methods

A structured open-ended interview schedule, focused on qualitative and process information, was used for health agent interviews. Client interviews were unstructured except for family planning users. (See Annex)

The interviews and analysis were carried out jointly by the Research Nurse for the CBD Project and a consultant researcher. Interviews were carefully reviewed each day for training purposes and to assess the appropriateness of various interview methods, such as asking indirect and non-leading questions and probing for additional pertinent information. Since interview situations were usually public and frequently interrupted by streams of

TABLE 1
NUMBER OF INTERVIEWS

Project Area	Maternity Center Area	CBD Workers		Clients	
		Female	Male	Illness Treatments	Family Planning
Pilot	Aroro	4	2	6	3
	Iroko	3	3	7	1
	Ijaiye	3	3	6	7
	Total	10	8	19	11
Expanded	Awe	6	2	6	1
	Akinmorin	1	1	1	-
	Farm Settlement	4	3	4	-
	Total	11	6	11	1
GRAND	TOTAL	21	14	30	12

curious well-wishers and client testimonials, a specific training objective was to teach flexibility in adapting the order of questions to the situation at hand. At times the repertoire of questions could not be fully completed.

Supervisors in the various areas were interviewed informally as time permitted regarding supervisory practices, performance assessment of communities and agents, the referral system, and case follow-up. A total of 35 CBD agents and 42 clients were interviewed in the selected areas (see Table 1). The thoroughness of the interviews varied according to time constraints and the interview situation. Several of the group interviews were less

complete, as were some of the interviews conducted with the Oyo supervisors. In the Pilot Zone interviews with CBD workers were on the average about 85 percent complete, yielding essential qualitative information. Client interviews were the least satisfactory, with on average about one-half of the desired information obtained. Interviews in the Expanded Area were generally less satisfactory.

FINDINGS

As a reference point for the findings presented here, two major differences between the original Pilot Zone and the Expanded Area should be noted. The Pilot Zone had been operational for about three years, while program experience in the Expanded Area was somewhat less than one year. Second, the original project design was implemented with an incentive scheme (10 naira a month) for the CBD agents which was later discontinued. In the Expanded Area, the program functioned without an incentive mechanism. Certain of the findings will reflect these differences in program experience, while others will apply equally to both areas.

A. Community Response

All of the CBD agents interviewed reported initially poor community response which was gradually overcome through many group meetings, publicity, and educational efforts with extensive home visiting. Villagers seemed to adopt a "wait and see" attitude for a time. Subsequently their inherently pragmatic nature led them to selectively test and adopt CBD services.

Community response may also have varied with their confidence in the individual agents.

A clear finding is that all communities studied highly value the CBD services, supported by the fact that all agents and communities complain about the shortage of drugs to meet the still growing demand. This esteem is greatest in the villages most distant from fixed-facility services; these workers and communities are most appreciative and have the fewest complaints, even about obvious shortages of drugs and supplies.

The most active agents appear to be accepted opinion leaders who are consulted and give advice on a range of matters including farming practices, marital and family disputes, and trading and financial management. Traditional status clearly is not the only criterion for leadership. Some of the most active and respected agents have higher educational and other achievements, suggestive not only of special personal attributes, but also of more contact with the modern sector.

Some interesting observations emerge concerning the ability of traditional leaders to influence public attitudes and practices regarding the CBD Project. Based upon informal discussions with agents and villagers, it appears that both the involvement and effect of the Bales (traditional chiefs) are highly variable. In villages where Bales and their families frequently receive CBD services or where they are indirectly involved in the supervision of agents' activities, their attention has been helpful. In contrast, in villages with factional leadership conflicts and in cases where the chiefs have made unreasonable demands on the workers or have insisted on

"political appointments" of workers, their involvement has been detrimental to the project's overall effectiveness. It appears that without the approval of the traditional chief, a project clearly cannot be introduced into a community, yet Bale approval does not guarantee community acceptance.

B. Coverage

Information is inadequate on geographic, sex-specific, and age-specific coverage of the population by CBD services, but some findings from the current study are enlightening. As distances between the agents and their clients increase, services decrease; this identifies a need for more agents and for a manageable caseload per agent in terms of distance and the number of households covered.

There appears to be considerable attention focused on women in the child-bearing age group, reflecting the special emphasis on maternity-related care in the training. It is not clear, however, why children under five, another important target group, comprise only 25% of the service beneficiaries. It may be that most children are taken to fixed facilities or to the traditional Iya omolo wewe for services, practices that warrant further study.

