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**FAMILY PLANNING PILOT PROJECTS
IN AFRICA: REVIEW AND SYNTHESIS**

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ABSTRACT

This paper reviews and synthesizes lessons learned through a variety of family planning operations research and pilot projects carried out in sub-Saharan Africa and North Africa over the last fifteen years. The substantive focus is on family planning projects but attention is also given to related health interventions.

Part I of the paper summarizes major findings in terms of seven major program approaches of special interest to African planners: community based distribution, integrated programs, social marketing, traditional midwives, postpartum programs, incentive programs and programs with a special focus on urban populations. In a section summarizing lessons learned, the author emphasizes that active outreach services may be most appropriate in Africa. Lessons to be considered in choosing program options are discussed although it is pointed out that settings for family planning experiments conducted in sub-Saharan Africa have yet to produce useful cost data for the analysis of the cost effectiveness of alternative delivery systems. An extensive annex provides summary description of the dates, institutional base, research design, principal results and pertinent remarks for each of the projects reviewed, organized by country and program type.

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Pilot Projects in Africa: Review and Synthesis

A variety of operations research and pilot projects have been carried out in Africa, which give guides to show how large scale programs should be designed. They by no means answer all questions, but for those they address they give evidence well worth considering. This paper reviews the projects undertaken and condenses certain lessons from them. Attention is directed to Sub-Saharan Africa primarily and to North Africa secondarily. The substantive focus is on family planning but with attention also to related health interventions.

The starting point must be the objectives of the programs in question. For family planning and related health efforts, the long range job is clear: to bring fertility and mortality into balance at low levels. Planners everywhere face large rural and urban populations that suffer disastrous mortality rates to infants, children, and mothers. One-third to one-half of all deaths are to infants in many areas. High rates of upper order births raise these risks to both mother and child, and excessive fertility rates almost everywhere carry negative social and economic consequences. The pattern of ill health is interwoven with elevated fertility, each reinforcing the other, and corrective action should be simultaneous on both sides.

In addressing problems of excessive fertility and mortality, high level planners will want to review a full set of policy options before narrowing in on the ones most fitting for each concerned ministry or department. Such a list for fertility, I wish to acknowledge the extensive assistance of Regina McNamara and Tessa Wardlaw of the Center for Population and Family Health, Columbia University, in the preparation of this document.

developed and improved over the years by Bernard Berelson* follows, with modifications. The options are divided into those intended to enhance the supply of fertility control services, vs. those intended to increase general demand.

FERILITY MEASURES AND GEOGRAPHIC STRATEGIES

I. To Affect Supply

A. Improve access to modern means of fertility regulation, both quantitatively (to more people) and qualitatively (with better services), through

1. Traditional family planning programs, in various forms and with currently available contraceptives (pill, IUD, condom) Provision of information, supplies, and services for voluntary fertility regulation via modern contraception and various delivery systems; many examples operating today
2. ... plus sterilization ... and adding sterilization, male and/or female.
3. ... plus abortion ... and adding induced abortion, on an equivalent basis, e.g., as in China
4. Community-based distribution of current contraceptives ... emphasizing contraceptive distribution through local agents and depots, including mothers' clubs etc.
5. Social marketing schemes, stimulation of the commercial sector Subsidy arrangements to encourage commercial sale of contraceptives, measures to ease import restrictions, help local manufacture, remove legal barriers
6. Postpartum arrangements ... systematically providing information and services in connection with institutionalized delivery, e. as in the Population Council-assisted program in 138 hospitals in 21 countries
7. Integration with maternal and child health programs ... organized as an integral part of MCH

* Berelson, Bernard, "Where are We Going?: An Outline." Working Paper, Center for Policy Studies, Population Council, May 1977.

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|---|---|
| 8. Integration into general health program | organized as an integral part of total health infrastructure |
| 9. Integration into community development programs | organized as part of rural improvement and community development |
| B. <u>Improve the product</u> , i.e., the acceptability, continuity, and/or effectiveness of new means of fertility control | Research programs directed toward that end now under way in both private and public sectors, e.g., drug comparison WHO Expanded Programme, and ICCR, to develop and test better methods e.g., implant, a side-effect-free IUD, a safer or more convenient pill, a non-surgical termination of pregnancy |

II. To Affect Demand

- | | |
|--|---|
| C. <u>Promote basic socioeconomic determinants</u> of fertility, or the most likely presumed determinants ("thresholds"), singly or together | |
| 1. General development; modernization, social change, socio-cultural transformation... away from the traditional (high fertility) society | Reliance on social change, modernization, development, social-structure transformation, "new international economic order" to reduce fertility rates "automatically" in the process |
| 2. Popular education: e.g., a goal of six to eight years of schooling for all | ... with special reference to extending popular education, particularly for girls |
| 3. Infant-child mortality: e.g., toward an infant mortality rate of 50 or below | ... with special reference to reducing infant and child mortality as a means of lowering desired family size |
| 4. Income: e.g., toward \$500 per capita or, better, \$800 (and perhaps more equitable income distribution) | ... with special reference to poverty reduction, particularly at the bottom of the income pyramid |
| 5. Industrialization: e.g., toward one-third or less of the labor force in agriculture | ... with special reference to industrial development, and its consequences for family, kinship, modern attitudes |
| 6. Women's status: toward liberation from traditional childbearing and rearing, through education and employment | ... with special reference to emancipation of women from traditional status, particularly via education and gainful employment |

7. Urbanization: toward 25 percent living in large cities (100,000+)

... with special reference to urban development, with its implication for housing, diminished economic value of children, etc.

D. Inform and educate

Persuade people to lower fertility through messages, arguments, appeals, reasons, through:

1. Mass media (radio, TV, newspapers, posters)
2. Person-to-person communication, individually (e.g., door-to-door field work) or collectively (e.g., group meetings including special interest groups)
3. Formal school systems ("population education")

Provision of energetic propaganda for smaller families (including encouragement by respected national figures and political leaders)

... the same through personal contact, including via residential or occupational communities

Incorporation of population materials into primary and secondary school curricula, for long-term effect

E. Manipulate incentives/disincentives

1. Housing and job opportunities)
2. Maternity costs, leaves, etc.)
3. Child allowances, educational fees, etc.)
4. Social security system)
5. Money, gifts)
6. Provision of communal benefits in return for specified fertility behavior

Adjustment of incentives/disincentives, in money or in kind, in antinatalist direction, e.g., as in Singapore, Taiwan, Indian Tea Estates, state provision of welfare to the aged, in order to reduce need for children (sons) for that purpose

Communal incentives (e.g., schools, water supply) for collective fertility performance at appropriate level

F. Manage community change
to develop an antinatalist
consensus, via

1. Youth corps, or equivalent
work program, to break tradi-
tional bonds away from the
home community

Proposals for collective employment
and instruction of young people, both
male and female, away from home ties
in order to delay marriage and modern-
ize attitudes and information

2. Community education to
discourage upper-order
births

Organized and systematic efforts to
develop community consensus in anti-
natalist direction

G. Impose legal sanctions, via

1. Increase in age at marriage

Increase in minimum age of marriage
for women, to at least 18 and
preferably beyond

2. Restriction of out-migration
from villages

Limitations in mobility, such that
villages cannot export local un-
employment to cities but must face
up to support of their own excess
reproduction

3. Direct limitation on family
size

Governmental imposition of a limit
to childbearing, e.g., as in recent
tendencies in China

Planners have here the basic measures that have evolved during recent decades. Some are controversial, while others are well accepted and well proven. None are individually adequate to do "the whole job". Some raise questions of cultural acceptability. With all their limitations however they represent essentially all we have in the fertility area and each government will necessarily have its own criteria by which to select from among these options.

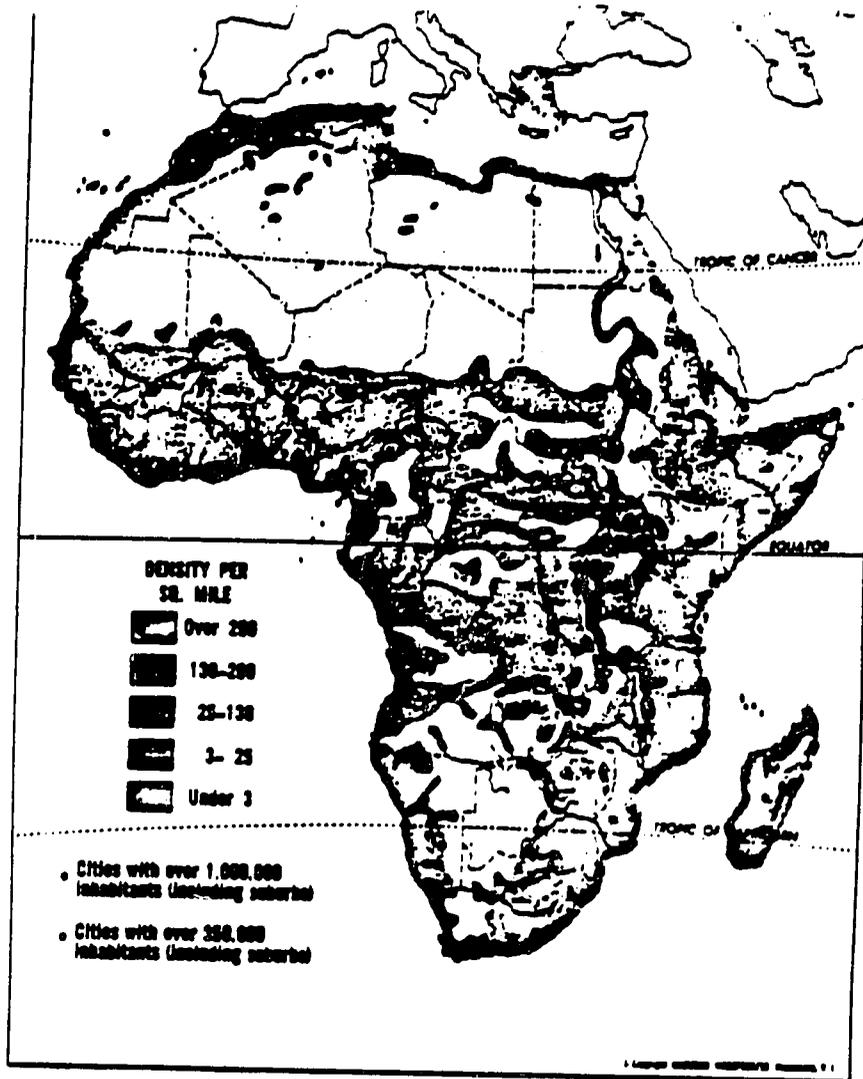
This paper is also selective, choosing to treat chiefly those efforts that work through health channels. In the African context these are by common agreement the realistic way to approach family planning concerns well as as/problems of morbidity and mortality. However, we also examine commercial channels and social marketing approaches. The organizing principle is to

lay out the probable best ways to provide family planning and related primary health care to large African populations. Needless to say there is no typical population group for Africa, but it is nevertheless worthwhile to seek those general conclusions that appear to have emerged, with attention to important exceptions. Particular statements will of course change as further experience accumulates.

Going from the general to the specific, we have placed regional perspectives first. These will be of greatest interest to World Bank staff and to regional African planners, and of less interest to planners within individual countries. It can be intimidating to consider "What to Do" in Sub-Saharan Africa. The region contains incredible diversity and basic conditions are extremely forbidding. The innumerable cultural groups and the fragmented national units pose large difficulties to strategy choices. As a start on simplifying the task, there are three items of interest. The first is the very uneven density pattern of the continent, which places sizeable populations together and leaves large open spaces; the second is surprisingly large concentrations in some cities; and the third is the predominance of a few countries among the total of fifty.

1. **By Density.** The map in Fig. 1 tells a story of extreme density variation. The vast and unsettled spread across the Sahara is of course the dominant feature; lying below that is Sub-Saharan Africa with its own, smaller areas of low density. For mass programs one key is to note the opposite: areas that are both populous and dense. These exist foremost along the coastline running from the Ivory Coast through Nigeria and around

Figure 1
Density Map of Africa



to Cameroon; also in the countries around Lake Victoria and along the Nile down into the Southern Sudan.

The empty areas are found especially in the Southwest, and in the other zones shown. While few areas are as sparse as the band of countries across the great Sahara Desert, there are still sizeable spaces with very few people in them.

2. **By Large Cities.** Programs for big cities must be different from those for the villages, and Sub-Saharan Africa has a substantial number of urban concentrations. The largest ones, those with over 1/2 million population, are listed below (from the UN Demographic Yearbook for 1982; counts are for various years prior to 1982.)

In Zaire the five largest places contain 14 percent of the entire population, or one person in seven. In Senegal Dakar alone has perhaps one-fifth of the total. Elsewhere a more common figure is about 5 percent, or one in twenty, as in Nigeria, Ethiopia, Sudan, and Tanzania: these are the largest countries in the region, and 5 percent represents a large total. Arguments for giving special attention to a few large cities in each country are spelled out in a later section.

3. **By Country.** Of the 50 countries in Sub-Saharan Africa (49 in official U.N. population summaries, plus Sudan), 15 contain over three-fourths of the total population. Nigeria alone has one-fifth (Table). The top five countries represent about half, the top ten about two thirds, and the top fifteen over

	<u>Thousands</u>
<u>Ethiopia</u>	
Addis Ababa	1,400
<u>Ghana</u>	
Accra	700
<u>Kenya</u>	
Nairobi	800
<u>Nigeria</u>	
Lagos	1,100
Ibadan	800
<u>Senegal</u>	
Dakar	800
<u>South Africa</u>	
Johannesburg	1,300
Durban	700
Capetown	700
Pretoria	500
<u>Sudan</u>	
Khartoum	600
<u>Tanzania</u>	
Dar Es Salaam	800
<u>Zaire</u>	
Kinshasa	2,200
Luluabourg	500
<u>Zambia</u>	
Lusaka	600
<u>Zimbabwe</u>	
Harare	700

three-fourths. The remaining thirty-five countries contain only 22 percent of the population. Thus as regards a regional strategy for resource allocation, and the location of key demonstration projects, there is a strong argument for giving weight to a small number of large countries.

Further, there are natural groupings among the top 15 countries. Experts always stress such major divisions as anglo-

phone/francophone, West/East/Central, and Moslem/non-Moslem, and the following clusters combine these criteria. A first pair is West African anglophone: Nigeria and Ghana (105 million population). A second group is West African francophone: Ivory Coast and Cameroon, with 16 million. Across the continent Sudan and Ethiopia are contiguous and represent 56 million population, but they probably need to be considered separately; moreover the Sudan is much different as between its northern and southern halves. Ethiopia, of Italian colonial background, is also a special case.

Coming down the Eastern coast, the anglophone group of Uganda, Kenya, Tanzania, and Zimbabwe (65 million) are a natural cluster (and the extremely high density areas of Burundi and Rwanda go easily with them). Mozambique (9.7 million), of Portuguese background lies nearby, and below that is South Africa (31.6 million) which for obvious reasons is kept aside.

That leaves Zaire in Central Africa (32.0 million). Its eastern fringe is culturally similar to the Burundi populations, but it is fundamentally a separate unit.

Only the large island of Madagascar (9.7 million) and Angola (8.5 million), formerly Portuguese, remain.

Thus by geographic proximity and rough cultural similarity there are three or four groups of large countries, with Zaire and a few smaller countries separate. South Africa aside, these 14 countries will control the future vital rates and health levels of Sub-Saharan Africa. If the job is to be done it must be done there. Indeed, five countries will tell half the story.

Estimated 1980 Population
000s

	<u>Sub-Sahara Total</u>	436,244	%	<u>Cum.</u>
1.	Nigeria	92,037	21.1	21.1
2.	Ethiopia	35,420	8.1	29.2
3.	Zaire	32,084	7.4	36.6
4.	South Africa	31,586	7.2	43.8
5.	Tanzania	21,710	5.0	48.8
6.	Sudan	20,945	4.8	53.6
7.	Kenya	19,761	4.5	58.1
8.	Uganda	15,150	3.5	61.6
9.	Mozambique	13,693	3.1	64.7
10.	Ghana	13,044	3.0	67.7
11.	Madagascar	9,731	2.2	69.9
12.	Ivory Coast	9,474	2.2	72.1
13.	Cameroon	9,467	2.2	74.3
14.	Angola (incl. Cabinda)	8,540	2.0	76.3
15.	Zimbabwe	8,461	1.9	78.2

Table note. After Nigeria the largest SSA countries fall into four groups by size, separated by the double spacing.

In review, the surface disarray of Sub-Saharan Africa -- its fragmentation, diversity, and endless subgroupings -- is greatly simplified by recognizing natural groupings of countries, by noting that most of the population lives in a very few countries, that large clusters exist in a few cities, and that many populations are not evenly dispersed but live in zones of high density. All these can lead to very important planning decisions in the struggle to lower the region's disease, mortality, and fertility levels.

PROGRAM CHOICES

We come now to the chief program choices to be made by officials within each country. These pertain to the fundamental question of what is to be done, involving decisions that take

priority over all else. Later we take up the question of how the more detailed implementation issues and matters of management on which few pilot trials have been done and suggestions must be more speculative.

Seven program approaches of interest for Africa are discussed below. These have survived the last two decades of world experience, and have been tried to greater or lesser extents in Africa itself. These are organized here roughly according to the essential problem of outreach. The great failing of the health system in most developing countries is its misallocation of resources. Slender as these are, they are not directed to low-cost measures that will have maximum effects on large populations. Present systems are overly clinical, curative, physician-oriented, and passive. Instead they should be based in ordinary workers who reach out to villages to implement changes that are already known to affect overall vital rates. Neglected channels outside the health ministry should also be used. Much of this is a matter of applying what is already known, and some is a matter of learning quickly through field trials what additional approaches will work best. The seven program choices below illustrate the general options.

1. Community Based Distribution

As regards fertility and early mortality it is now clear that the priority measures, the first programs to mount, fall under the general heading of community based distribution (CBD). The two key words are "community" and "distribution". The first signifies that above all else the program must be a strong presence at the local level, and the second signifies that simple

commodities and services must be actively delivered. CBD programs often but not always go to the doorstep, at least for a few rounds of visits. They also create local depots to which people are encouraged to come for contraceptives, ORT packets, anti-malarials, etc. and they often use village meetings along with, or instead of, personal contacts. But they invariably go outside of clinics and offices to the community level, and achieve thereby the basic outreach that passive, clinic based systems can never attain.

The chief argument for CBD in Sub-Saharan Africa is that without it, the large rural populations cannot be served. One world-wide summary finds that: "... in the last 12 years more than 70 community-based family planning programs have been undertaken in at least 40 countries. These programs involve village leaders, women's clubs, traditional midwives, or local retailers. Local workers distribute condoms, oral contraceptives, and sometimes other items, either free of charge or for a small fee, sometimes on a household-to-household basis, sometimes through convenient community supply points. An objective they all share, however, is to improve access to family planning services by removing some of the geographic, financial, bureaucratic, cultural, and communication barriers that limit use of these or any health services. Greater availability is an important goal of all community-based services." (Kols and Wawer, "Community-Based Health and Family Planning," Population Reports, Series L-3, 10(6), November-December 1982).

CBD experience is reassuring in Nigeria, Zaire, and Sudan in

the projects reviewed (see Annex). In North Africa CBD plans have worked well in Morocco, Tunisia, and Egypt (Table). Despite many differences among them, these projects have usually had the two features of home visits by lower-level personnel, backed up by inexpensive local resupply points. Items distributed, with accompanying efforts to encourage their use, have included contraceptives, ORT, dietary supplements, anti-malarials, and anti-parasite preparations. Within this general format there is room for much flexibility, which permits the program to adapt to local conditions. Here is a partial outline of variations, both actual and potential:

1. **Home visits.** Sometimes one only, sometimes two or three, rarely repeated indefinitely.

2. **Stimulus.** Information, samples or supplies, persuasion. (Sometimes with interviews to gather data, with queries about recent use.) Discussion of income generating activities.

3. **Commodities/Services.** Pills, condoms, foam, with referral coupons for IUD and sterilization. ORT. Anti-malarial, anti-parasite medications, iron, vitamins other. Referral for IUDs, sterilizations, inoculations.

4. **Personnel types.** Volunteers, paid lay workers, fieldworkers, regular staff reassigned to home visiting, regular "itinerant" rural staff given new duties (as in Morocco), midwives, other.

5. **Resupply points for commodities.** Small depots in homes, health "huts," outlying small clinics, mothers clubs.

6. **Charges.** Supplies given at home, almost always free, or at depots, sometimes charged for. Charges meant partly to insure voluntarism and to reduce courtesy acceptances.

7. **Training and Supervision.** Highly variable, depending chiefly upon the kind of agency and the scope of the pilot project.

A typology like this can be expanded, but it is sufficient to show the numerous combinations of features that can be used. Each application will take a form dictated largely by local

Selected Community-Based Integrated Family Planning and Health Projects

Region, Country, Project Name, Project Loca- tion, Dates (Ref. No.)	Approximate Size of Area	Contra- ceptives	Major Health Measures	Distributors	Training	Impact	
						Family Planning	Health
AFRICA & MIDDLE EAST							
Egypt, Matrouha Governorate, 1978-81 (229, 233, 283, 264, 346, 383)	104 villages 500,000 people (Year 1)	Pills, foaming tablets.	Oralvite ORS.	Teams of high school- educated female volunteers from area made sweep of households.	2-week course taught by staff of American Univer- sity in Cairo.	Prevalence: from 19% of MWRA in 1978 to 23% in 1980.	Mini-survey found ORS used in 61% of 348 diarrhea episodes; no effect on mortality.
	200 villages (Years 2 & 3)	Pills, foaming tablets.	None	As above.	One-week course.	NA	With household visits, ORS used in 58% of diarrhea episodes; with deposits in 35%.
		None	Oralvite ORS.	Teams of college-educated female volunteers dis- tributed ORS through household visits in some areas; deposits in others.	2-week course.		
Chana, CBD area, Dania Project, 1977-78 (130)	9 villages 3,700 people	Pills, condoms, foam.	Chloroquine for malaria, worm medication, nutrition edu- cation, penicillin, aspirin, cough mixture, kafen.	13 male, 5 female part-time, volunteer village residents, nominated by village commit- tees; each served part of a village through some sweeps and village depot.	11-week course (10 hours/week) taught by public health nurse, sanitarian, and health center super- intendent.	NA	NA
Morocco, Expanded Visits & Demos de Médication Systématique (VDMSS) Project, Bani Malla El Jadida & Meknes Provinces, 1982- (211)	2.5 million people	Pills, condoms.	Oralvite ORS packets, malaria medications, iron and vita- mins to pregnant and lactating women, wear- ing loadi.	500 male and female full- time, salaried workers, chosen by project staff, visit each household in their districts of 1,500-4,500 people every 6 months.	1-2 week course taught by project training staff.	NA	NA
Nigeria, Oyo State 1980-82 (202, 383)	65,000 people	Pills, condoms, foaming tablets.	Oralvite ORS, cl. orochine for malaria, mebend- azole for worms, vitamins, cough medicine, first aid.	171 traditional birth atten- dants and male health center workers, selected by project staff and village committees and paid commissions; each serves 500-1,000 people through household visits.	3-week course taught by project co-director, university nurses, and government midwives; bi- monthly in- service training and periodic refresher courses.	NA	NA
Sudan, Community Based Health and Family Planning Project, Khartoum Province, 1979-83 (87, 151, 205, 302, 383)	125,000 people	Pills	Oralvite ORS, nutrition education, coordination with mass immunization campaigns.	About 80 salaried govern- ment midwives made one sweep for each health measure and one for family planning; sweeps coordinated with immunization program.	3-week course taught by government mid- wife trainers and project staff; 1-day course before each sweep.	NA	NA
Tunisia, Jendouba Governorate, 1977-79 (149, 217, 461)	Femana Delegation) 41,800 people	Pills, condoms, foam.	None	Team of 5 full time, salaried female workers from area made 2 sweeps, 6 months apart, of all households.	2-week course.	Prevalence: from 16% of MWRA in 1977 to 23% in 1979.	NA
	Jendouba Delegation) 68,149 people	Pills, condoms, foam.	None	As above; team made one sweep.	As above.	Prevalence: from 33% of MWRA in 1977 to 39% in 1979.	NA
	Ain Draham Delegation) 34,057 people	Pills, condoms, foam; foaming tablets (2nd round only).	Child weight and height measure- ment, tetracy- cline ointment for conjunctivi- tis; Oralvite ORS (2nd round only).	As above; two sweeps; male driver distributed condoms to men.	As above.	Prevalence: from 24% of MWRA in 1977 to 29% in 1979	90% of women surveyed who had been given Oralvite packets and whose children had diar- rhea used the packets.

Region, Country, Project Name, Project Loca- tion, Dates (Ref. No.)	Approximate Size of Area	Contra- ceptives	Major Health Measures	Distributors	Training	Impact	
						Family Planning	Health
Zaire, Family Educa- tion Project (PRODEF), Kinshasa, 1981-83 (52, 53, 398)	35 villages 56,000 people	Pills, condoms, foam, foam- ing tablets.	Oralvax ORS, chloroquine for malaria, meten- dazole for worms, aspirin.	Teams of 3-6 full time, salaried female workers, chosen by project staff, visit each village and hold a meeting, followed by dis- tribution; 2 more sweeps of all households are held after 6 months and 1 year; resupply through depot run by female volunteer in each village.	12-day course taught by 2 donor-agency consultants and project medical director.	NA	NA

Source: Kols, A. J., and M. J. Wawer. "Community Based Health and Family Planning," Population Reports, Series L-3, 1982.

conditions and preferences. The overriding guides must be coverage, and realistic adaptation to the available resources. The goal is to cover the population with limited funds and personnel, and the solutions developed must vary.

CBD programs are eminently suitable for meeting latent demand for family planning, whether in rural villages or urban slums. Where there is even a modest demand, the utilization produced by a CBD program over time helps make the new practices more acceptable both to individual families and to the community at large. The projects reviewed show that household distribution and local resupply can work. The need now is for wider implementation, and for more demonstrations in contexts that are representative of large population groups.

2. Integrated Programs

The integration question contains not one but many issues, some of which appear to be essentially resolved, at least as regards field experiments. Large, multi-purpose undertakings such as Danfa and Calabar (see Annex), while producing some results of interest, have also documented the high risks and exceptional difficulties of trying to follow a fixed research protocol over several years and with complex institutional arrangements. At the other extreme, "integration" in the sense of offering multiple services (e.g. contraception and ORT) in one home visit can work quite well, as shown recently in Bas Zaire, the Sudan, and in numerous other sites in Africa.

However, the matter of "working well" is complex. Where the intent is to get good results in two programs, e.g. family

planning and nutrition, it may make sense on cost grounds to merge them, even though neither one does quite as well as when implemented alone. But if the question is shifted to focus on family planning only, any second program may become a brake on the family planning output and damage its cost-effectiveness. Of course it is also possible that the family planning effort would be helped, not hurt, by working in combination with another appeal.

Maguire (1982, p. 23) highlights these issues in a discussion of results from the PPFC (Family Planning for Rural Couples) project in Tunisia (Annex). One area (Ain Draham) tried a combined FP/MCH scheme and experienced lower prevalence and only one-fourth the acceptance rate of another area (Fernana) which used family planning only. While extraneous factors might explain much of this, it appears that canvassers in Ain Draham were spread thinly in home visits by attempting to cover multiple topics. Outputs were probably less satisfactory for both objectives, with the MCH aims also not being met satisfactorily.

But interestingly, the key local powers all preferred the combined system. Project staff, community leaders, and the Ministry of Public Health all favored it on the grounds that association with simple health interventions helped the field-workers' image and strengthened other health work. Thus in a larger sense the program's political base and long run acceptance may be superior under the combined plan, enhancing its "effectiveness" in a different sense.

This case, from Tunisia, neatly poses some of the key integration issues: the question of which interests to serve,

how best to do so, and intangible vs. tangible trade-offs. In the Sub-Saharan context political factors will usually require household distribution schemes to combine family planning with other interventions, making the research question moot.

Nevertheless, such plans should take care not to burden workers with too many duties. Following the Sudan lessons they should consider doing complex training on a phased basis. In the Sudan and Tanzania an intervention was taught and the CHWs went immediately to the field to apply what they had learned; having introduced that, they returned for training in another intervention, and then returned to the field. A further advantage of the approach of one intervention at a time both for training and on home visits is that it helps avoid the problem of overloading the CHW during any one visit.

Countries should also consider adaptations of the Training and Visit (T & V) System of the agricultural field, now used in over forty projects in about twenty countries and adopted by thirteen Indian states. An important paper exploring applications of the T & V system has been written by Richard Heaver, "Adapting T & V to Family Planning, Health, and Nutrition Programs" (mimeo, PHN Dept., World Bank).

Most Sub-Saharan African countries will wish to supplement family planning with related health activities, at least in many of their programs. If the combinations are well chosen and worker duties are kept manageable, such programs can be effective, and they can address fertility and mortality concerns simultaneously at the family level.

3. Social Marketing

A further option for large scale effects outside the clinic system is the commercial sector. It is a separate channel that contacts many people who do not patronize health facilities, and it reaches out into the countryside through small shops and entrepreneurs. The key is to stimulate it: to set it in motion with the products of interest.

"Social marketing projects are a hybrid -- public-health-oriented social action programs grafted onto commercial distribution and marketing systems. The goal is to cultivate a mass market for contraceptives sold at the lowest feasible prices. Basically, social marketing projects in family planning promote, distribute, and sell a contraceptive product to consumers through an existing sales outlet at a relatively low, subsidized price to achieve a recognized social goal -- expanding contraceptive use". (Altman and Piotrow, "Social Marketing: Does It Work?", Population Reports, Series J-21, 8(1), January 1980.)

The same authors review worldwide experience and conclude that: "Experience from more than 30 social marketing projects in 27 countries suggests that this combination can work. At least half a dozen projects with three years' experience or more have improved contraceptive availability, increased sales of contraceptive products, spread knowledge of and stimulated wider use of the methods promoted, and provided a substantial measure of protection against unwanted pregnancy at a cost below that of most other programs."

But can the same conclusion hold in Sub-Saharan Africa? Basically it is too early to tell, since only in Kenya and Ghana

Programs for Social Marketing of Contraceptives, Major Features and Sales

Location (Population in millions), Dates	Ref. No.	Sponsor/ Management	Potential Customers ¹	Product/ Brand(s) ²	Price in US \$ (per unit)	Points-of- Purchase	Distribution	Promotion	Sales to Retailers
AFRICA									
*Ghana (11.3) start: 1970; product launch: 6/1971; pro- gram curbed and modified: 7/1971	58, 121, 122, 156, 223	Government/ Ghana National FP Program	Urban and semiurban married couples	Condom/ (Sultan) Pressurized foam (Emko)	.09 (3) .45 (can)	Ghana Na- tional Trading Corporation stores (government- owned), licensed pharmacies	Ghana National Trading Corporation (government distribution)	Consumer: POP — displays; Media — comprehensive cam- paign planned to include press, radio, cinema, TV, bill- boards. All promotion material after 10 days of press ads (see p. J-414). Retailers: none. Pils: none.	7/1971-6/1972: condoms, 532,080 pieces; foam, 121,288 cans
*Ghana (11.3) start: 7/1976; product launch: 1/1979 Panther, SSS, 11/1979 Coral	32, 77, 150, 343, 344	Government/ Westinghouse Health Systems	7.5% of non- pregnant women age 15-44 who are not con- tracing, not living in deep rural areas, and do not wish to be pregnant (N=62,250)	Condom/ Panther, SSS Foaming tablets/ Coral OC/Pioni	.018 (each) .216 (6) .36 (6) .36 (cycle)	Condoms, foaming tab- lets; retail shops, dance halls, bars, "mummy traders" (women street vendors) OC: pharma- cies	Commercial distributor	Condoms, foaming tablets; Consumer: POP — counter- top displays, posters, doorway banners; Media — press, radio; Other — billboards. OC: Consumer posters in clinics, pharmacies, hospitals. Retailers printed train- ing/informational materials. Pils: none.	1/1979-10/1979: condoms, 1,265,020 pieces; OCs, 68,124 cycles.
Kenya (15.4) start: 3/1972; product launch: 10/1972; end: 7/1974	53, 113, 246, 249	Government/ PSI	One-half of "at risk" males age 18-30 with disposable cash in Meru test area (N=60,000)	Condom/ Kings	.07 (3) (cash or stamp)	All retail ou- lets, emphasis on larger shops	Commercial distributor (pro- vided exclusive salesman, van, and sound equipment; mail-order	Consumer: POP — dispensers, metal shop signs, mc'sies, shelf strips, booklets; Media — radio, cin- ema, press; Personal — samples, field educator; Other: leaflets, pamphlets. Retailers: field educa- tor/salesman, printed training materials. Pils: day-long picnic/ seminar for 350 local leaders.	10/1972-9/1973: 137,827 (includes 9,700 samples)
Kenya (15.4) start: 8/1974; end: 3/1976	25, 75	PSI	Urban males in cash economy	Condom/ Kings (Prime) (Featherite) (Cossamer)	.07 (3) .20 (3) .15 (each) 30 (3)	Urban and semiurban shops	Commercial distributor; mail- order	Consumer: newspa- pers, booklets	500,000 pieces per year average
MIDDLE EAST									
*Egypt (40.6) start: 1978; product launch 6/1979	118, 130, 169, 170, 262	IPPF/Egyptian Family Planning Association	Lower socio- economic groups in greater Cairo area: 100,000 new users in year 1	Condom/ Tops Foaming tablets/ Amman IUD/ (Copper-7)	.075 (3) .45 (20) 27 (10) 2.10 (each)	Pharmacies, other retail outlets	Commercial distributor; 4 field supervisors also promote and sell IUDs to doctors; free doctor training for IUD insertion	Consumer: POP — posters, sockets, dis- plays, booklets, list of participating doctors for IUD insertion; Media — radio, press, TV; Other — booklets, sampling. Retailers: samples, discounts, training. Pils: radio, press, TV.	NA NA NA
Morocco (19.4) start: 4/1969; end: 7/1970	60	Government	Undefined	Condom	.04 (3)	633 tobacco shops in Casablanca	Government Tobacco Board	None	4/1969-7/1970: 100,800 pieces

*Ongoing program
FP = family planning
FPA = family planning association
ICARP = International Committee for Applied Research in Population
IPPF = International Planned Parenthood Federation

OCs = oral contraceptives
POP = point of purchase
PR = public relations
PSI = Population Services International
USAID = United States Agency for International Development

¹Source: Kane & Hensler (Population Reference Bureau) (168); US Bureau of the Census (333) (Antigua, St. Kitts, St. Lucia only).

²As defined by program

³Manufacturer's brand names, where known, appear in parentheses for products not locally packaged and branded.

⁴Sales to wholesalers

Location (Population in millions), Date	Ref. No.	Sponsor/ Management	Potential Customers ^a	Product/ Brand(s) ^b	Price in US \$ (per unit)	Points-of- Purchase	Distribution	Promotion	Sales & B
Tunisia (6.4) start: 7/1976;	31. 93	Government/ Synmat Corporation 5/1978- present: Government	Married couples who never used contraceptives and OC dis- continuers	Condom/Waha OC/OP 50	.025 (3) .12 (cycle)	Pharmacies	Central Pharmacy of Tunisia; 4 commercial wholesalers	Consumer POP — displays, brochures, posters. Retailer pro- motion by firm repre- senting pharmaceuti- cal companies, product brochures. Medical community: detailmen and seminar for doctors and pharmacists.	NA

Source: Altman, D.L., and P. T. Plotrow. "Social Marketing: Does It Work?" Population Reports, J-21, Jan. 1980.

has social marketing been tried. As the project reviews (Annex) suggest, the results were mixed in both cases, not because the public reacted badly but because of difficult political conditions and inconsistent government support.

North Africa has more experience than does Sub-Saharan Africa, and more of it may be favorable. Some of it is documented in the accompanying review table, and additional projects are included among the Individual Project Descriptions in the Annex.

The question is what energy and resources should go into social marketing trials. It is, as mentioned, a hybrid across profoundly different institutions, and it may be peculiarly fragile where governments change frequently or bureaucratic caution is strong. Yet it offers the possibility of a powerful distribution network, reaching into most parts of the country, for simple contraceptives. The best policy is perhaps one of reserve, but with openness where key figures from both sectors, government and commercial, are strongly committed to the effort, and expert market analysis is encouraging. Under the right circumstances social marketing can make a major difference.

4. Traditional Midwives (TBAs)

Here we include a program possibility, TBAs, on which there is rather little formal experimentation with objective data. Nevertheless enough has been done, and the TBA approach is possibly important enough, to include it. It appears to work very well in some cases.