C. CBD Worker Efforts

The majority of agents, especially the females, are either farmers or traders and all participate to some extent in both activities. Many of the men have additional part-time occupations such as tailors, repairmen, contractors, buyers,

produce growers, etc. Only a relatively small number of older agents appear to be less active. Overall, the workers appear to be very energetic and active in their own economic activities, which may be a reason for their selection by the communities as CBD agents. Many of the workers stated that the current level of their CBD work seriously interfered with their occupations at times, and virtually all recommended that more agents should be trained, particularly for villages where there currently are none.

The agents incur both tangible and intangible costs in carrying out their CBD work. Transport expenses to the maternity centers for group meetings, resupply, and taking in referral cases may be substantial. In many cases, the agent will pay transport for a patient who must be referred if the patient has no means; they consider this part of their community service obligation. Most workers expended significant amounts of time and physical energy to make the "rounds" of their hamlets, to make home visits, and to provide the required follow-up treatments. Those furthest from the centers, where hamlets are often most scattered, have a disproportionately greater amount of work with greater direct and indirect cost. In addition to their service provision, some agents hold regular community meetings which involve additional costs in terms of time and transport.

Almost all workers have established criteria for home visits, for responding to summons for visits in the case of illness, and for follow-up. Perceived or judged seriousness is invariably a decisive factor, as are distance from the worker's house and the number of hamlets the worker is expected to cover.

Just as workers have established patterns, villagers have learned the most satisfactory means of obtaining services. For example, some clients reported that in serious cases they are most likely to directly seek the agent rather than to send for him.

Gains to the CBD workers from their efforts include enhanced community status, possibly greater opinion leadership, an unmistakable sense of accomplishment, and a demonstration of community service. Some find their work quite interesting and challenging, while others have been rewarded in kind by satisfied clients.

The enthusiasm and success of the agents in the Expanded Area demonstrate that monetary incentives to the CBD workers are not required. Their greater enthusiasm is partly due to the recency of their training and the newness of the program. Yet, the level of enthusiasm among the workers in the Pilot Zone is surprisingly high given their frustrations with supply shortages and negative feelings connected to the somewhat distracting incentive program that led them to focus on monetary rewards.

D. Division of Labor/Specialization

In most local communities there is both a male and a female CBD worker, and a natural division of labor has emerged. The female worker specializes in maternity care and pregnancy, but not to the exclusion of the other treatments. Treatment of most ailments was said to be shared equally by both types of workers, although it appears that in some areas females are in fact treating relatively more young children than are the male workers. Agents in the Pilot Zone have consciously evolved a

division of labor with regard to injuries and deep wounds in which the females treat only the minor cases and refer the serious ones to the male workers. This pattern is not nearly so evident in the Expanded Area. It seems that, with work experience, the CBD agents have pragmatically evolved a mode of operation with which they are comfortable and one that fits their environmental setting. The system of meeting informally with each other has probably served to lend greater uniformity to the work patterns. In the Expanded Area this process is most likely still under development.

However, an interesting aspect of the specialization issue is the fact that relatively few of the female CBD workers, called TBAs by project staff, had actually delivered children prior to their CBD worker training, and few do now, as can be seen in Table 2. Most of the female worker interviewed, especially those from the Expanded Area, have attended deliveries only since the training; the "true" TBAs are "grannies" over age 45 who cannot recall the total number of births attended.

It was thought that the younger women were using the training to establish themselves in the TBA profession, a practice openly encouraged by the supervisory personnel in the Expanded Area where the fewest number of "true" (experienced) TBAs were found.

T A B L E 2

Number of Reported Deliveries

Female CBD Workers Interviewed -----	Age ---	Before Training -----	Since Training -----
Pilot Zone:			
TBA # 1	45	"Many"	4 (1983 only)
TBA # 2	45	"Many"	2 (1983 only)
TBA # 3	59	"Many"	8-10 (1983 only)
TBA # 4	54	"Many"	5 (1983 only)
TBA # 5	35	0	3
TBA # 6	30	0	3
TBA # 7	36	0	6
TBA # 8	25	0	6
TBA # 9	45	0	6
Expanded Area:			
All	All less than 45	0	1-2

In family planning activities, there tends to be a similar but less pronounced division of labor. It was explained by some agents that women go to female CBD workers for family planning advice and services, while men go to male agents. This appears to be more of a normative than an actual breakdown, and may not hold when clients belong to the worker's extended family.

E. Selected Treatment Practices

The interviewers probed the workers' perceptions of what

were the most common ailments, particularly in reference to young children, and how they managed these, with occasional discussion of particular cases.