One comprehensive review summarizes the potential of TBAs as

follows: "...traditional midwives can learn new concepts if they are presented in an appropriate way; they do influence their own clients and encourage some to adopt family planning. On the other hand, they are rarely active recruiters outside their own clientele, and they cannot serve as the principal agents of change in a national program. But, as attitudes shift, traditional midwives can help to meet the growing need to distribute family planning supplies especially to women who are not well served by other programs." (Simpson-Hebert, et al. "Traditional Midwives and Family Planning" *Population Reports*, Series J-22, 8(3), May 1980)

In Oyo State, Nigeria, the record is encouraging (Annex). Illiterate midwives, selected to serve as volunteer workers under supervision, have performed well there in providing illness treatments, prenatal pill disbursements, contraceptive distribution, and health talks. Supply records indicate that about 25% of women of reproductive age used family planning, with current use at about 10%, up from about 2% before the project.

In Ghana, the Danfa project trained traditional midwives (matrones), both males and females. Evaluation was partly favorable and partly unfavorable: they were observed to be handling an increasing proportion of deliveries in the project area while the untrained midwives there and the Health Center handled fewer; they also saw more postpartum women than did the Health Center. However, a few matrones were especially active and the rest much less so, and on average they referred only about one new family planning acceptor per year. One study recommended that they be given fuller administrative and professional support to use and protect their new skills, and

this comment is echoed in other writings on TBAs.

Liberia trained some 900 TBAs between 1956 and 1976, and in a 1977 report credited the program with reducing neonatal tetanus.

Sierra Leone instituted a three week training program for TBAs (bundo mamies), with a family planning component. Sponsored by the Ministry of Health and UNICEF, it tried to encourage TBAs to refer women to clinics for contraception, but early experience was discouraging. As in other countries, TBAs in Sierra Leone possess a tantalizing potential: they attend 70 percent of deliveries, they are firmly entrenched, and they have been given increasing de facto recognition, even attaining non-voting status with the official Midwives Association. But as elsewhere they also have sobering drawbacks: They are very independent, not especially desirous of classroom instruction, and preoccupied with their own primary concerns. Thus their actual potential for advancing MCH or family planning objectives on a large scale will vary.

TBAs may be best regarded as simply one among several resources in any rural program. Certainly more field experimentation is merited in how to involve them productively. Probably no general rule exists on how well they will do. The key issues include their place in the community and the exact set of new functions expected of them, along with careful selection, truly effective training, supervision or light monitoring, and remuneration.

5. The Postpartum Approach

The postpartum approach is well proven and thoroughly established in Asia and Latin America. The problem in Sub-Saharan Africa is not the low percentage of deliveries seen in medical facilities -- that limitation exists generally in the developing world and is accepted as a boundary on the contribution of postpartum programs. The special problems in Sub-Saharan Africa are the customs of extended breastfeeding and of sexual abstinence after childbirth, which to some extent reduce both interest in and need for contraception early after delivery. The Family Health Clinic experiment in Lagos for example found little desire for postpartum services, and it consequently stressed other approaches.

Nevertheless there are ample reasons for encouraging postpartum programs everywhere in Africa. One is the presence of subgroups that will not practice abstinence or breastfeeding and will be exposed to unwanted pregnancy. These subgroups will enlarge as traditions weaken and as bottle feeding gains ground. A further reason is to establish attractive services for groups other than delivering women: for those with septic abortions and for "indirect" acceptors -- those hearing of the services by word of mouth and coming during later stages of the birth interval, when many have finished abstinence or breastfeeding. In the Nigeria and Ghana postpartum programs (see Annex) indirect acceptors made up three-fifths (61% and 58% respectively) of all acceptors. Further, postpartum programs in urban medical facilities involve a country's medical leadership; they also provide a training base for personnel drawn from wider circles.

The original rationale for postpartum programs holds as well now as it did in the mid-1960s, when the International Postpartum Program, established by the Population Council, grew rapidly from some 25 hospitals to about 140. Fundamentally the approach makes very efficient use of pre-established facilities; it can offer every contraceptive method; and it does so at a time when birth planning --- either spacing or stopping --- may be especially salient to the mother's thinking. For some women ovulation will resume soon, and pregnancy potential will be at its highest. On a group basis the monthly probability of pregnancy declines very rapidly over the first year or two after first ovulation, with a remnant gradually emerging who are either infecund or are contracepting on their own. The most highly fecund women, those who will produce the most births in the future, either start contraception early or become pregnant again, repeating the cycle of an unwanted birth and an unfavorably short birth interval.

Postpartum activity therefore continues to be one of the most attractive approaches to fund and to institutionalize. Besides its logistical advantages in providing service where women already come, it affords a special opportunity to add the sterilization method. There is one weakness in initiating ordinary contraception soon after a birth, i.e. the overlap with amenorrhea, and so for postpartum programs sterilization can be an important component, in that (a) the overlap does not matter, sterilization being permanent (whereas with the IUD or pill, wastage occurs as the normal duration of use duplicates other protection), and (b) women may favorably associate the steriliza-

tion opportunity with hospital delivery, even in some cases having an extra birth in order to get access to it. Postpartum medical facilities are very helpful in providing female sterilization to an urban population and they are sometimes the only auspices under which it can be officially introduced. It is becoming a more acceptable approach than before, given the simplified methods of mini-lap and laparoscopy, which permit the use of local anesthesia and outpatient services at the six week checkup visit or later in the birth interval.

Besides sterilization, semi-permanent methods also deserve consideration at delivery or at the six week checkup. Long acting IUDs are now available, and progesterone injectables have been suggested (they appear not to impair the flow of breast milk; but possible progesterone effects on the infant require further study).

In sum, this well known approach has so far spread less in Africa than elsewhere in the world, and much unrealized potential for it exists in both urban and rural areas. Foreign donors can conveniently meet its needs in urban areas: new equipment, expansion of facilities, financing of training, occasional technical assistance, communication materials, and contraceptive supplies. New transport is usually not needed, except for occasional outreach programs. In rural areas everything depends upon the specific program, and upon the identification of a workable channel by which to reach delivering women.

(A useful exercise, perhaps not difficult, would be a run-down for each major country on the proportion of urban deliveries that are seen in hospitals, and the approximate percentages that

are otherwise medically attended. In selected countries studies should also be done in rural areas, since in addition to the encouragement of urban postpartum programs, pilot trials are needed to find productive rural channels for offering contraception and related services to delivering women.)

Note:

By 1973 the Tunisian National Postpartum Program was implemented in 58 maternity centers. It was however experiencing low acceptance ratios, perhaps due to insufficient staffing. **Morocco:** the Casablanca Maternity Hospital was conducting as of 1973 a postpartum program. **Algeria:** three university hospitals and several MCH centers were offering postpartum family planning services with WHO support (circa 1973). In Sub-Saharan Africa programs had been or were to be started at the Hospital Mama Yemo in **Zaire**, at the University of Lusaka in **Zambia**, and at numerous sites in **Kenya**, in addition to the Ghana and Nigeria programs described herein in detail.

In Kenya circa 1973-74, the African Medical and Research Foundation arranged a multi-site trial to offer IUDs to postpartum women immediately after delivery (Cuca and Pierce, 1977, p. 163).

Recent reports are that about 8% of the approximately 5000 deliveries per year at the Kenyatta National Hospital in Nairobi are accompanied by tubal ligation. At some smaller rural mission hospitals some 15-18% of deliveries are accompanied by tubal ligation. Four or five hospitals in Kenya recently sponsored a sterilization camp doing some 200 procedures.

Reference

Castadot, Robert, G., et al. "The International Postpartum Family Planning Program: Eight Years of Experience" Reports on Population/Family Planning, No. 18, November, 1975, The Population Council. 53 pages. (Contains extensive references and an exhaustive treatment of all features of this program).

6. Incentives

Incentives are by no means untried in Sub-Saharan Africa, but experiences with them are scattered and poorly documented.

Botswana, Ghana, Mauritius, and Zimbabwe (and Tunisia) have given special payments to doctors or family planning workers for contraceptive and/or sterilization acceptors (Jacobsen, 1983, p. 8; Barnett, 1984). Mauritius has offered small, one-time payments to contraceptive and vasectomy acceptors (Tunisia has done so for contraceptive and sterilization acceptors; Egypt only for contraceptive acceptors).

Incentives (or disincentives) of other kinds are recorded as follows (Jacobsen, p. 21 citing Fincancioglu, 1982):

- . employed mothers receive maternity benefits for no more than three births (Ghana)
- . paid maternity leave is allowed only once every three years (Tanzania)
- . child allowances (income supplements usually paid to government employees) are limited to three or fewer children (Ghana)
- . income tax deductions for dependent children were eliminated (Tanzania)

In Kenya, tax allowances are limited to four children (Barnett, 1984), and the Corat (Johns Hopkins) project will test non-monetary incentives. All these are examples of interventions whose effects cannot be measured, and which may apply only to a modest proportion of the population (those employed in government or large firms, or paying taxes). However, as stressed by Singapore's leaders in regard to incentives there, such measures can signal new directions to the population and can act as important symbols, speeding the creation of new norms in family size.

As these examples make clear, the heading "Incentives" is a very broad one. The options developed by Berelson as given at the outset of this paper include incentives to both individuals

and communities, are both short and long term, and are both direct and indirect. For high level government planners the intention here is simply to direct attention to a varied set of possibilities. Decisions on which ones (if any) to use will be very individual, but one or more may well offer potential for signalling new norms and encouraging new behavior.

Barnett (1984) has compiled a listing of all known individual and community plans for incentives and disincentives; the items from African countries follow.

References

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Fincancioglu, Muray. "Carrots and Sticks." People 9, November 4, 1982.

7. Special Urban Programs

Some countries (notably Indonesia outside Africa) have tried to create a set of special programs for the cities, since the mechanisms available there differ so greatly from those in the village context. This strategy has much to recommend it, as medical and para-medical personnel are more available in the cities, mass media have more effect, and commercial activity is more intense. On the other hand localized leadership networks are weak and community organization may be thin.

Selecting the largest five to ten cities for intensive attention can offer significant advantages. As documented above, 5-15% of the population in certain countries lives in a small

INCENTIVES FOR FAMILY PLANNING (from Barnett, 1984).

COUNTRY	DATE	DESCRIPTION OF INCENTIVE	RESULTS	SOURCE
BOTSWANA	1981	Cash bonus to distributors of contraceptives and to suppliers.		50
GHANA ZGA	1970	Planned Parenthood Association of Ghana tried experiment in urban area of Accra -- family planning workers gave women who accepted family planning services coupons which they could redeem at clinic for 2 lbs. powdered milk. FP workers also could win powdered milk based on the number of FP acceptors they recruited.	Acceptors increased from 11 to 200 of eligible couples and increased 1.6 times when both workers and acceptors received coupons. Association felt this result demonstrated effectiveness of non-monetary award.	3, 27
	1978	Payments to physicians, nurse/midwives and field workers for participating in FP clinic sessions.		15
	1969	Government employee maternity leave and allowances limited to 3 children.		6, 16
KENYA		Tax allowances limited to 4 children.		36

MAURITIUS	1966	Family Planning Association gave cash incentives to acceptors of vasectomies (\$4.50) and to recruiters (\$1.85); also to recruiters for IUD and pill acceptors (\$0.37).	2, 14
	1979	Cash payments given to physicians, clinic assistants and recruiters for all types of FP services in the form of monthly stipends -- Rupees 3,000, 400 and 20 respectively.**	16
	1981	Cash bonus to distributors of contraceptives in 2 installments; second paid only if acceptor continued practicing FP.	50
TANZANIA		Maternity leave limited to once every 3 years.	16, 36
		Tax allowances limited to 4 children.	
ZIMBABWE	1979	Physicians, nurse/midwives and medical assistants paid for all types of FP services.**	16

** Not planned as an incentive program per se but may, nevertheless, function as an incentive.

COUNTRY	DATE	DESCRIPTION OF INCENTIVE	RESULTS	SOURCE*
EGYPT	1966	Under the National Family Planning Program, proceeds of sale of pills at clinics distributed as incentive to staff: 50% to doctor, 25% to social worker and 25% to remaining staff. Clinic personnel given one Egyptian pound ⁴ for each IUD insertion.	Proved ineffective in recruiting or maintaining family planning acceptors. Also prevented extending family planning services beyond clinics because clinic staffs depended on payments.	7
		Cash payments to IUD acceptors and to physicians and paramedics for IUD insertions. Later extended to recruiters.		2
	1967	Payments to IUD acceptors made only upon follow-up visit -- delayed incentive.		2
		Cash payments later discontinued.		
	1977-	Local, regional and national coordinators for Population and Development Program (see Community Incentives) get salary supplements as incentives.		63
	Jan '77- Jun '78	Government experiment with home visits by male and female team to persuade couples to use family planning. Team expected to make 9 visits to same family in 18 months. Family given token gift, not considered an incentive, and team visitors given money.**	Success of program depended upon the skills of team. The token gifts were not sufficient motivation.	3
	1977-81	Food supplements given bi-weekly to mothers accepting FP services and their pre-school children at selected clinics run by Egyptian Family Planning Association. Food supplied through CARE.		63

26C

** Not planned as an incentive program per se but may, nevertheless, function as an incentive.

EGYPT

260

EGYPT
COMMUNITY
INCENTIVES

1978 - Date	Recruiters receive small cash incentive payments.		
1978 -	Physicians, paramedics, nurses and acceptors get cash payments for IUD insertions and each cycle or orals.	Payments received 6-15 months late. Therefore, workers do not associate payments with job performance.	16, 69
1979 -	"Family of Future" Program, Cairo: Volunteer motivators get incentive payments plus expenses.		35
1980	By administrative action, family allocation limited to 2 children, income tax exemption for 3 children, family rations limited to 5 persons and pregnancy leaves reduced.		8, 62
	Maternity leave with full pay for 3 births.		62
1977-	Population Development Program: community level economic and social development tied to achievements in FP.	Supporters claimed: By September 1980, project working in 12 governorates reaching 525 village councils.	15, 26
	Aim to get all groups in community involved in planning for development; Community Assistance Fund created by rewards on basis FP performance. CAF projects should have some relation to increasing FP acceptance.	Number of FP acceptors in these villages increased significantly, but no demographic measurements yet available.	
	FP promoted through female extension workers who visit homes and promote contraceptive use.	By June 1982, PDP was active in 72% of rural villages representing 75% of rural population.	
	Government gives villages loan or grant to establish CAF Fund. Villages are supposed to contribute an equal amount. Fund becomes revolving as loans are repaid.	Despite these claims, it appears that the program has not been pushed vigorously and has been ineffective to date.	

MOROCCO	Child allowances limited to 4 children.	36
TUNISIA	Family allowances for certain public employees reduced progressively from 1st to 4th child, thereafter none - 180, 160, 140, 120 - 0.	32, 36, 47, 50
1975 -	Cash payments made to women who are sterilized; payments to men were discontinued in 1976.	
1977 -	Small cash payments to physicians and anaesthetists for doing abortions, sterilizations and IUD insertions.**	16
1981	Cash bonus to distributors and suppliers of contraceptives.	50

26E

** Not planned as an incentive program per se but may, nevertheless, function as an incentive.

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number of urban centers. Besides this logistical argument, there are considerations of influence: in the capital city leaders can be engaged and persuaded. Major regional cities will come next, perhaps with teaching hospitals or other training centers, and accompanying medical leadership. Model family planning activities should be established in these influential environments and should take advantage of the special resources present there. Moreover each major city has its own hinterland and can be a point of diffusion for building infrastructure.

Specifically, urban programs can build on such components as postpartum efforts, mass media IEC, training efforts involving medical facilities, the testing and manufacture of contraceptives, and social marketing. Demonstration clinics can also be created to illustrate better practices than usually prevail in government health centers (convenient hours, a full range of methods).

Other Programs

Mobile teams are useful when well-administered. They have been frequently used, though seldom if ever on a large-scale to constitute a complete program. Thus no "formal" trials were found. Mobile teams appear to deserve support where local personnel are capable and a clear need can be shown. They can however be wasteful of both personnel and funds, and they are especially risky when large, costly vehicles are involved. Much administrative discipline and good supervision are necessary for consistently good performance.

We have found very few field experiments on a number of

topics that are nevertheless of interest for future program planning. These include work through factories and unions (see Tanzania in the Annex), military groups, women's organizations, religious groups (see Kenya), and a variety of channels that offer opportunities within each country for useful education or service. These are quite numerous and a judgement should be made in each case whether the channel can have a significant effect on a population basis. If not it probably deserves only a modest priority for new field research, as much still remains to be learned about even the major and most promising methods at hand.

Summary

As a recap, here are the major options as regards donor and government decisions on what large measures to take in the field of family planning and closely related health care.

Community based distribution, including door to door visits. This takes many forms, but the evidence is strongly supportive of CBD approaches in one version or another. Better outreach is the key, if not the key, and the varieties of CBD set forth above show some of the possibilities. These are both cost-efficient and effective in absolute terms. That is, they offer ways to achieve widespread rural coverage, at minimal cost. Of all rural approaches described here they appear to hold first place.

Integrated Programs. Experience in both Africa and elsewhere weighs against the creation of additional experiments of the Danfa type. But experience throughout Africa argues for continued trials of combined services in household visits and local supply arrangements. These services need to be chosen judiciously and personnel trained carefully, but it has been

repeatedly shown that such programs improve acceptability to the community and can work well. These programs are now called "CBD" more often than "integrated," a term that has largely lost any precise meaning.

Social marketing. Experience to date is not encouraging, but the door should not be shut on this approach. Public response to social marketing experiments has been generally good; the problems in Kenya and Ghana lay in the political context: unstable in Ghana and unsupportive in Kenya. Social marketing is fragile in requiring unaccustomed links between government and the private sector. Either sector alone can act effectively in family planning, but programs requiring their cooperation invite difficulties. However, where conditions are right social marketing can have a substantial effect, as shown in Bangladesh and Sri Lanka, and it deserves support selectively.

Traditional midwives. TBAs certainly have substantial potential; the question is how far this potential can be realized in practice. Oyo State of Nigeria has operated a successful system that uses TBAs as community volunteers under supervision, and experience elsewhere, including trials outside Africa, shows that in at least some circumstances TBAs can be helpful. Across Africa there is no single type of TBA. No set rule can be applied everywhere; workable local combinations of status, functions, and training and supervision methods must be sought.

Postpartum. There is good evidence from trials as much as fifteen to twenty years ago that postpartum services pay off,

both for in-patient OB/GYN cases and for out-patients coming by word of mouth. The Nigeria and Ghana experiences through the International Postpartum Program are examples; Egypt also participated in this program, and Kenya has postpartum experience. Postpartum programs should be advanced everywhere.

Incentives. This broad heading can be addressed only by reference to sub-types. It is much too broad a term, with too many provocative meanings, to be very useful by itself. Small payments to staff are one thing and to acceptors quite another. Regulations affecting taxes, child allowances, or maternity leave are much different, and require no funding action by either donors or governments. As stressed above, each government must be highly selective in its choices from this variety.

Special Urban Programs are a final option, and one of particular importance. Urban slum populations growing from both fertility and im-migration, are exploding at perhaps the fastest rate of all. They thereby include heavy components of children and of young couples in the active childbearing years. Problems of adolescent fertility are conspicuous in these populations, and specially designed programs must be developed for the urban context. Rural methods cannot be expected to work well.

Urban programs can use several of the methods already listed, but they inevitably take on a different character from rural activities. They can exploit the advantages of mass media, medical personnel and facilities, and high density, and a significant proportion of the population can be reached in the few largest cities.

Other approaches of interest exist, including mobile teams,

factory and labor unions, women's organizations, and religious groups. All of these merit consideration, to identify which ones in each country exist with enough potential to make a real difference.

The review above shows that at least a few Sub-Saharan African governments have been open to each of the measures listed. Local interests will continue to vary greatly, and the best approach in future pilot trials is no doubt also the only possible approach, namely to follow the lead of the individual country and to assess as closely as possible the effects of the measures decided upon.

LESSONS LEARNED

A variety of conclusions have emerged from the African work that take a more detailed form than the basic program approaches above. These are now summarized under individual topics of interest, with the focus in each case on issues of concern for planning and administration.

(1) The Bas Zaire experiment has yielded conclusions that are typical for community based distribution, which is clearly,



the most promising method for attaining the outreach needed to change behavior in large rural populations: (from Bertrand, International Family Planning Perspectives 10(1),1984)

-- The household distribution of contraceptives is acceptable..., provided that certain cultural norms are respected.

-- The promotion of family planning services is facilitated if they are integrated with child health services, but this does not seem to be essential in urban areas.

-- Emphasis in family planning services should be placed on childspacing, not family limitation.

-- In an area where there is a scarcity of trained health personnel, the use of para-professionals to distribute contraceptives is acceptable to community officials and the general population.

-- Household distribution of contraceptives achieves levels of awareness and initiation of use that would take much longer to achieve if the methods were simply made available in service outlets.

Two other conclusions are less typical:

-- Spermicides are more popular in this population than would be expected from the experiences in other regions of the developing world. (See "methods" discussion, Item 4 below).

-- A coupon system for encouraging resupply at an existing service outlet yielded mixed results. (The actual proportions using the coupons may not have been much worse than in other trials, but other commentators have taken a more positive tone

toward coupons and referral efforts, which are quite inexpensive to include).

(2) As regards the integration question, the discussion already devoted to this topic reflects some of the mixed results and ambivalence that attend it. But there are so many meanings to the term that any general discussion is difficult. Maguire says regarding the PFPC experiment, in explaining why the integration program performed poorly, "The most compelling reason ... appears to be that the inclusion of health services greatly diluted, rather than enhanced, the canvasser's efforts to motivate and recruit new family planning acceptors" (p. 23, Charlottesville, Va. paper, 1982), while other authors have stressed the necessity of doing family planning within the health context or through health structures. These are not necessarily inconsistent positions -- a new program can be started under the umbrella of the health ministry but still be selective in the duties of workers in the field. What is vital is that the front line staff, in direct contact with the people, have a manageable set of functions, easily understandable to them and to their clients. As Rosenfield says, "It has become increasingly clear that at village level, programs attempting to implement a wide range of interventions are probably doomed to failure. Experience increasingly suggests that these interventions should be limited to three or four, such as distribution of non-clinical contraceptives, including the pill, education about and distribution of oral rehydration packets, nutrition education, and perhaps one or two others" (p.6, 1984 NCIB paper). It has been clearly demonstrated that such a "package" can include

contraceptives and simple health commodities, with referral for medical services, and that this can produce a major breakthrough in the delivery of services.

(3) As regards males, results vary. Sai states that "Special efforts should be made to educate males about family planning and their roles and responsibilities. So far, most family planning programs have concentrated almost exclusively on women. This characteristic may be creating a backlash; men may begin to think that the programs are against them and that they encourage women to be too independent, even outright licentious. Although there is no evidence that this is in fact occurring, program strategists must see to it that appropriate education counters this possible growing obstacle" (paper presented at Conference on Reproductive Health Management, Sierra Leone, Nov. 1984). Among the projects reviewed (Annex) some investigators have found that male workers were quite acceptable in personal contacts with women (Morocco, Nigeria). Some have found that male villagers were open minded and would attend meetings, while others found them unresponsive and uninterested. Different projects have obtained varying results in the acceptability of the condom. We conclude that no general rule has emerged, but that, as Sai stresses, males are important everywhere and programs should be persistent in discovering ways to gain their approval and, if possible, involvement.

(4) Regarding contraceptive methods, the pill is the only method not frequently neglected in the projects reviewed. It is clearly of first importance in CBD trials and deserves continued emphasis.

The IUD has not been the subject of special experimentation, except perhaps in one Kenyan experiment (Cuca and Pierce, 1977, p. 163). It has been a referral method in African CBD projects. It has usually been viewed as a medical method, and much more could be done to establish precedents for insertion by paramedics and away from fixed clinics. Indeed, there are already examples of government midwives being trained to insert IUDs, with apparent success in doing so safely. And outside Africa there are many programs that use paramedic IUD insertion.

There is little to say regarding the condom, except that it goes hand in hand with programs directed to males, as well as females, and male programs have been under-utilized. In general condoms should be added to more programs and used more vigorously. Their acceptability seemed evident at least in the Kenya PSI experiment and in the Ghana sales figures. Both sectors, private and public, can offer them, and they are suitable either for import or for local manufacture, both of which can usefully absorb donor assistance. Much the same can be said regarding other barrier methods, although international evidence shows them to have high failure rates and usually low acceptability. Bas Zaire may be a partial exception to this rule, or the African pattern may be genuinely variable.

Injectable methods are a promising option. A review just published (Population Reports, Series J-28, Sept.-Oct. 1984) states that they are used by about 3.5 million women in over 100 countries, and that recent large studies set to rest concern about their possible impairment of fecundity. Injectables are

typically a clinical method, but the way would seem open to careful trials of paramedic injection with a checklist of contraindications, outside the clinic. It is in fact surprising that these trials have not been done.

The implant is also a very promising method, It is now at the stage of field trials, and deserves the closest attention. it is also reviewed in the recent issue of Population Reports (Series J-28, Sept.-Oct. 1984).

Sterilization, both male and female, is probably the most neglected and the most able to absorb special funding, particularly in combination with postpartum programs, which can also absorb funds (see Postpartum section). Female sterilization has often been a part of the projects reviewed here. In household visits it, with the IUD, has been a referral method. No trials were found that were devoted to sterilization alone, but it is present in many established programs and it deserves continuing emphasis as a one-step option for stopping. It (and the IUD) should be available in postpartum programs at the six-week check-up visit and later, using the simple minilap or laparoscopic procedures under local anesthesia.

Regarding vasectomy it seems clear from non-African experience that provider constraints can be as serious as lack of male interest. As trials in presumably unfavorable areas have shown, expert prognostications are simply unreliable. Public response cannot be known until a good service is actually established and made known, with proper counseling and reassurance to initiate the new method carefully. Vasectomy is cheaper than female sterilization and far safer, and it can be

done at any time of the birth interval and by less sophisticated medical personnel. There are good reasons to add it to both old and new programs.

(5) Cost-effectiveness is a difficult but important subject. Good cost data are rare anywhere, and Africa is no exception. Recent reviews* using partial data put the cost per acceptor at US \$28 to \$66 in the Danfa project, and US \$7 to \$10 in the Morocco VDMS study (vs. about \$50 in the previous clinic based program). Maguire (Charlottesville, Va. paper, 1982) reported US \$32 and US \$70 respectively in the PFPC and PFAD experiments in Tunisia. (In the PFPC trial cost effectiveness was much better in the Fernana area.) In Egypt estimates of \$14 and \$5 have been calculated for the Shanawan project and the 38-Village project respectively.

Costs per user have been estimated for 1980 in an extensive and original analysis by Speidel (Ch. 5 in footnoted reference), with the results in the table.

As Speidel emphasizes there are many sources of error in such estimates, but they do set the order of magnitude and suggest further lines of work. He draws out several implications for donor and regional planning.

For officials within a particular country, useful cost data will be uncommon. More to the point, estimates in money terms will usually be only one consideration, and often not the most

* See Sirageldin, I., D. Salkever, and R. Osborn, *Evaluating Population Programs*, New York: St. Martins Press, 1983, Ch. 2, 5, 9, 11.

<u>North Africa</u>		<u>Sub-Saharan Africa</u>	
Egypt	US \$26.5	Burundi	US \$33.2
Morocco	\$8.4	Ghana	38.1
Tunisia	25.8	Guinea	10.6
		Kenya	71.6
		Liberia	76.1
		Mauritius	23.8
		Sierra Leone	48.3
		Swaziland	445.8
		Tanzania	35.0
		Zaire	6.6

salient one in shaping new programs. Often the selection of supervisory personnel is more critical than a budget increase. Or liaison with community groups may be the real need for improvement. It is quite likely that the cost per acceptor or user, or the cost per increment in contraceptive prevalence, will be less in cities than in villages, due to the logistical costs of deploying a program in rural areas. But that does not logically lead to concentration in the cities. If the job is to be done at all in rural areas it may well have to use more cumbersome and expensive methods.

On the other hand, village culture may make possible a network of effective volunteer workers and mothers' groups, giving high effectiveness at low cost. Or under-employed health workers may add contraceptive distribution to their duties with little increase in real costs. The thrust of these observations is simply that (1) costs and cost-effectiveness should be estimated wherever possible, with unremitting attention to how

both efficiency and effectiveness can improve, and (2) given the defective data common in this field, planners should never get caught in cost judgments without a very thorough grasp of how they were derived, and how the real resources at hand can be exploited.

(6) As regards project development, Rosenfield's conclusions reflect a considerable body of experience (1984 NCIB paper, p.5).

a. "Such projects are best developed in a relatively small project area with members of the community and of the health care agency involved in the planning, implementation, and evaluation efforts. Winning the trust of the community and demonstrating that the program is indeed geared to their needs is an essential first step. Without this collaborative effort from the onset the project is faced with major difficulties.

b. "The evaluation should be geared towards intermediate outcome measures such as services accepted or drugs and commodities distributed. Reasonable conclusions can be drawn from these intermediate measures in an 18 to 24 month period, a period which is too short for longer term objectives such as changes in fertility, mortality, and morbidity. (The latter are in any case more difficult to measure accurately.)

c. "One must be ready, despite the research design, to discontinue components of the project which appear not to be working at an early stage in the project or to make significant modifications, as indicated. One advantage of the operations research approach is the lack of rigidity of research design,

allowing for such modifications so that the effort remains practical in orientation.

d. "In some projects, quasi-experimental research designs are possible. In others, a simple demonstration project involving an approach tried elsewhere is worthwhile."

(7) The larger question of how the lessons learned from short or small scale experiments can be incorporated into national programs requires more extensive discussion. The experience of Columbia University with its pilot projects and field experiments points above all to the importance of involving high level officials from the outset. When they help plan the project, go personally to the field to see it operating, receive copies of early results, and find that they are genuinely listened to, the probability rises dramatically that lessons from the project will be adopted. A second result from the Columbia Center's experience concerns the issue of auspices, i.e., who should conduct the pilot trial. The question is whether or not the project is best administered under the very large agency that may later apply the results nationally, usually the Ministry of Health. Alternatively, the project can usually be started more easily and run more effectively by a smaller agency, but it must then confront the obstacle of later obtaining the commitment of the Ministry of Health. A university or a carefully selected health center is also likely to have exceptional leadership, which may make the results atypically favorable. Able personnel can often make a defective plan work, but when that plan is implemented through a larger bureaucracy it may perform badly.

So there is a mix of conflicting considerations, and no

rigid rule can be recommended. It does seem clear however that where initial work is in the hands of a small local agency, every effort should be made to involve personnel from the provincial or national-level, and to do so genuinely, not merely as a courtesy. Experience is particularly salient in Oyo State of Nigeria where CBD workers (mainly illiterate female TBAs) were deployed to villages. Administration was handled by a local university, but state personnel spent time in the pilot area to observe the functioning of the program, assisted university staff in initial steps of an expanded project, and gradually took over the training activities and other functions. Overall management is now jointly undertaken and the project is expanding again into additional areas.

Further ways to encourage the generalization of lessons from small scale experiments fall under the heading of the dissemination of results, and this is generally approached through publications, seminars, presentations, etc. In Oyo State however, excellent use was made of the mass media and of interested politicians to get the word around, and this generally neglected method should probably be used more frequently.

Other encouraging experiences have occurred between the University of Khartoum and the Ministry of Health in the Sudan. In this case expansion was to the national level, whereas it was to the state level in Nigeria.

There are of course many other issues -- an almost endless list of particular questions and decisions, the resolution of which becomes more individual as the level of detail increases.

Efforts to set general rules on these quickly enter a no-man's land of speculation and qualifications, which are not particularly helpful to top planners. They must work in the large, and focus on a manageable agenda. At lower administrative levels the best judgement of program people "on the ground" will very often remain the best source of wisdom. To researchers it is humbling but true that answers to many questions lie beyond their methods, and that they will forever know less about many things than village leaders and provincial directors.

ANNEX

Individual Project Description

In summarizing each project we have found it useful to follow the standard format of the Cuca and Pierce world-wide review of pilot projects (*Experiments in Family Planning*, 1977). The few that existed then for Africa are repeated below, and the ones developed since are presented with the same sub-heads.

In selecting projects to include, our rule has been to look for interventions with reasonable quantitative data by which to assess results. We have applied this rule leniently however and have also included new projects that are expected to yield data only later. We have excluded activities that plan no objective information by which to assess effects. Projects included are divided first into Sub-Saharan vs. North Africa, then by country alphabetically, and then usually chronologically. The Table of Contents lists all projects in this sequence and indicates the type of each one.

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CODES

Adol: Adolescents
CBD: Community-Based Distribution
FP gen: Family Planning general
FP/Other: Family Planning and other aims
I: Incentive
Int: Integrated
Multiple: Multiple objectives over several projects
Nat'l: National program
Pol: Political party used as channel
PP: Postpartum
PHC: Primary Health Care
SM: Social Marketing
Socio: Various social and economic stimuli
Training: Chief component is training
Union: Labor unions

GHANA

International Postpartum Program

Time and place: 1969-1973 and onward. Three participating hospitals: Korle Bu in Accra, Effia Nkwanta in Sekondi, and Komfo Anokye in Kumasi.

Institutions: The above, with assistance from Population Council and USAID. After 1973 financial assistance from Ghana government and USAID.

Objectives: To test the postpartum approach in hospitals.

Research Design: Experimental group only. continuous monitoring through service statistics.

Intervention: Contraceptive services and information were offered to women delivering at the hospitals and to those returning for the six-week postpartum checkup visit. Services were also available to "indirect acceptors," i.e. those coming by word of mouth or waiting more than three months after birth to seek contraception. Multiple methods were offered, especially IUD, pill and sterilization.

Results: In the three hospitals combined, there were 93,000 obstetric/abortion cases. Some 9,000 of these became direct acceptors, and there were 11,000 indirect acceptors. Thus the ratio of all acceptors to all cases was 20%, which was of course lower in the early years, beginning at 5% in 1969, then 11% in 1970, and rising to 26% by 1973. One reason for the relatively high proportion of indirect acceptors was the limited availability of contraception elsewhere. Some 25% of acceptors took the IUD, 60% the pill, 7% sterilization, and the rest other, a method mix that produced an average of 3 couple years of protection per acceptor. The estimated cost per acceptor was U.S. \$3.60 vs. an estimated \$23 in Ghana's small national program in the same year (1972.) (See Nigeria postpartum section for further cost comparisons.)

Problems/Remarks: In one comparison of 21 countries participating in the International Postpartum Program, Ghana and Nigeria ranked near the bottom in terms of the acceptance ratio, i.e. the ratio of all acceptors (both direct and indirect) to the OBS/abortion caseload. However, this ratio was 25-26% after a few years of operations in Ghana, at a very low cost per acceptor. The method mix was favorable, and the steady improvement in the response to the program was encouraging.

On this evidence, the postpartum concept clearly deserves a prominent place among program options. As tested in this experiment it pertains only to urban hospitals, and equal attention should go to extensions into rural areas, using whatever

institutions and personnel are in best contact with women at the time of pregnancy and delivery. In some areas the strong custom of postpartum abstinence and breastfeeding may make the suggestions of contraception somewhat irrelevant at the time of birth, but the question remains how large the sub-group is in each area which will observe neither of these and actively desires contraceptive protection.

Reference

Castadot, Robert G. et al. "The International Postpartum Family Planning Program; Eight Years of Experience." Report on Population/Family Planning 18, November 1975.

The Commodity Experiment¹

Time and place: A five-week period in 1970 in urban areas of Accra.

Institutions: Planned Parenthood Association of Ghana with the support of International Planned Parenthood Federation.

Objective: To evaluate the effectiveness of a simple commodity incentive in increasing the proportion of referred women who came to the clinic for service. Powdered milk was chosen as a commodity which had both real and symbolic value.

Research design: Control only.

Intervention: During the first and third week field workers distributed a numbered gift coupon to all women they were referring for family planning. The coupon informed the woman that if she came within ten days she would receive a free two-pound tin of powdered milk for herself and her baby. During the second and fourth week workers distributed only the regular numbered referral slip and did not mention the free milk offer. During the fifth week free milk coupons were again offered and the workers were also offered an incentive. They would receive one point for each woman referred, three points for each one who actually came to the clinic. The worker with the most points would receive six tins of milk (the equivalent of one week's wages). A registration fee of US\$1 was charged as a way of insuring that the woman had serious intentions of practicing and was not coming merely to receive the milk.

1. Taken from Roberto Cuca and Catherine S. Pierce. Experiments in Family Planning: Lessons From the Developing World, pp. 111-112. Baltimore: Johns Hopkins Press (for the World Bank) 1977.

Results: During the control weeks the proportion of referred women who accepted was 11%; during the incentive weeks it was over 20%. During the fifth week (patient and worker incentives) acceptance was three times greater than the control weeks and 1.6 times greater than with patient incentives only.

Problems/remarks: The experiment demonstrated the attractiveness of a nonmonetary commodity incentive for both patients and workers. The presence of an incentive also shortened the interval between referral and acceptance. The cost of the commodity incentive was more than offset by the increase in the number of acceptors. During the fifth week the cost was approximately US\$3.47 for each acceptor.