CBD workers were extremely competent in employing standardized treatments according to their standing orders. With experience, workers in the Pilot Zone have learned improvisation and problem solving; that is, they will treat familiar symptoms, then refer the patient for further treatment. Since some of the CBD workers' drugs are popular and sold commercially for a variety of symptoms, the improvisation is not surprising.

Similarly, experienced workers recognize and treat multiple symptoms and ailments with ease, such as fever with diarrhea, or fever and cough with anemia. More recently trained workers in the Expanded Area appear to treat only the dominant symptom.

The recording of multiple ailments on the Tally Sheets that the agents maintain tends to be generally correct, but there may be both under-recording and some (less likely) over-recording due to the confusion of marking symptoms instead of clients. It was noticed at several monthly supervision meetings that agents were helping one another to complete or correct Tally Sheets for the month.

During interview situations in the villages, the writers noticed at least one or two young children with highly suspicious nutritional status. Discussions of these children with the agents revealed an almost total lack of recognition of poor nutritional status or undernutrition, coupled with a corresponding lack of concern. Although elements of nutrition had been included in the training program, this evidently was not

translated into practical application.

Workers were found to be exceedingly proprietary about their carefully locked drug kits, so that family access to drugs or the assistance of "helpers" -- so often feared by health authorities -- does not pose a problem.

F. Oral Rehydration Therapy (ORT) Use and Supply

Diarrhea was not identified by the CBD workers as a serious health problem in most of the villages, and their supplies of Oralyte are used primarily for adults and school children and rarely for young children or infants. Oralyte is generally thought to be effective, but its irregular supply has discouraged the workers from using it widely and confidently.

G. Family Planning Practices

It is clear that the CBD program has successfully introduced the concept of family planning, and a limited number of methods are currently being used by the more pragmatic and "innovative" segment of the village society. It is equally clear that the CBD workers are conscientiously fulfilling a need in their communities by providing family planning services.

Public discussion of family planning is still sensitive, necessarily impersonal, and accompanied by both humor and embarrassment. Personal information is sought discreetly in private, usually at the occasion of an illness treatment and through informal channels in selected social networks.

Four types of family planning acceptors were identified from the client interviews:

1. "Stoppers" are high parity women who want no more children. They experience little public censure.
2. "Postpartum spacers" use family planning usually with their husbands' complicity and consent. They are breaking the taboo against intercourse during lactation and are, therefore, reluctant to be found out.
3. "Extended spacers" are holding off their next pregnancy with or without their husbands' consent.
4. Adolescents between 14 and 18 years are irregular but established family planning clients. (No adolescents were interviewed.)

The following clients illustrate examples of the above categories:

1. Woman, age 35-40, para 8, six alive, stated that she was the "first" family planning user in Ijaiye village. After the agents returned from training she learned about the methods, but "thought about it for a while" during her last breastfeeding period of 20 months. She has been on oral contraceptives (OCs) for more than one year and now has decided she does not want more children. Occasionally women come to her for advice and she takes them to the female agent. Her supply is now regular, though in the past she had a problem because the nurses did not bring the supplies on time. She missed her menses but was taken to UCH and "checked out," and is now taking the pills correctly.
2. Woman, age 25-28, para 4, three alive, currently 7 months pregnant. After 6 months of breastfeeding with the last child she started on OCs from a clinic in Maiduguri before coming to Ijaiye and continued with supplies from the TBA for a total contraceptive use of 2 1/2 years. Though currently pregnant, she considers herself a family planning user. She says that since many men are becoming more accepting of family planning, women are now reducing breastfeeding to shorter periods of 6 or 9 months, perhaps 12 at most. She felt that men are increasingly using

condoms, and that, at times, they send school children for them.

3. TBA, age 45, IUD user since the CBD training program. She previously had 11 regular clients, but because of the irregularity of supplies, 3 dropped out. Though contraceptives are available at the health center, she says people are ashamed to go there, but they will send school children for condoms. She herself took one client to UCH for an IUD because it was not available at the health center in Ijaiye. Since breastfeeding is now followed for only 9 months to one year, she feels that contraceptive supplies to the CBD agents should be doubled.
4. Woman, age 20-25, last child is 7 months old. She chose foam and condoms because this method will not interfere with breastfeeding. Her supply is regular (she lives in the VHW's hamlet) and she has been using for 6 months without a problem.
5. Man, age 30-35, has been using condoms for six months now on the VHW's recommendation. He usually gets 6-8 condoms (time was not specified), depending on the VHW's supply. Since he has used condoms, there has been no pregnancy and he is satisfied. He first heard about family planning on the radio, but accepted only after it was reinforced by the VHW.