Reference

Gordon W. Perkin, "Nonmonetary Commodity Incentives in Family Planning Programs: A Preliminary Trial." Studies in Family Planning, 57: 12-15, September 1970.

Danfa Comprehensive Rural Health and Family Planning

Time and place: 1969 (feasibility study); 1970-1979; Danfa District, about 23 miles outside of Accra, population approximately 60,000.

Institutions: University of Ghana Medical School, Department of Community Health; and University of California Los Angeles, School of Public Health, Division of Population, Family and International Health, funding support from the Government of Ghana and US Agency for International Development.

Objectives: Overall project objectives were: 1) to investigate the factors associated with effective participation in health programs in rural areas; 2) to conduct research on the most efficient means of using available manpower and resources in the operation of comprehensive rural health programs; and 3) to train staff for rural health work. This summary covers only the project's major family planning research objective which was to compare the effectiveness (against cost) of three strategies for delivering family planning services. This objective was modified in 1975, deemphasizing the comparative research aim in the interest of maximizing the effectiveness of the family planning services.

Research Design: Three test areas, for the three different combinations of services, and one control area were designated. Baseline demographic and KAP surveys were conducted and a vital events registration system was set up. There was an annual census, and the KAP survey was repeated at two and a half year intervals. A computerized system was used for recording and analyzing service statistics.

Intervention: The project area was divided into four sub-areas, each of about 100-125 square miles, with populations from 12,000 to 15,000. The original research design called for comprehensive health care services, including health education and family planning services in Area I. Area II received health and family planning education, plus family planning services. (A small health clinic had been operating in that area independently of the project, which continued). In Area III, family planning services alone were offered, and Area IV was the control, receiving no services. A small government health post was opened in Area III in 1976; otherwise in Areas III and IV traditional practitioners were the only health service providers. Initially, project services were standardized, with the same staff members working in all three test areas.

The project was revised after a 1975 evaluation to relax the constraints on service delivery which had been imposed by the quasi-experimental research design. This modification of the research design was in response to the Government of Ghana's policy decision that family planning would be integrated with basic health services. Comparison of areas on cost-effectiveness as a basis for replication throughout the country was therefore no longer a useful objective. Additional reasons for altering the original design were underutilization of staff in some areas while people in other areas were without services, as well as the high mobility of the population.

The modified program strengthened the family planning functions of the staff of the health center in Area I and incorporated family planning motivation and education in the training of TBAs. The family planning services that evolved included: 1) the family planning team--a mobile unit comprised of nurse, assistant, clerk, and driver, which visited three clinic sites in each of the three Areas every two weeks and additional villages enroute to the scheduled clinics; 2) health center staff in Area I and health post staff in all three Areas; 3) volunteer village health workers throughout the district; and 4) in Area II only, a small commercial distribution effort. Staff was employed by the Ministry of Health, under the supervision of the Ghana Medical School. UCLA staff were responsible for the research aspects of the program and was substantially involved in planning the service program and its revisions, as well as in training and evaluation.

Results - Effectiveness: The changes in family planning KAP indicators between 1972 and 1977 in the four project areas, and acceptance rates for residents of the three test areas were as follows:

Changes in Female Family Planning KAP and Acceptance Rates, 1972-1977.

		Area I	Area II	Area III	Area IV
Know of pill	1972	72%	72%	50%	64%
	1977	92%	91%	80%	86%
Approves of family planning	1972	70	69	70	76
	1977	89	86	85	88
Number additional children wanted (3 living children)	1972	2.9	3.3	3.7	2.8
	1977	1.2	2.2	2.3	1.0
Couples ever using modern FP	1972	11	7	2	8
	1977	34	21	8	9
Couples now using modern FP	1977 only	18	9	2	5
Female Acceptors per 100 WRA	7/72 6/77	27.2	16.7	5.8	
Couple Acceptors* per WRA	7/72	37.6	31.0	14.2	

* All female and male acceptors divided by mean WRA.

There were no great differences between the areas in levels of knowledge and approval in 1977; all areas were impressively high. The important difference was the high level of ever use and current use in Area I, which had the integrated comprehensive health services. The health center in Area I also served people who lived outside the project area; 32 % of all female acceptors and 45% of all male acceptors at the center during the years of the project were non-residents.

In Area I the birth rate declined from 43 to 33, and the general fertility rate from 226 to 178. These differences were statistically significant, while in Areas II and III no significant differences were observed. Because births were underreported, especially in the baseline years, the magnitude of fertility decline could not be measured with confidence.

Results - Costs: While the standardization of services in the test areas was not maintained throughout the project years, allocation of costs to areas and to service components permitted some estimation of cost-effectiveness differences. Costs per acceptor and costs per contraceptive month were lower in Area I

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than in Area II (the highest cost), or in Area III.

These comparisons are understood to be approximate, partly because the use of Area I services by non-residents raised Area I per resident WRA costs by an unknown factor. The high cost of research and development was considered a non-recurring expense and is not shown. Training costs for the family planning and health education workers were particularly high because of UCLA staff participation. For replication with Ghanaian personnel this cost would be reduced by about 70%.

Problems/remarks: As regards cost-effectiveness, use of the services by non-residents probably created an over-estimation of Area I costs, and reduced the apparent magnitude of the advantages of the integrated program. In and out migration was heavy (30% of the sample was lost in the first three years). Proximity to Accra and the high visibility of the project (many visitors, close supervision by the medical school, strong participation of the UCLA personnel) may have created a Hawthorne effect, common to many demonstration projects, which established expectations for performance that may be unrealistic in later applications.

References:

Blumenfield, Stewart N. "Cost Analysis of the Danfa (Ghana) Project Family Planning Component." In Evaluating Population Programs: International Experience with Cost-effectiveness Analysis and Cost-benefit Analysis ed. I. Sirageldin, D. Salkever, and R. Osborn, pp. 228-244. London and Canberra: St. Martin's Press, 1984.

University of Ghana Medical School and UCLA School of Public Health. The Danfa Comprehensive Rural Health and Family Planning Project, Ghana: Final Report. 1979.

Ghana Social Marketing Experiment, 1970-71

Time and place: Program began in 1970, product was launched in June 1971, program was curtailed and modified in July 1971. Directed primarily at urban and semi-urban married couples throughout Ghana.

Institutions: Ghana National Trading Corporation (a government distributor). Sponsored by the Ghana National Family Planning Program.

Objective: To market contraceptives on a national scale in a commercial manner.

Intervention: The advertising campaign was planned with the expertise of a private advertising agency, Lintas-West Africa, Ltd. and the product was to be distributed through some 200 wholesale and retail outlets of the semi-private distributor, the Ghana National Trading Corporation.

- The campaign was to take place in three stages
- (1) creating an awareness of family planning and the National Program
 - (2) motivating the target population to use family planning, and
 - (3) making the contraceptive devices available and communicating their availability to those motivated to use

The target audience consisted mainly of urban or semi-urban married couples as over 40 percent of the Ghana population live in towns of over 5000 people and the concentration of retail outlets is greater in these areas. A considerable "spill-over" into rural areas was anticipated as "fashion starts from towns and then goes to rural areas".

The design of the awareness and motivation campaigns took into consideration that the desire for large families is deeply rooted in the people of Ghana. The National Demographic Sample Survey of 1968-69 showed that 76.5 percent of married women with 1-3 children and 50 percent with 4-5 wanted to have more children. The average ideal family size was 5.9 children in urban areas and 7.1 in rural areas. As a result the advertising campaign was aimed at spacing rather than the limiting of family size.

The promotion campaign used the press, radio, television and outdoor and point-of-sale posters.

Two types of contraceptives were to be promoted in the product campaign sultan condoms and Emko foam. This final phase of the program was planned to explain their availability, where they could be purchased, what they were, to make the target population familiar with their packaging and to remove them from the realm of embarrassment.

Results: Only two weeks after the promotional campaign was started (in June, 1971) all press and radio advertising was stopped. Outdoor, television and cinema projects were never started. This came about as a result of major criticism by some influential public officials which could have been a potential source of danger to the National Family Planning Program. The product campaign, however, was initiated on July 15, 1971 but received only a short press advertising.

Sales figures for the program were not well documented. One source reported that in 1970 condom sales amounted to 900 gross and in 1971, 2000 condoms were sold through the Program and 2000 through private sources. The report cautioned, however, that these figures may not reflect the actual market for condoms because of the "severe importation difficulties in Ghana". An

increase in acceptors registering at family planning clinics was also reported for this period. Increased public debate and discussion of family planning and contraceptives were also cited as achievements of the program.

Remarks: Project participants have noted the following lessons learned through the experience of this project.

- (1) Set action standards before any work begins and adhere to them
- (2) Use professional research agencies
- (3) Seek the advice of an expert in population control
- (4) Pay for services rather than obtain them as favors
- (5) Establish a method for immediate response control.

The project staff concluded that advertising can change a person's attitudes if the arguments used are "convincing, persuasive, attractively presented and repeated often enough". However, they warn that these changes should not be expected to occur too soon.

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Obetsebi-Lampsey, J., 1973. "Development of the Ghana Advertising Campaign," in McMillan (ed.) Using Commercial Resources in Family Planning Communication Programs: The International Experience, University of Hawaii, Press, pp. 83-97.

Altman, D.L. and P.T. Piotrow, 1980. "Social Marketing: Does It Work?" Population Reports, Series J, No. 21, p. J-414.

Contraceptive Retail Sales Program

Time and Place: 1976-1980, Ghana.

Institutions: Government of Ghana, Westinghouse Health Systems.

Objectives: To establish a sales program for contraceptives through existing commercial networks.

Research Design: Before and after surveys. No control groups. Essentially a national program, assessed by interviews, sales figures, and intermediate indicators such as advertising material produced and distributed.

Intervention: Launch of contraceptive products in the commercial sector: condoms, foam tablets, and orals. Very intensive advertising through a variety of media.

Results: The "mini-RAP" surveys done before and after the action period showed a substantial rise in the proportion knowing two or more methods of contraception, and the acceptors in this group "... regularly purchased supplies at chemist's shops, market stalls, pharmacies, small shops and other outlets." Sales over the period January 1979 through June 1980 amounted to about 37,000 couple years of protection, but with large monthly swings due to supply disruption and other program disturbances. Nevertheless the peak months of sales closely matched the peak months of advertising.

Remarks: A change in government, national economic upsets, and a variety of administrative difficulties hampered the project. The marketing effort itself demonstrated considerable promise; the question is to what extent some of the larger difficulties in administration and government relations are inherent to this mixed private-public sector approach.

Reference

Westinghouse Health Systems. "Contraceptive Retail Sales Program, Ghana." September 1980, 23 pp.

KENYA

The Kenya/Kinga Experiment

Time and Place: From October 1972 to November 1973 in the Meru district with a total population of 600,000 and an estimated market for condoms of 60,000 males. The average annual income was about US\$220 per family; approximately 5 percent of the population had more than a primary education.

Institution: Population Services, Inc.

Objective: To discern the implications for Kenya and the donor community of social marketing -- the application of commercial marketing techniques to accomplish social objectives -- in a national contraceptive program.

Research Design: Control only. Kirinyaga district was used as a control area.

Intervention: The name, color, and sales symbol of lubricated condoms were selected on the basis of an initial marketing survey. An aggressive advertising and sales promotion campaign was then launched using all available media (radio, cinema, and displays). Condoms were sold through village stores, and the price was subsidized. Ongoing market research was used to ascertain and monitor the reactions of the promotion.

Results: In the experimental area the current use of condoms among survey respondents increased from 4 percent before the program to 15 percent twelve months after its initiation; current use of any method increased from 21 percent prior to the campaign to 35 percent after twelve months. There was no change in the level of contraceptive use in the control area.

Problems/Remarks: It is questionable whether Kirinyaga was really a suitable control area because its population was more traditional and less informed than that of Meru. The experiment demonstrated that commercial distribution of subsidized contraceptives through local outlets offers an effective avenue for reaching the rural market.

In its early stages the experiment encountered some opposition from the community. An influential physician, who operated four private rural family planning clinics, alleged that the program was selling to children. This accusation prompted local shopkeepers to become more vocal in their support of the program. Sales in Kinga were largely unaffected by the controversy, and the issue was eventually resolved. This project ended in 1974, but was immediately followed by another one that ran to 1976.

References

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Health for the Family - Chogoria Hospital

Time and place: 1974 - ongoing.

Institution: Presbyterian Church of East Africa with funding from Family Planning International Assistance (FPIA), Church of Scotland, Ford Foundation, Swedish International Development Authority (SIDA).

Objectives: 1) To conduct community-based and clinic activities in order to increase acceptance of family planning among men as well as women. 2) To expand the family life/sexuality education young adult program through training new group leaders and conducting seminars on "preparation for marriage" and "preparation for employment" for school drop-outs.

Intervention: Project activities include integrated, curative and MCH/FP service delivery at 25 delivery points and 6 mobile clinics, a CBD and a youth program. Youth program leaders make contact with both students and youths who are not in school and who do not belong to any organizations. This is often at informal gatherings, market places, weddings, etc. Other out-reach activities bring family planning information and services to hard to reach areas through volunteer health workers, teachers, and peer group opinion leaders. Using "satisfied users" as volunteers enables Chogoria hospital to provide services at a low cost. Eventually the hospital plans to bear this cost independently.

Results: Preliminary results from a Centers for Disease Control (CDC) evaluation indicate that an estimated 27-30 percent of all eligible women in the area are now active users. By January, 1984, over 30,000 new family planning acceptors had been served. Since 1978, over 500 voluntary sterilizations had been performed.

Reference

Family Planning International Assistance (FPIA). "Project

Summary. Health for the Family", from project files with permission from FPIA, 1984.

Saradidi Community-Based Health Project

Time and place: July, 1980 - present. Siaya district in Western Kenya, located about 400 miles from Nairobi and 50 miles from the nearest health facility.

Institutions: Project is implemented by the Saradidi Rural Development Project Committee under supervision of the Department of Community Health, Faculty of Medicine, University of Nairobi with funding from Family Planning International Assistance (FPIA).

Objectives: 1) To expand the community-based distribution (CBD) of contraceptives in thirty-five villages through the efforts of sixty Village Health Helpers (VHH) and eight Male Peer Motivators who conducted family planning IEC and motivation sessions in their respective villages. 2) To place greater emphasis on male participation in family planning.

Intervention: In the first year of the project the Saradidi Health Center was opened to provide comprehensive health services, including family planning. IEC sessions are held for both men and women and meetings to encourage use of contraceptives among males are held at bars and taverns and other informal meeting places. There are also meetings with women only, as well as income generation activities including poultry raising, sewing and gardening.

Results: A survey conducted by the Department of Community Medicine prior to initiation of the project indicated that there were less than a dozen family planning acceptors in the entire project area. Since 1980, CBD programs have been expanded to 35 villages, almost 10,000 people have received health services, 9,000 have received family planning services and 13,000 cases of malaria have been treated.

Reference

Family Planning International Assistance (FPIA), "Project Description and Budget," from project files for Saradidi Community Based Health Project, used with permission from FPIA, 1984.

Tumutumu Family Planning Supplementation Project

Time and Place: July, 1983-1984. This funding period is the first of three to five years of anticipated operation. Tumutumu Hospital outreach clinics serve the Nyeri district in Kenya.

Institutions: Presbyterian Church of East Africa (P.C.E.A.) Tumutumu Hospital with funding from Family Planning International Assistance (FPIA).

Objectives: To strengthen and expand family planning services currently offered by Tumutumu Hospital by training three dispensary/clinic nurses in family planning service delivery, initiating family planning services at two out-reach dispensaries and by augmenting the family planning services at the MCH/FP clinic at the Hospital.

Intervention: Tumutumu hospital offers family planning services through the MCH/FP clinic at the hospital and through two new out-reach dispensaries. In order to increase efficiency and effectiveness, three new dispensary/clinic nurses will be trained in family planning service delivery and clinic management. It is anticipated that in the future, family planning services will be integrated with other services of Tumutumu Hospital, and when FPIA support ceases, some of the costs of the services will be absorbed by the income generated from fees collected for services.

Results: Tumutumu Hospital reports "increasing support of its services by the community and village leaders." In the first eight months of this project 600 new family planning acceptors were recruited and over 200 sterilizations were performed.

Reference

Family Planning International Assistance (FPIA). "Project Description and Budget" from project files with permission from FPIA, New York, 1984.

Corat Project

Institution: Johns Hopkins University (JHU), with US Agency for International Development financial support. Various Kenyan organizations.

Time and Place: Kenya, 1983 onward.

Objective: "CORAT is a non-profit management consulting organization that works exclusively with churches and Christian organizations. Based on its familiarity with church-sponsored groups in Kenya, CORAT identified four subprojects to incorporate family planning into church-sponsored service programs. JHU will provide technical assistance in the design of each subproject, including a research component that addresses one or more practical service delivery issues. JHU will also assist in the implementation and evaluation of each subproject. CORAT will administer subproject funds, provide management assistance, and arrange for dissemination of findings through seminars and the development of training materials" (from Capsule Summaries).

Design: Baseline survey data for the four sub-projects are under analysis; no information on intermediate or outcome variables is yet available. The projects include tested non-monetary incentives and natural family planning.

The four sub-projects are briefly as follows.

1. Community Health Program--Mt. Kenya East: to improve management and effectiveness, emphasizing family planning. Coverage of up to 100,000 population; sample surveys planned.
2. Diocese of Maseno South Community Health Program: to expand the community health program and to add CBD family planning to it. Population of about 200-300,000 with about 200 community health workers. Baseline survey done; resurveys planned.
3. Tenwek Hospital Community-Based Health Care Project: CBD health and family planning project in the Tenwek Hospital region, using community health workers (CHWS) serving in their own communities. Various incentives will be tested for their effects on worker performance and acceptance and use of services. Initial implementation in three communities with 30-50,000 population. About 180 CHWs. Household surveys planned.
- 4 Diocese of Nueri, Nyahururu Natural Family Planning Project: to field and evaluate a natural family planning program and investigate alternative training approaches. Population of 180,000; surveys planned.

Reference:

Personal communication from Dr. Bob Parker, Johns Hopkins University.

NIGERIA

International Postpartum Program

Time and place: 1969-1973 and onward. Four participating hospitals: Ibadan University College, Adeoyo State, and Inalende Maternity Hospital, all three in Ibadan, and; Lagos Island Maternity Hospital, in Lagos (confirm).

Institutions: The above, with assistance from Population Council and USAID. After 1973 financial assistance also from Nigerian government, UNFPA, IPPF, and Ford Foundation.

Objectives: To test the postpartum approach in hospitals.

Research Design: Experimental group only. Continuous monitoring through service statistics.

Intervention: Contraceptive services and information were offered to women delivering at the hospitals and to those returning for the six week postpartum checkup visit. Services were also available to "indirect acceptors," i.e. those coming by word of mouth or waiting more than three months after birth to seek contraception. Multiple methods were offered, especially IUD, pill, and sterilization.

Results: From 143,000 obstetric/abortion cases there were 7,000 direct acceptors; in addition there were 11,000 indirect acceptors. The ratio of all acceptors (both direct and indirect) to all OBS/abortion cases was 13%; it began at 4% in 1969 and rose to 16% in both 1972 and 1973. This is a one-sixth ratio, with substantial numbers for only four sites. However, hospitals elsewhere did even better, with Ghana (the only other African participant) rising to 26%. Of all acceptors, 49% took the IUD, 47% the pill, 2% sterilization, and 2% the injectible, producing an average of about 3.3 couple years of protection per acceptor. The estimated cost per acceptor was U.S. \$12.65, well above the estimated cost of U.S. \$3.60 in Ghana. However, the absolute number of acceptors was about the same in the two countries (19,00 in Ghana, 18,00 in Nigeria) as was the ratio of direct to indirect acceptors (8:11 in Ghana, 7:11 in Nigeria). (The reasons for the higher costs in Nigeria are unclear; perhaps costs per client are higher for normal hospital operations there. No comparisons are at hand as to the relative personnel costs in the two countries, which were by far the largest single category of expense in the International Postpartum Program.)

Remarks/Problems: Although separate figures were not available for Nigeria and Ghana hospitals, the family size and age of acceptors in the International Postpartum Program generally were well below those in normal national programs. This in combination with the favorable continuation rates experienced in the overall program suggests an encouraging duration of protection

against pregnancy.

Reference

Castadot, Robert G. et al. "The International Postpartum Family Planning Program: Eight Years of Experience. Reports on Population/Family Planning 18, November 1975.

The Gbaia Family Health Nurse Project

Time and place: 1967-1970, Lagos.

Institutions: Department of Community Health, College of Medicine, University of Lagos; Institute of Child Health of the University of Lagos; Department of Pediatrics, Lagos University Teaching Hospital; Ministry of Health, Federal Republic of Nigeria; Ministry of Health, Lagos State; Public Health Department, Lagos City Council; Johns Hopkins University; USAID.

Objectives: 1) To demonstrate economical and efficient delivery of primary health care to children under five years of age, using nurses as providers of basic services. 2) To train staff in the team approach to primary health care. 3) To demonstrate the relationship between improved child care, improved child health, and acceptance of family planning.

Research Design: Patients for the project were randomly selected from registrants at a Ministry of Health (MOH) clinic. Random selection was continuous through the duration of the project. Research conducted in 1970 on acceptance of family planning was based on the assumption that improved child care and increased child survival would result in a desire for fewer children (smaller family size) and increased knowledge of, more favorable attitudes towards, and greater use of family planning methods. A study of height and weight of project children, compared to non-project children, and KAP survey were conducted.

Interventions: The project was modeled on the "under fives" demonstration clinic in rural Nigeria (Ilesha). Nurses were responsible for primary patient care. Health education and integration of preventive and curative services were emphasized. The family planning component consisted only of counseling and referral; no contraceptives were provided.

Results: The 1970 research indicated that the project had been successful in integrating preventive and curative services to children, and fewer project children than non-project children were in the lowest weight categories. It was not possible to measure acceptance of contraceptive methods because records on this were not kept.

Significantly more project mothers believed that child survival is better now than in the past (81-90%) than non-project mothers (59-71%) according to the 1970 study. They differed also in ideal family size (4.9 for project, 5.3 for non-project) but project mothers indicated a somewhat larger desired family size for themselves than did the other mothers. Project mothers were significantly more favorable towards child spacing and contraception, but the groups did not differ on attitudes towards abortion and sterilization, appropriate intervals between pregnancies, and age at which women should stop childbearing. While more project mothers had heard of family planning clinics, many did not understand their function. Significantly more project than other mothers had used or were using the pill or IUD (9.7% vs. 3.5% for the pill and 8.7% vs. 3.2% for the IUD).

Remarks: This is an example of an early IEC effort. Its modest but positive experience was expanded upon in the later family health clinic in Lagos (see following entry) which did provide a range of contraceptive services.

(See Oguntolu Street Family Health Clinic Project.)

Reference

Wellman, John. "The Gbaja Family Health Nurse Project Lagos, Nigeria, 1967-1970: An Examination of Its Family Planning Impact." Dr. P.H. Thesis, Department of International Health, Johns Hopkins University, June 1971.

Family Health Clinic (Oguntolu Street Family Health Clinic, Shomolu)

Time and place: July 1974---- Lagos. Target population: community of about 30,000.

Institutions: Institute of Child Health of the University of Lagos; US Agency for International Development (Nigerian Family Health Project).

Objectives: 1) To develop and demonstrate a model comprehensive health service, using nurses in expanded roles in the care of mothers and children. 2) To serve as a training site for teams of nurses who were to function in expanded roles in other locations in Nigeria.

With respect to family planning, the objective was to test strategies that would be compatible with traditional practices of lactation and postpartum abstinence and would be effective in spacing births at least 30 months apart.

Research Design: Periodically data were collected on socioeconomic and demographic characteristics and health conditions, and on health and family planning attitudes and practices. The intention was to document declines in infant and maternal mortality, and the crude birth rate, as well as to measure changes in understanding and attitudes regarding child care and family planning.

Intervention: This project was modeled on an earlier one in Lagos, known as the Gbaja Street Clinic, which was modeled on the demonstration project in rural Nigeria (Ilesha) that, in the 1960s, pioneered the utilization of nurses and midwives as the basic providers of direct medical care of mothers and children under five years of age.

Services included preventive and curative care, health and nutrition education and counseling, a home-based record system, and integrated family planning services. Family health workers visited homes periodically for education and referrals.

The family planning strategy tested was to emphasize contraceptive information at the time of weaning rather than at the postpartum stage when motivation was weak because of breastfeeding and abstinence. Readiness to wean was assessed at clinic visits, and at home visits which were scheduled four months apart. The focus was on spacing and the individual counseling stressed the often desired longer period of rest before another pregnancy.

A Father's Club was formed, meeting once a month and operated by representatives elected by the fathers. They discussed topics of health education and information was given on postponement of the next pregnancy. An approach to men was considered important because of 1) unfavorable attitudes of males in Southern Nigeria toward family planning, 2) general male domination in the culture, and 3) the common association by men of modern contraception with promiscuity. One effort was to replace this attitude by establishing a link between modern contraception and the health of mothers and children.

Results: Early results suggested that there was a favorable response to the mix of field and clinic contacts and counseling of fathers. Later results are not available.

Home discussions indicated a need for infertility and subfertility services, since nearly one-fourth of the women who wanted another pregnancy said they were experiencing difficulty in conceiving. Although a primary-level health service would have limited resources for such services, some response was thought to be important because of the strong felt need in the community.

Remarks: A program that depends upon precise timing of the

initiation of contraception, as this one does, requires unusual information on the stage where each woman is within the birth interval, and upon frequent individual contacts. Many mothers may not be using the health services at the time of weaning and the intensity of home visits necessary to know and act upon readiness may be impractical, even in densely settled urban locations. Administrative costs would probably be high.

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- Fischman, Susan H. and David J. Fitch. "Consultant Report for the Evaluation of Family Health Training in Nigeria - Project 620-11-580-789." Report prepared for USAID, February 14 - March 18, 1978.

The Ishan Experiment

Time and place: a three year period, 1969-1972, in Ishan Division, Midwestern State, Nigeria, roughly 300,000 population.

Institutions: Zuma Memorial Hospital; the Institute of Population and Manpower Studies, University of Ife; with technical and financial support from the Population Council, using funds provided by USAID.

Objective: To establish a new program working out of a hospital, offering family planning information and services to the population of the Division, with outreach workers going out to tribal compounds.

Research design: experimental area only. Assessment through service statistics and through annual surveys of the entire Division.

Intervention: A family planning program was begun at the Zuma Memorial Hospital providing family planning information and services as a part of the outpatient clinic's regular services. The IUD, pill, and injectable were offered, with a fee charged for the clinic visit. News of the clinic spread by word of mouth and through full-time motivators, i.e. 10 women who regularly visited tribal compounds within a 25 mile radius of the hospital, talking with individuals and conducting group meetings.

Subsequently, this system was replaced by short-term, intensive campaigns done three times a year. Bus transportation was provided for some clients, while others came on their own. Family planning services were blended with other outpatient services to providing anonymity. Attention was given to cultural nuances: besides the anonymity protection, the field workers in the campaigns did not discuss individual methods of contraception in detail but rather tried to stimulate thinking regarding spacing or planning the arrival of children. Discussions with clients in the hospital were handled with delicacy, recognizing the reluctance of women to discuss sexual matters with anyone other than their spouses.

Results: Four independent annual sample surveys of the area, conducted from 1969 to 1972, showed large increases in knowledge of at least one contraceptive method (rising from 13 to 55 percent of currently married women) and in contraceptive prevalence (rising from 1 to 24 percent), though with some methodological problems that may have produced error in either direction. The mean age and parity of acceptors at the clinic declined over the three years, from age 32 to 30 and from parity 8 to 5. Numbers of acceptors rose to reach 1,298 in a 12 month period. During the three years a sizeable number of private and semi-private maternal and child health clinics began work in Ishan Division and offered family planning services; of the 24% practicing in the 1972 survey, 9% gave the Zuma Family Planning Clinic as their source and 15 percent these other sources.

Discussions: The area was undergoing rapid change during this period, due partly to the discovery of oil in Midwestern State. Before the experiment began it had experienced growth in education, health services, and physical infrastructure, with a rising standard of living. Health was still precarious and mortality high, with the crude death rate estimated at 21 and infant mortality at 112. Fertility was also quite high, at an estimated completed family size of 7 children and a crude birth rate above 50.

The program tried in this project appears to have worked, both in its information/stimulus features and in its service component and would appear to have been largely responsible for creating an awareness of family limitation among Ishan women" (Farooq and Adeokun, 1976, p. 165).

A side note is that the program was not successful in motivating males to take up contraceptive methods; whether that would be true now, a decade later, would be worth exploring.

The emergence of a large role played by other service points is reassuring that the public response was broad based, and was not due to the special features of the Zuma institution.

References

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Calabar Rural Maternal and Child Health Family Project

Time and place: 1975-1980, Cross River State, approximately 200,000 population in about 280 villages.

Institutions: The Cross River State Ministry of Health and the Population Council with United Nations Fund for Population Activities funding support.

Objectives: The Calabar project was part of an international program designed to test methods of delivering maternal and family planning services in combination to large rural populations lacking good health infrastructures. Instituted by Howard C. Taylor and Bernard Berelson (1971), it aimed to test three hypothesis: "that integrated maternal and child health/family planning programs are feasible in rural areas of developing countries and can be implemented at a reasonable and replicable expenditure of money and manpower; that the linkage between maternal and child health and family planning is mutually beneficial; and that a program based on maternal and child health care can effectively deliver family planning education and services to large populations in the rural areas of developing countries." (Cuca and Pierce, p. 151.)

The four countries (Nigeria, Turkey, Philippines, Indonesia) that conducted trials all did it rather differently, but the Nigerian version reflected the original intent by trying essentially to determine what it would take in facilities, personnel, money, supplies, and administration to provide basic MCH/FP to all eligible rural women.

Research Design: No control or comparison groups. No before survey. Initial data were gathered to assess existing health service resources, cultural factors, and health practices. Estimates of the size of the population of the area and its location relative to health services were obtained by a count of villages and dwelling places, with the average number of persons per dwelling estimated from a pilot survey. In 1978 a follow-up survey of family planning acceptors was conducted, and in 1979 a large-scale household survey collected data on the project's total population. Medical assessment of mothers and children was based on clinical, anthropometric, and laboratory hematological evidence. Service statistics were gathered continuously for family planning and health indicators.

Interventions: Six health centers were upgraded and one was

constructed. Nursing personnel and traditional birth attendants (TBAs) were trained. Family Health Workers (FHW), who were paraprofessionals recruited, trained, and supervised by the project, were based in simple one-room clinics in 35 villages. The FHWs held morning clinics and treated common illnesses, screened women and children for referral to the health center, gave immunizations, dispensed contraceptives and some drugs, and provided health and family planning education. In 1980, fees for the drugs were instituted, which made this service self-supported. Home visiting, primarily for education and referral, was done in the afternoons.

Results: Antenatal care was received by 35-40% of the pregnant women in the project area; 20% delivered at a hospital or at one of the maternities. The number of children under age 6 treated at facilities doubled. The 1979 project-wide survey indicated that 43% of the children age 7-12 months had been to a clinic. Immunization coverage was rather low -- about 15-20% of the children receiving DPT immunization by project end. From 1979 survey data an estimated 70% of the children over 2 years of age had no immunization. While 63% of all women in the area remained ignorant of modern family planning methods as of the 1979 survey, those who had interacted with project workers had both higher levels of knowledge and of use. Ever use of family planning was 18% among those who had discussed it with project personnel, compared to 8% among all respondents in the large-scale 1979 survey. The discontinuation rate for all women was relatively high, so that only about 2% of the sample of women age 15-54 in the 1979 survey were currently using modern contraceptive methods. Effects on maternal and child health status were limited. The prevalence of wasting at 7 to 36 months was little changed, although an exception was children whose mothers attended antenatal clinics at the health center, i.e. who had high levels of interaction with health workers. The home visiting by the family health workers was a weak component in the project, possibly because this aspect was not well supervised, and their training did not create ease in communicating health and family planning information.

Problems: 1. Clinic services were used only by those residing in the village in which it was located. With only 35 village clinics, about half the project area population was uncovered.

2. Because of in-migration, the target population for MCH/FP grew by 40% in the 5 1/2 years of the project period.

3. The project operated independently of the State Ministry of Health, which probably was a short term advantage, but probably also made for little impact on local decision-makers. State planners rejected a low-cost, low-level personnel strategy for rural health care.

4. Training of the family health workers was not in their

indigenous language. They seemed to lack ease with health and family planning education concepts and terminology, and were consequently relatively ineffective in giving information to the village people.

5. Supervision of the workers was based at the project headquarters, which worked against integration with the operation of the health centers. The evaluators concluded that the failures to meet project goals in coverage and improvement of health status were due to day-to-day problems with logistical support (supplies, transportation, supervision, training and retraining), not to the concept of village level care. However, part of the very problem is to find programmatic measures that are not administrative intensive, and especially so in areas with few human resources. The lighter the managerial load for a given objective the more likely a favorable outcome, and the more feasible a wider replication. This project, like others with multiple objectives and long time periods, suggests that fruitful experimental work and field trials should be kept modest and relatively simple.

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Oyo Community-Based Delivery Health and Family Planning Project

Time and Place: 1981 onward, Oyo State, Nigeria

Population: Pilot Area - 85,000
Expanded Area - 150,000

Institutions: University College Hospital, Ibadan; State Health Council; Ministry of Health, Oyo; Center for Population and Family Health; The Pathfinder Fund.

Objectives: 1) To demonstrate and test the effectiveness of low-cost rural health and family planning services provided by trained community volunteers under the supervision of the existing government MCH program. 2) To introduce family planning to rural areas of Oyo State in a manner that is acceptable to the community.

Sub-objectives: 1) To develop and test appropriate training programs for the community fieldworkers and their supervisors. 2) To assess community receptivity to the services provided. 3) To determine which individual and community characteristics differentiate effective from ineffective fieldworkers. 4) To evaluate the cost-effectiveness of alternative systems of fieldworker motivation, home visiting, field supervision, and community participation.

Research Design: Pre- and post-surveys; evaluation of service statistics and monitoring of disbursements of drugs and contraceptives; special studies of specific issues (e.g. types of field workers, methods of supervision, fee and incentive systems).

Interventions: In the Pilot area, 165 volunteers were selected by the communities and trained to provide basic health services (health and family planning education; referrals; treatments for malaria, diarrhea, worms, cough; first aid for cuts and bruises; and distribution of vitamins, iron, and contraceptives). Although the project was initially administered by the University College Hospital, the fieldworkers were supervised by the nurse midwives from the existing government MCH program and services were integrated with those of the maternity/health centers. Two-thirds of the workers were TBAs, and one-third were male Voluntary Health Workers.

In the Expanded area, volunteer workers, also selected by the communities, were trained to carry out the same services in the remaining health areas in Oyo State, and the government gradually took over administrative responsibility. Workers in the Pilot area had received a monetary incentive when the project was initiated, but that was discontinued and no monetary incentive was given to the workers in the Expanded area. Small service fees were charged, and the funds are administered by a village committee for community projects.

Results: A baseline survey in the Pilot area found that only 36% of the respondents' families had used any government health service in the prior year. In its first full year of operation (1982) the community-based workers provided 33,788 illness treatments, 2,051 prenatal pill disbursements, 6,662 contraceptive disbursements, 575 deliveries, and almost 5,000 health talks. The system did not allow for collection of client data but estimates of use from disbursement of contraceptives indicate that about 25% of the women of reproductive age used modern contraception, with current use estimated at 10%. Pre-program survey estimates were 2.5% for ever use and 1.5% for current use.

Dissemination on the local level of information on the University College Hospital pilot project led to a demand from other areas of Oyo State for similar services and resulted in its prompt replication by the state government.

Remarks: The major lessons from this community-based project are:

- 1) Integration of family planning with basic health care makes the initiation of the topic of childspacing acceptable at the village level and it allows family planning to be associated with the much appreciated health services.
- 2) Although the leadership of the University College Hospital was invaluable in initiating the project, supervision by government-facility personnel was more effective when the university role in administration was reduced and the local roles in training and management were expanded. The successful transfer of the pilot project was the result of a carefully planned "apprenticeship." State personnel first observed the functioning of the pilot program, then participated in a training-of-trainers program, then observed and assisted university staff in the initial steps of the Expanded Project, and gradually took over the training and other local program functions.
- 3) The community-based approach has changed the MCH program emphasis from services for those attending a fixed facility to providing services for all people living within a particular area.
- 4) The non-professional MCH personnel have effectively assisted in implementing the community-based program, especially in supervision of the field workers and family planning education.
- 5) A major value of the TBAs and Voluntary Health Workers has been to link the people in the rural areas to the facilities and services provided by the government, especially through information on the services and referrals (workers frequently accompanying clients to the facility).