The methods available from the CBD workers are oral contraceptives, condoms, and foam tablets, and they are trained in IUD referral. The methods are well understood and, in the Pilot Area, some agents have addressed contraceptive problems by changing clients from one method to another.

It was found that the agents carefully screen prospective pill acceptors according to the contraindications they were taught. Their concern for contraindications, in fact, may inhibit pill use since some agents feel insecure in their judgment and therefore will not recommend this method. For example, the agents find it difficult to determine when a client's "obesity" should bar her from pill use. Also, although

agents accept requisite blood pressure checks as an important screening mechanism for pill use, this poses a logistical obstacle since the client must be brought to the maternity center.

Foam tablets are not popular in some areas because of reported failure and irritation. In other areas, foam tablets are acceptable but unsuitable for women who practice family planning without the permission of their husbands.

Condoms are increasingly gaining acceptance, but use is determined by the available supply. This is sometimes a problem for those who wish to use foam tablets with condoms for greater insurance.

IUDs are not well known and, from the agents' perspectives, are not readily available, except at the University College Hospital.

Contraceptive supplies and disbursements to the agents were found to be inadequate and erratic in many cases, resulting in inconsistent disbursement to clients and some client dropouts.

Each worker interviewed was asked to demonstrate his or her recording of family planning services on the Tally Sheet. The results were mixed: some agents tallied correctly, but many others confused new and continuing clients, and still others indicated the number of contraceptive units disbursed instead of the number of clients seen. Several factors may contribute to this problem including the confusing nature of the form itself and confusion even among the supervisory staff. It was noted by staff that refresher training was needed in this area.

H. Referral Practices

Although the CBD agents have referral cards for their patients, in most areas the usual practice is that a patient is actually accompanied to the health center or hospital. In interviews clients revealed that they not only expect to be accompanied by the CBD agents, but that, in fact, in most cases it does happen. Health center personnel confirmed this.

Completed referrals were systematically recorded in one area. Analysis of these records showed that CBD agents do recognize their limitations and that serious and questionable cases were referred.

Referral practices varied by worker, and a few agents accounted for the majority of referrals. This may be due, in part, to the system of informal consultation and referral among the agents, particularly in the Pilot Zone. Although there is no conclusive evidence to support the impression, it appears that the more "respected" workers, who are also most frequently consulted, may in fact be determining the majority of non-emergency referrals to the centers.

Some workers reported that when taking a patient to the health center, they receive a most useful refresher training concerning their management of the case. However, if this learning experience is limited to a small number of agents who do most of the referrals, it may reinforce the already more "respected" status and authority of these same workers.

I. Health Education Practices

It appears that there may be some division of labor between female and male CBD workers both in health education topics and methods. They tend to give health education separately, rather than as a team. While both types of workers talk about general health matters, personal hygiene, family planning, and environmental sanitation, the female agents tend to "specialize" in maternity and child-related topics. Both groups of workers reported giving individualized health education during treatment sessions, and both reported talking to informal small groups of people. However, the important "evening time" discussions with large groups seem to be dominated by the male workers. In the general village meetings it appears that the female agents defer to the male workers.

Villagers reportedly are eager to hear about any health topic and enjoy health education sessions. Family planning and personal hygiene are most popular because these topics, according to the agents, lend themselves to humorous treatment. Since the open-air educational sessions are attended by scores of village children, the potential future impact of repeated educational exposure to family planning and modern health concepts and practices should not be underestimated.

Radio appears to be an important source of health information in the villages. In one area, villagers proudly explained having learned from radio programs the means of controlling guinea worm in their villages. In another case, the initial learning about family planning came from the radio. The information was verified and reinforced by the CBD worker,

however, before being turned into practice.

CONCLUSIONS AND RECOMMENDATIONS

The field research study documented the following major conclusions:

- The CBD program has achieved most of what it set out to do, which was to provide basic health and family planning services to the large proportion of the rural population not effectively served by fixed facilities. The importance of the CBD services increased as the distance between communities and fixed facilities increased.
- The community volunteers in all areas were found to perform the tasks they had been trained to do conscientiously and correctly. They contribute significant efforts despite high direct and indirect costs to themselves.
- Family planning is integrated into the CBD services and is promoted by the CBD workers, often through their own contraceptive use or through use by members of their families. Nevertheless, the general taboo against and public censure of contraceptive use remains and limits open discussion.
- There appears to be a division of labor among the CBD agents. The female workers specialize in maternal and child health and family planning but are also active in other service areas. The males specialize in serious wounds and injuries in addition to the general treatment of ailments. Health education is shared although females often concentrate on MCH topics.
- An informal referral or consulting system has emerged among the CBD workers in which more respected workers are called upon by the others to confirm or assist treatment or recommend referral to a health centre.
- An effective and frequently utilized system of referral has been set up linking the CBD workers and their communities to government health facilities.