- 6) Individual monetary incentives are not necessary to motivate the volunteers. Once incentives are given, however, it creates difficulties if the system is changed. (The incentives were the most costly item in the budget of the pilot project, and when the government took over its administration it could not accept this expense.)
- 7) Small service fees are an acceptable part of the community-based program, but they are not likely to be adequate for complete support of the program.
- 8) Illiterate field workers can properly treat malaria and other common illnesses, and they can keep reasonably accurate records using pictograph forms.
- 9) Open communication about family planning is very difficult and it is important to have both male and female community agents to introduce and promote modern contraceptives in the rural areas.
- 10) Controlled quasi-experimental experimental studies are extremely difficult to carry out in rural settings such as this part of Nigeria. It is more fruitful to follow on the naturally occurring variations in the program, with both statistical analysis of records and field interviews.

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SENEGAL

Sine Saloum Rural Health Services Development Project

Time and place: (Phase I) 1977-1982; (Phase II) 1983-1988; outlying villages of secondary rural towns in Sine Saloum region in Senegal.

Institution: Ministry of Health, Government of Senegal; technical assistance and financial support from US Agency for International Development.

Objective: To develop a self-sufficient village-based PHC delivery system which can effect a reduction in the incidence of infectious diseases among the rural population and serve as a delivery system for maternal and child health interventions, including family planning services. Phase II objective is to increase agricultural production of workers and reduce the population growth in the region of Sine Saloum.

Intervention: Self-supporting health huts in 600 villages in the region, including all six departments of the Sine Saloum were established. Each village health hut was staffed by three community health workers (CHW): a first aid worker, a traditional birth attendant (TBA) and a sanitation worker. Villagers built the huts, paid for services and medicines, and supported the unit through communal labor and contributions. Project activities were planned on a phased basis beginning with construction and training and followed by village level promotion and operations.

Results: Early management problems, largely related to a too-ambitious scale, were overcome and evaluations in 1982 indicated considerable progress. Over 90% of the villagers were using the health huts, which contributed to a significant decline in the demand for more expensive basic care at the health post. Villages demonstrated a willingness and ability to manage the collection of funds and the procurement and distribution of stock, and over 58% of the health huts were surviving financially. The record-keeping system at the health huts collected data on utilization, drug sales, and vital events. Training programs were extended to 576 CHWs, 378 village health committees, and more than 100 MOH and "Promotion Humaine" staff. At least 63% of the health post nurses were making supervisory visits to CHWs in the village twice a month.

On the negative side, greater emphasis on preventive and promotive health efforts was needed. The recurrent costs of program supervision were high and had not been assumed by the involved local communities. Project management had not been fully integrated into the existing regional MOH structure, resulting in an inefficient use of MOH staff resources. Project incentive payments to departmental MOH personnel added an unnecessary costly element to the project which could not be assumed by the GOS.

References

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SIERRA LEONE

Family Welfare Education and Counselling Project

Time and Place: 1978 onward, Freetown

Institutions: Sierra Leone Home Economics Association; Family Planning International Assistance.

Objectives: The primary objective when the project was initiated was to prevent adolescent pregnancies which were causing many young women to leave school. Provision of information and counseling services for youth continues to be the main objective, but older men and women are also reached.

Interventions: Initially the project provided only information and counseling, but soon expanded to include distribution of condoms and foam. Youth in and out of school are reached by trained fieldworkers who visit schools, markets, and church meetings. They also conduct radio programs and weekend groups, and operate a telephone hotline. Contraceptives are distributed at gasoline stations, football associations, and other social meeting places (75% of the acceptors are male). When home visiting, fieldworkers also counsel on nutrition, child care, and home management.

Results: From December 1978 to October 1982, more than 63,000 people were counseled on family planning; about 68% were youths. More than 18,000 new acceptors and 14,000 continuing clients were provided with contraceptives.

References

Family Planning International Assistance. Annual Report 1983 (Africa Region). New York: Family Planning International Assistance, n.d.

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SUDAN

The Sudan Community-Based Family Health Project

Time and place: Original project: February, 1980 - April, 1983; Expanded project: May, 1983 - October, 1985. 137 villages along both banks of the Nile River in rural areas north of Khartoum. Target population 130,000 (total for both projects).

Institutions: Department of Community Medicine, Faculty of Medicine, University of Khartoum with technical assistance from Center for Population and Family Health, Columbia University. Financial support from USAID.

Objectives: To demonstrate and test how integrated MCH/FP services could be provided at the village level. The expanded project was designed to test the replicability of the project in the existing health system by regional, provincial, and local health personnel with limited available resources.

Intervention: Village midwives were selected to introduce a limited number of health interventions to the community. Three of the interventions (oral rehydration therapy, birth spacing, and nutrition education) were phased in over successive rounds of household visits. Each household visit was linked with a mass immunization effort. Training consisted of a two week course followed by short refresher courses preceding each round of household visits. In addition to the 103 village midwives, 50 other local health personnel, including medical assistants, nurses and community health workers were trained in these basic MCH/FP services.

Rationale: Although Sudan was committed to provide PHC, most village level PHC workers are male and strongly biased toward curative medicine. When it was observed that these workers provided limited MCH and Family planning services, the decision was made to test the Feasibility of training the existing government midwives to provide selected MCH and Family planning services.

Research Design: Baseline and one-year follow-up survey. For the baseline survey a sample of 2112 eligible women was drawn from a list of all households in the project area. A similar procedure was used to select 2420 women for the follow-up survey.

Results: Government village midwives, largely illiterate, were effectively trained to deliver a package of MCH/FP services to people in their own communities. Before the project began, it was generally assumed that only physicians could provide family planning services. Training courses markedly improved the understanding of proper nutritional practices and knowledge of contraceptives among the midwives.

The personal characteristics of the midwives in combination with the household delivery system proved to be an effective strategy for achieving high coverage rates, particularly in the more remote, hard-to-reach areas. Approximately 65 % of women interviewed along the less developed west bank reported discussing family planning with the project midwives and 57 % on the more developed east bank.

Despite the religious conservatism and traditional values of these communities, provision of family planning services was shown to be quite acceptable. Negative attitudes towards modern contraception changed and general knowledge of family planning methods improved. In the baseline study 27.5 % of women reported that they were not using contraception because it was against their religion, it was harmful, or their family forbade them to use it. This proportion decreased to 14.4 % in the follow-up survey.

Overall contraceptive prevalence increased from 10.6 to 13.9 % over one year, but with interesting differences among sub-groups. Increases were particularly high in the less accessible areas; for example in the more remote areas along unpaved roads on the west bank of the Nile, contraceptive use increased from 4.8 to 11.2 %. Little increase occurred in villages closer to Khartoum (located on paved roads on the east bank of the Nile); current use there increased only from 17.6 to 18.6 %. Increases in contraceptive use were also slightly greater among women with pre- or elementary schooling than among those who never attended school. Furthermore, women who discussed family planning with the project midwife were 1.7 times as likely to contracept than women who did not. This pattern supports the effectiveness of using a local agent who can sensitively introduce services and it demonstrates the presence of unmet demand for family planning even in remote rural areas.

Field observations and results from a mini-survey conducted after two rounds of household visits indicated that the phasing in of a variety of services was a workable means of overcoming the overloading and confusion that can result where too many services are introduced at once.

To encourage community participation, meetings with local councils before activities began was found to be an effective way of introducing the project to the villagers. More time should have been allowed however for involvement of the villagers in the project planning process, and improvements are expected in the expanded project.

The oral rehydration therapy component of the project was a particular success, as maternal knowledge and use of ORT in treating diarrhea increased dramatically. Data from the follow-up survey indicated that 97 % of women interviewed recognized the ORT package and 93 % knew how to mix the solution correctly. Three-fourths of the women with diarrheal children

used ORS as a treatment. At the time of the interview, over half of the women had ORS packets in the house. The other two components were somewhat less successful. Although immunization rates increased, the mass campaign approach experienced logistical difficulties, and the nutrition component did not produce marked behavioral changes.

References

Center for Population and Family Health, (CPFH), Columbia University. "Lessons Learned in the Sudan Community Based Family Health Project", from project files with permission from Dr. Don Lauro, 1984.

Center for Population and Family Health, (CPFH), Columbia University. "Sudan Project Summary", from project files with permission from Dr. Don Lauro, 1983.

SWAZILAND

Temnodeni

Time and Place: October 1980-- , cities of Manzini and Mbabane

Institutions: Family Life Association of Swaziland; Family Planning International Assistance

Objectives: Initially, the objective was to provide family planning IEC and referral; later it was also to meet the demand for non-clinical contraceptive services.

Interventions: Family planning information and services were given by an agency that provides a wide range of social, psychological, and legal services to families in need. Activities included family life education, radio broadcasts, lectures in schools, church organizations, and government departments. Educational materials have been developed and distributed and local leaders and teachers were trained in family life education. The agency also works on the national level to organize family life education talks, workshops, and training sessions.

Results: The major result of this project appears to be the dissemination of information about and generation of support for family planning on the local and national levels along with service delivery. Local community participation and the wide range of other services offered by the agency have been notable elements in its success in attracting acceptors. From 7/83 to 2/84, more than 2,000 new and more than 800 continuing family planning clients were served. About 1000 were counseled on family planning.

References:

Family Planning International Assistance (FPIA). **Annual Report 1983 (Africa Region)**. New York: FPIA, n.d.

"Project Description and Budget", From project files with permission from FPIA, 1984.

TANZANIA

JUWATA MCH/FP Project

Time and Place: 1980---, Dar es Salaam

Institutions: Jumiya ya Wafanyakazi wa Tanzania (JUWATA) trade union; Family Planning International Assistance.

Objectives: To assist the trade union to provide MCH/FP services for its membership (nationwide membership is more than 305,000 workers).

Interventions: A family planning clinic was set up at Ilala, a densely populated area of Dar es Salaam. Five nurses were trained to provide FP/IEC services. Family planning was promoted by articles in newspapers and through health education materials for the workers.

Results: By 1983, 1,450 new and 2,137 continuing family planning clients were served; 570 women and 576 children received MCH services.

Reference:

Family Planning International Assistance (FPIA). Annual Report 1983 (Africa Region). New York: FPIA n.d.

----- . "Project Description and Budget," from project files with permission from FPIA, 1984.

Maasai Health Services Project

Time and place: 1981 - June 1984. Arusha region of northern Tanzania. Target population between 55,000 and 200,000. The former figure represents those within a five mile radius of dispensaries and the latter those within 20 miles.

Institutions: Center for Population and Family Health (CPFH) of Columbia University in cooperation with Evangelical Lutheran Church in Tanzania (ELCT). Financial support from Lutheran World Federation and USAID.

Objectives: To evaluate and strengthen Maternal and Child Health/Family Planning (MCH/FP) activity in the Maasai Health Services Project, a community-based primary health care program involving the training of community health workers (CHW) and MCH

aides.

Interventions: The project began with visits to individual villages for a detailed needs assessment. Subsequently, seventy-two CHW's were chosen to provide primary health services on an outreach basis. Training was provided by a team of project staff, Lutheran Synod dispensary workers, and community members. The project also involved retraining of dispensary workers in new roles of training and supervising the CHWs. Major emphasis was placed on the role of the community in managing the program.

Services were provided through seven dispensaries. Five of these served the seminomadic "pastoralist" Maasai and the other two served the "settled" people practicing farming and herding (called Waarusha). (Lifestyles differ among the people of these two areas, but they share a common language and many traditions.) A pilot project was initiated in Engasmet in 1982 before services were extended to other communities.

Research Design: (1) Community health needs were assessed using three methods: informal interviews with traditional village leaders, church leaders, teachers, TBAs, dispensary staff members, and women; analysis of proceedings from village meetings; field observations of social and economic conditions and operation of health services. (2) A pilot project was carried out to assess training needs, logistics, support of field staff, community participation, and other aspects of planning, implementation, and evaluation. (A village considered to be representative of the "pastoral" Maasai was selected for this purpose.) (3) Baseline and follow-up surveys were fielded for evaluation. (4) Pre and post training tests for each CHW training module were performed.

Results: As the project progressed, both the content and the approach of the activities were continuously modified. Some of the lessons learned with respect to community participation have been summarized as follows: "that project staff must resist the role of expert and maintain that of facilitator; that the role of the CHW must be a compromise between satisfying the felt need for curative services and the underlying need for preventive services; that the pace of the project must be in step with the communities' understanding and readiness to accept it; that the project must recognize and adapt to the differences between project sites; and that the projects which advocate change, as this one does, must invariably confront the political nature of change in a community." (Comm.Part. p 2)

The project also recognized the importance of working through the village government and elders. These individuals were very influential and well-informed about the community and held a strong sense of responsibility towards its members. It was found that frequent meetings in the community with elders, elected leaders and the general public contributed involvement in project activities.

Community involvement and support was more difficult to attain in the more urban settings than in the traditional Maasai communities.

Project administrators also learned that broad definition of health development was needed in order to respond to the felt needs of a community and to gain trust.

Although some difficulties were experienced over remuneration of CHWs, Maasai communities have demonstrated a willingness and ability to provide financial and/or in-kind support to CHWs. Even though communities agreed to provide support from the outset, it was slow in coming and led to discouragement and frustration among the workers. This issue of payment needs to be fully discussed and agreed upon early on, and a contract drawn up specifying respective CHW and community responsibilities. Training was an important component of this project and much time and effort was dedicated to it. The lessons learned from this experience are discussed elsewhere in this paper (see "Training" section).

Clinic attendance and MCH coverage improved markedly as a result of the outreach services provided by CHWs. The baseline and post-training surveys in the pilot region found that:

- MCH clinic attendance increased from 20% of mothers bringing their pre-school children irregularly to 86% of mothers attending monthly
- ORT awareness increased from 10% of women to 90%
- 87% of pre-school children were in the process of receiving the full immunization series compared to virtually no children prior to the project since those services were unavailable
- No measles deaths occurred in the pilot area after vaccination services commenced though several such deaths were reported in neighboring areas
- 75% of children under 5 had up-to-date and accurate growth charts at the end of CHW training vs. no children prior to the project
- Over half of the women interviewed had been taught about and practiced eye-washing to prevent conjunctivitis.

The project also offers some recommendations for methodology in field trials. First, the initiation of services in a pilot area was an efficient use of scarce resources and a valuable way to investigate applied research questions. The extensive time spent by staff in the field greatly enhanced their effectiveness

in training and organizing community participation. It was also demonstrated that large-scale and sample surveys are possible among the semi-nomadic Maasai people. The smaller surveys and service statistics if analyzed rapidly can provide valuable feedback to project administrators. Focus groups were also a valuable tool and women were found to be quite open in discussing topics related to family planning and child spacing.

Results from the final project survey are not yet available, and quantitative measures of project impact are still pending.

Finally, the project staff concluded that traditional practices of birth spacing may be destroyed by modernization. Restraint is needed in introducing foreign elements to Maasai life style, and caution is advised against inducing changes too rapidly.

References

Center for Population and Family Health "Project Description. Maasai Health Services, Tanzania," with permission from Dr. Don Lauro, 1984.

Center for Population and Family Health "Community Participation in Health Programs: Experiences from the Maasai Health Services Project, Tanzania, unpublished, 1984.

Center for Population and Family health. "Lessons Learned Maasai Health Services Project. Tanzania." Unpublished, 1984.

ELCT Synod in Arusha Region, 1983. "Maasai Health Services Project. Phase I: Planning Preparation and Initiation." unpublished, 1983.

ZAIRE

Le Programme d'Education Familiale (PRODEF) in Bas, Zaire

Time and place: Late 1980 to present. Region of Bas, Zaire. This includes the city of Matadi, with a target population of 133,000, and the neighboring rural zone of Songololo, with a target population of 25,000 living in 53 villages.

Institutions: The Communauté Baptiste du Zaire Ouest (Baptist Community of West Zaire) in collaboration with Tulane University, with funding from AID.

Objective: To try a program of community-based distribution of contraception, specifically household distribution, in a Francophone area, among both rural and urban populations with low contraceptive prevalence. Carried out in combination with the delivery of drugs to combat malaria, intestinal parasites, and dehydration from diarrhea among children below age five. The setting is one of high infant mortality and pro-natalist attitudes.

Interventions: Two alternative strategies were tested for increasing the use of contraceptives and drugs. Both used readily accessible resupply outlets, but one (Treatment A) added home visits to educate mothers about the products and to distribute contraceptives, as well as group meetings to increase community awareness and knowledge regarding child health and family planning. The other strategy (Treatment B) had no outreach activities, and consisted only of stocking and resupplying service outlets with contraceptives and drugs for children under five. The urban program was family planning only, whereas in the rural program family planning was integrated with the three interventions for children under five as mentioned: anti-malarial drugs, anti-helminthic drugs, and Oralyte. Three household visits were made by the "community based distributors" (called matrones) in rural communities lacking dispensaries. Husbands were encouraged to be present. After discussing benefits of child spacing and explaining the different methods the matrone offered a free limited supply of one of the methods (pill, foam, vaginal tablet, or condom), with a coupon for resupply for acceptors.

Research Design: Baseline survey and service statistics. A follow-up survey in the rural area, conducted in July-November, 1983, with data now under analysis. In the urban area a follow-up survey started in January, 1984 with completion expected by April, 1984. Service statistics included the volume of sales of contraceptives and drugs distributed through the different service outlets over time, with conversion to CYP for contraceptives. Data were also collected by home visitors during each of the three rounds.

Results: Service statistics obtained during home visits indicate that only about 43 % of urban women and 56 % of rural women were reached during the first visit. Among the eligible women visited during the first round, 37 % in urban and 25 % in rural areas obtained a free supply of contraceptives. The second and third rounds resulted in a substantial number of additional new users in both urban and rural areas.

Information was obtained to assess whether women who accepted contraceptives actually used them. (Because of inconsistency in the rural data only urban data were reported). "Of the 1261 women who had obtained a method in the first round and were revisited in the second round four to six months later 83 % indicated that they had used the method" (Bertrand, Mangani, and Mansilu, 1984, p. 24). Continuation, as measured during the second visit, was not impressive. Overall, 51 % of first round acceptors reported at the second visit that they were still using the method. This was somewhat higher among users of pills (57 %) and vaginal tablets (50 %) than for condoms (47 %) and foam (42 %).

The main reason for not using the contraceptive method obtained at the first round was that the woman had become pregnant. The second reason most frequently reported was that women did not know where to get resupplied. Another important reason for discontinuation was fear of side effects (especially in urban areas). Other reasons included: desire for another pregnancy, husband's opposition or absence, unfavorable attitude of the woman herself.

In urban areas the most popular methods were vaginal tablets (selected by 39 %) and the pill (35 %). The proportion of pill users increased in the second and third rounds, probably due to a change in project policy which held that the pill no longer need be restricted to non-lactating women. In rural areas the vaginal tablets were not available in the first round of home visits and 54 % chose foam, 23 % condom, and 17 % the pill.