- The expanded program carried out by the State Health Council has proven that monetary incentives are not needed to promote effective volunteer CBD work.
- Community response and support for the CBD program is generally very positive, mostly because of the treatment of illness. This plays a large part in the continued motivation and effectiveness of the CBD worker.

The study was very helpful to the project in identifying areas of CBD worker performance that required additional attention during training and ongoing supervision visits. These included the role of female CBD workers in assisting deliveries, the recognition and management of undernutrition cases, the recognition of diarrhea as a serious and treatable ailment, and appreciation of the target group of children under five. The study was also useful in suggesting ways in which logistic difficulties could be alleviated, such as increasing monthly supplies, particularly to workers from distant villages, to prevent the need for resupply visits during the month. The study also helped identify "supervisory assistants" from among the ranks of the CBD workers who can provide guidance in the villages and ensure that reporting is done correctly.

Annex

Interview Structure for CBD Workers

Interviews had to be adapted to varying situations. In most cases, numerous villagers and other CBD workers joined the meeting to find out what was going on and to comment; the categories of questions were adapted to the flow of the conversation.

1. General Questions

The CBD workers occupations and how they combine the CBD work with their own work; number of hamlets and houses covered; how they decide on home visits vs. having clients come to their homes; amount of time necessary to do the CBD work; referrals; direct and indirect costs to them of the CBD work; and the perceived optimal number of houses and hamlets they can cover/cope with successfully.

2. Division of Labor

Is there a division of labor among male and female agents in their various activities, (care of young children, antenatal, family planning, wounds and injuries, health education, etc.)

3. Common ailments encountered

In children and adults, how they treat and how they record on the tally sheet; what they do about ailments for which they are not trained; how they manage cases with multiple ailments and symptoms and how these in turn are tallied.

4. Family Planning Services

Which method do they feel is best and why; which are the most popular methods in their village and why; have there been problems with any method; have they handled changes in method; do they currently have any regular clients in the various methods; do they experience shortages in family planning supplies and how they are handled; what are their follow-up practices; do they refer clients to other CBD workers.

Demonstration of how they tally new and continuing acceptors for each method; further discussion where possible.

5. Child Diarrhea and ORT

Their judgment of the effectiveness of Oralyte; community acceptance of Oralyte; when and how it is used; is their supply regular and adequate; how was diarrhea treated in small children before CBD training, i.e., alternative and competing practices; how frequent is diarrhea in small children; in which season; how can they increase use of Oralyte.

6. Supervision

How often do health center staff come to their village; are these visits helpful; what do the health center staff do when they visit; do they visit their clients/patients; has the Area Coordinator visited them; does she visit homes?

7. Health Education

How do they prefer to give health education, i.e., on an individual basis when they treat, at home visits or to groups; do they do all types; which topics do they think are most important; which topics do the villagers prefer to hear about; how is family planning discussed (openly or privately).

8. Opinion Leadership and Consultation

Do the CBD workers consult each other on treatment in specific cases or for referrals; do the CBD workers from different villages meet informally among themselves to discuss their problems and treatments; does the individual CBD worker also give advice/consultation on other matters such as trading, farming, marital problems, disputes.

Outline of Questions for Family Planning Clients

1. Method being used.
2. How long has this method been used? Does the husband know?
3. Has she changed from another method, and if so, why?
4. Why did she/he decide on the method currently used? Was choice based on the CBD workers recommendation, or (if choice was based more on personal perceptions about one method being "better") for reasons of safety, personal convenience, or what people say?
5. If oral pill user, how many cycles has she completed; does she know how to use them properly; was she examined by the CBD worker; did she go to the health center to have her blood pressure taken?
6. If foam tablets, how many has she used?

7. If condoms, how many used per week and since when?
8. For all, is supply regular and sufficient?
9. Has she had any home visits from health center staff about her use of contraceptives?
10. Any problems or complaints about the method used?
11. Has she/he also gone to the CBD agent for the treatment of personal ailments, antenatal care?
12. Has she/he taken small child to this CBD worker for any ailment?
13. Has she used Oralyte? How useful was it? Will she use it again?
14. How did she/he first hear about family planning from the CBD worker?

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24

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