Some of the more important conclusions drawn from this project about the feasibility of the community-based distribution approach in Sub-Saharan Africa are summarized below (from Bertrand, Mangani, and Mansilu, 1984).

- "The household distribution of contraceptives is acceptable in this population, provided that certain cultural norms are respected." Acceptability was enhanced by the following factors
 - a) Director of program is a public health physician well known and respected by rural population
 - b) Respect for conventional channels of authority

- c) Special consideration was given to social norms governing male-female relationships. Home visitors distributed contraceptives only if the husband was present or gave his written consent.
- "The promotion of family planning services is facilitated if they are integrated with child services, but this does not seem to be essential in urban areas." It was easier to build rapport with women by talking about health of children before introducing subject of family planning. However, in urban areas where the program was family planning alone it was not a problem.
 - "Emphasis in family planning should be placed on child spacing, not family limitation." There is wide-spread recognition of importance of child-spacing in traditional societies in Sub-Saharan Africa. Practice of post-partum abstinence is widespread. With modernization this is no longer acceptable to some. Therefore the concept of child spacing is appropriate but family limitation is a concept still inappropriate in pronatalist society.
 - "In an area where there is a scarcity of trained health personnel, the use of paraprofessionals to distribute contraceptives is acceptable to community officials and the general population."
 - "Household distribution of contraceptives achieves levels of awareness and initiation of use that would take much longer to achieve if the methods were simply made available in service outlets."
 - "Spermicides are more popular in this population than would be expected from experiences in other regions from the developing world." One reason is that lactating women are a prime target group. Vaginal methods appear to be culturally acceptable.
 - "A coupon system for encouraging resupply at an existing service outlet yields mixed results. In urban areas 54% women who took contraceptives during first home visit redeemed their coupon. In rural areas 80% of women did not redeem their coupon."

References

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EGYPT

Shanawan Area Household Distribution Project

Time and place: November, 1974 - November, 1975. Shanawan village of Menoufia Governorate. Target population: 14,000.

Institutions: Social Science Research Centre, American University in Cairo, with funding assistance from US D HEW., Ford Foundation and USAID.

Objectives: To develop a system that is "safe, cost effective, and reliable for distributing contraceptives in the rural areas of Egypt."

Interventions: Villagers were trained to carry out household visits in a one-year period. During the first two visits women were informed about family planning and offered oral contraceptives. During the third women were informed that pills would be available at the family planning clinic and out the home of a village distributor.

Results: Contraceptive prevalence, was increased from 18% to 31%; much credit for this was attributed to the personality of the village distributors and support of the village leaders. However, despite extensive instruction, 30% of users were taking the pills incorrectly and many were not going to the clinic for help over side effects.

Factors which may have contributed to change in attitudes toward family size included decline in infant mortality, increased opportunity for work in nearby factories, education for girls, pressure on available land, electric light and television.

Constraints on extending the project include opposition to distribution of contraceptives by non-medical personnel and lack of cooperation between officials and local community leaders.

Reference

Rowley, J. "Lessons for all to See." People 4(1):9-16, 1977.

Menoufia Gouvernorate Household Distribution Project

Time and place: February, 1977 - November, 1977, two counties in Menoufia Gouvernorate in rural Egypt: Tala and Shebin El Kom. Target population: 21,743 couples (200,000 total population).

Institutions: Social Science Research Centre of the American University in Cairo, with funding assistance from USAID.

Objectives: To test a short term household contraceptive distribution system, on the hypothesis that a major increase in contraceptive use could be realized without accelerating the existing socio-economic changes.

Research Design: Pre- and post-intervention surveys were conducted nine months apart. No control group. Experimental variation to test free vs. charge resupply.

Intervention: In February, 1977 canvassers interviewed 21,743 women who were married, fecund, and aged 15-44. At the conclusion of the interview eligible women were offered four cycles of oral contraceptives at no cost. Those accepting were instructed in how to use the pills, possible side effects, and when they should consult health unit personnel. Women who did not accept pills were told where they could obtain them if they changed their minds and where they could obtain other locally available methods.

House-to-house visiting was done first with the intention of making contraceptive information and methods available to the population. The primary source of resupply was the existing rural health units, supplemented by some village resupply depots. All women were told how the resupply system worked in their own community.

The study also tested the effect of charging for contraceptives as compared with free distribution. During the initial household visit all cycles were free. For resupply, however, half the population was charged EL 0.05 per cycle. (This division was made on an areal basis.) During the follow-up survey in November, 96.5% (20,988) of the women were simply reinterviewed, without offering any supplies.

Results: An increase in contraceptive prevalence from 19.1% to 27.7% occurred between February and November, 1977. In rural Egypt, contraceptive users are typically older and of higher parity. However, the program significantly increased contraceptive use among low parity women. In the 8 months after the initial household canvass, contraceptive use among women with one or two living children increased from 9.2% to 15.3%.

Thirty-seven per cent of all eligible women in the study refused contraceptives during the first visit, 8 % of them, however, had changed their mind and were using by November.

Essentially no difference in contraceptive prevalence was found between a group that was charged for pills and one that was not.

The community-based distribution helped the clinics to become more active: percentage of all oral contraceptive users receiving their supplies from clinics increased from 50% to 69% after the intervention.

"The delivery system was culturally, logistically and administratively feasible." As a result of the experience gained in this project, expansion of this delivery system was planned to cover the entire rural population of 1.4 million. Proposed modifications to the system included: 1) increasing the range of family planning methods, and 2) integrating the family planning activities with a health and nutrition component.

Remarks: The authors note that the impact of the household distribution system may be limited and very short-lived because the distribution took place over such a short period of time and personal exposure to the system was very short (Gadalla, et al., 1980).

During the time of the distribution a sizable percentage of the population was not in immediate need of family planning due to pregnancy, lactation, and less than 3 months post-partum, as well as pre-existing contraceptive use. Short term assessment of response to household distribution should take into consideration those women who are temporarily not at risk of accepting. Long-term assessment should include such groups.

Reference

Gadalla, S., N. Nossier, and D.G. Gillespie. "Household Distribution of Contraceptives in Rural Egypt." *Studies in Family Planning* 11 (3):105-113, March, 1980.

The Menoufia Integrated Social Services Delivery Systems Project

Time and place: September, 1978 -; 303 villages in Menoufia Governorate, target population 1.5 million.

Institution: Social Science Research Center of the American

University in Cairo; funding support from USAID.

Objective: To promote family planning, health, and social welfare services through an integrated developmental approach.

Interventions: Three types of services were implemented:

- 1) family planning through household distribution and clinic resupply (pill and foam distribution, referrals for IUD).
- 2) health measures including distribution of oral rehydration salts (ORS) also with clinic resupply, and
- 3) social welfare measures consisting of community development activities.

In addition, there were training programs for official personnel in health and social welfare sectors, and for community leaders. Rural health facilities were also upgraded and social activities were promoted in the communities.

Research Design: Interventions were phased in over a three year period in all "treatment" villages. Evaluation through a baseline and a one-year follow-up survey, both were in the same stratified sample of villages. For purposes of the survey, villages from first-year counties were stratified as follows:

- 1) Villages with both health and social welfare units.
- 2) Villages with health units only.
- 3) Villages with neither health nor social welfare units.

A comparable set of "control" villages were also selected from third year counties (where intervention had not yet taken place).

Results: Preliminary results from the one-year follow-up survey indicate that the major achievement of the project was in improving the effective knowledge and correct use of contraceptives and oral rehydration salts. The increases in contraceptive prevalence, and use of oral rehydration salts although they reached statistical significance ($p < .05$) were very small. Villages in stratum 1 attained higher prevalence than those in strata 2 and 3 (from 22.7% of all women to 25.1%) and also experienced a slight decline in overall pregnancy rate from 19.1% to 17.6% (denominator not clear). Of the three methods promoted (pills, foam, and IUD) pills were the most popular. The use of health services remained unchanged over the one year period examined.

Reference

Nosseir, N. "The Short-Term Effects of an Action Program, Menoufia, Egypt." Paper presented at Population Association of America Meeting, San Diego, California, April 29- May 1, 1982.

Family Planning Service Delivery In Egypt

Time and place: 1975-1977 in two Egyptian governorates. 60 health units in Cairo governorate and 40 health units in Qualubiya governorate.

Institution: Egyptian national program, both public and private facilities.

Note: This study is somewhat different from a localized intervention accompanied by data bearing on how well it worked. The intervention here is the regular program, and the analysis focuses on process more than on outcomes. This can yield valuable information for program guidance, by exposing some of the "why's" behind mediocre performance.

Objective: To identify delivery system factors associated with low participation and high discontinuation.

Research Design: A systematic random sample of 100 out of 276 health units delivering family planning services, including also private family planning clinics, were selected for evaluation through analysis of unit records and interviews with family planning service staff members. A random sample of new and continuing clients was interviewed. (No dropouts were interviewed.)

Results:

- Availability and capability of manpower:

Although the number of staff per unit was high, the actual number involved in family planning service provision was only 3 per unit. Administrators indicated that absenteeism was high and physicians were overburdened with tasks that could easily be relegated to paramedical personnel. The amount of time spent on family planning service (6 hrs. per week) by each staff member was not enough to provide one-to-one patient education at the clinic nor to implement a comprehensive outreach program. Training of personnel consisted mostly of what they learned on the job.

- Availability and accessibility of family planning services:

Because units were only open in afternoons (in 65% of cases) actual accessibility was decreased. Units seemed to be fairly well distributed (1 to 3 km from target population) but the long waiting time was not utilized by clinic staff for education or motivation of clients.

- Choice and availability of contraceptive methods:

The range of available methods was narrow. Analysis showed 23 units offered only one method while 11 units offered no method. Oral contraceptives were the most widely used method. This appeared to be an inappropriate choice considering the health status of target population. Malnutrition, anemia, liver problems, cardiovascular disease and lactation are all highly prevalent among these women and are all conditions contraindicated for pill use. Complaints about side effects contributed to high rates of discontinuation.

- Insufficient recruitment, motivation and follow-up:

Data indicate that it was still basically a clinic-only program lacking family planning educational and communication outreach activities. There was also a lack of good client records and consequently data on dropouts, reasons for discontinuation and follow-up were not available.

Recommendations: The author suggests the following to improve the deficiencies described above:

1. Establishment of outreach and communication activities at all units to attract the less highly motivated, to motivate new family planning acceptors to continue, and to re-enlist those who dropped out.
2. Provision of a broader range of contraceptive methods so that potential acceptors will not be lost to the program because of a lack of choice.
3. Increasing the number of family planning personnel and training more personnel in IUD insertion and follow-up and in client-oriented barrier method service provision.
4. Improving the management of the delivery system, including establishment of unit-level acceptor target and evaluation procedures and facilitating regular dispatch of contraceptive supplies from regional centers to individual units."

The author emphasizes that after 1976 Egyptian policymakers and administrators took measures to increase contraceptive supplies and train medical personnel in IUD insertion. They also implemented communication campaigns stressing community involvement and clinic outreach.

Reference

Hassouna, Mary Taylor. "Assessment of Family Planning Service Delivery in Egypt," Studies in Family Planning 11(5): 159-166, 1980.

Social Marketing Project of Greater Cairo

Time and place: June, 1979 onward. Greater Cairo (includes 25 percent of total population of Egypt)

Objective: To increase the knowledge and practice of family planning through mass media advertising for family planning, in general, and specific branded products, in particular; to sell these family planning methods in a variety of retail outlets.

Institutions: International Planned Parenthood Federation and the Egyptian Family Planning Association.

Research Design: A comprehensive evaluation component was planned which included shelf-auditing for measuring sales, retail outlet analysis, consumer profile survey, measurement of mass media impact and effectiveness, distribution survey and contraceptive prevalence survey. The results were to be used in management decision-making, and future marketing plans and strategies.

Interventions: The target groups were defined on the basis of a market survey. The primary target group consisted of eligible men and women living in peri-urban and slum areas of Greater Cairo with limited income. A second target was made up of a similar group only receiving a relatively higher income.

A mass media advertising campaign was planned to promote the products. Again using a survey to measure the impact of various media, it was determined that television and radio, followed by newspaper and cinema would be the most influential channels through which to launch this campaign.

The consumer profile survey findings were also used to prepare the most "creative" message for use in advertising. The project planned to measure the impact and effectiveness of various media and messages and for making changes and improvements.

A public relations campaign was designed, including special events, TV and radio discussions, newspaper articles, etc., to increase awareness of the project and its objectives and obtaining support from local leaders.

Pricing, packaging and brand-names were based on findings from consumer surveys.

The product mix was carefully planned to complement the existing range of available products. The methods selected were oral contraceptives, condoms, foam and copper-T IUDs.

The distribution channels were selected so as to ensure the greatest improvement in accessibility and availability of the methods and the most cost-effective means of distribution. Pharmacies, perfumeries, doctors were determined to be the best distribution points. Other outlets such as consumer cooperatives, kiosks, barber shops, etc. were also considered as possible additions later in the project period.

Results: (We were not able to locate any published results of the project).

Reference

Kaussari, S., 1979. "Design and Development of a Social Marketing Project for Greater Cairo," London, International Planned Parenthood Federation, p. 16.

Population and Development Program (PDP)

Time and Place: 1976 onward. By 1980 the PDP covered rural areas in 12 governorates: 2848 villages and about 14 million people (70% of Egypt's rural population).

Institutions: Egyptian Population and Family Planning Board (EPFPB) with technical assistance from Cornell University's International Population Program and funds from UNFPA. The Egyptian Contraceptive Prevalence Survey (ECPS) by EPFPB in collaboration with Westinghouse Health Systems was funded by USAID.

Objectives: Increase in contraceptive use and reduction in birth rate; other population related objectives through an overall development program. In addition to promoting family planning, the program was designed to increase the pace of local socio-economic development and upgrade local management capabilities.

Research Design: No pretest. Complex interventions. Evaluation was based on the results of the 1980 Egyptian Contraceptive Prevalence Survey (ECPS); data from villages without PDP intervention were compared with villages exposed to PDP for less than two years and for two or more years. The analysis was done separately for Upper and Lower Egypt since the two areas are generally considered to be socially, economically and culturally different.

Interventions: The program consists on the one hand of female extension workers (called Raiyda's) who carry out home visits to promote contraceptive use, and on the other hand, of a variety of economically and socially productive village-level projects in such areas as agriculture, transportation, and cottage industry. These projects use loans in particular to encourage participation, to raise village morale, and to provide concrete benefits.

Results: Although the PDP had no significant effect on fertility rates, it did have some impact on family planning knowledge, attitudes and practice (KAP), particularly in Upper Egypt. Differences between program and non-program villagers were not due to confounding social, economic or demographic factors, so far as this study could measure. Use levels were roughly 35(?) % higher in PDP than in non-PDP areas. Program effects were largest in Upper Egypt where attitudes were especially conservative and knowledge of family planning particularly deficient. In Lower Egypt the program effects were usually in the expected direction but were smaller and often not large enough to reach statistical significance.

The influence of duration of the PDP project upon the attitudinal and behavioral measures was also examined. Approval of family planning and smaller family size preferences, as well as contraceptive knowledge and use were positively related to duration of program activity in Upper Egypt. However, none of these variables were influenced by duration of PDP activities in Lower Egypt. CPS data suggest the extension workers played a relatively minimal role. In Upper Egypt, only 15 % of all women in PDP villages reported that they were aware of the Raiyda's presence and only 8 % of all women had met her; of those who had only 20 % actually received contraceptive supplies. In Lower Egypt, the Raiydas were somewhat more active, but other research suggested that the population each was to cover (3000 women) was too large, and training, incentives, and supervision needed improvement.

With respect to the awareness of PDP activities in their village, only 12 % of women in PDP villages in Upper Egypt and 16 % in Lower Egypt had ever heard of committees related to family planning.

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Planning in Rural Egypt 1980. A Report on the Results of the Egypt Contraceptive Prevalence Survey." Population and Family Planning Board, Westinghouse Health Systems, pp. 159-177. December 1982.

Khalifa, A. and A. Way. "An Evaluation of the Impact of the Population and Development Program (PDP), Based on Data from the 1980 Contraceptive Prevalence Survey" Paper presented at an international donor's meeting in Cairo, Egypt in April, 1981.

MOROCCO

Marrakech Household Distribution Experiment (VDMS)

Time and place: Marrakech Province, 1977-1980. Expanded (see below) to 13 provinces containing about 40% of Morocco's population.

Institutions: Ministry of Public Health, Morocco; USAID; International Fertility Research Program (IFRP) (now Family Health International).

Objective: To test a system of household distribution of contraceptive supplies and information, with community-based resupply, toward a rise in contraceptive prevalence and a fall in desired family size and fertility.

Research Design: Experimental group only. Two visits three to five months apart, to over 150,000 households. At both visits the purpose was to (a) gather information on fertility and contraceptive use and (b) offer contraceptive information, supply, and referral.

Interventions: Existing public health personnel, from several levels, were trained to visit homes, interview the residents, and offer contraceptive supply. Prior contacts were made with local religious and political leaders before household visits began.

A first round of home visits tested the feasibility of obtaining information on fertility and contraceptive use and of offering contraceptives (four cycles of the pill or supply of condoms; referral coupon for the IUD). The second round 3 to 5 months later gave further tests: of the acceptability of the home supply system; of the feasibility of community-based resupply for the future; and of an effort to encourage previous non-acceptors to initiate use.

The resupply points used were local dispensaries. Each acceptor at the second visit was given a card that could be presented at any dispensary for additional supplies.

Approximately 150,000 households were visited, 38% of them in Marrakech city and 62% in the rural areas of the province. One purpose of such a large scale operation was to determine the feasibility of extending this type of system to additional provinces.

In the urban sector, 86 workers were chosen from among nursing personnel, including 50 women and 36 men. Eighty-eight rural workers of a similar training level were chosen from among personnel employed at rural dispensaries. These workers were accustomed to going out among rural households for a variety of

health duties related to tuberculosis and malaria patient follow up, immunization, recording of vital events, and health instruction. They continued some of these activities while they were primarily assigned to the VDMS project.

Regarding supervision, the regular structure of the provincial health system was used. For example, in the first phase 86 fieldworkers reported to 18 section chiefs, who reported to seven superiors, who reported to a single official and the accompanying top leadership of the province. These ratios were favorable ones and the system worked well for the project.

Results: This program was essentially successful in all major respects: it not only proved acceptable to the population at large, but it obtained encouraging specific outcomes. Sixty percent of the women offered pills at the initial visit accepted them (urban: 67%, rural: 56%). Among women already using pills, ninety-three percent were willing to accept additional pill supplies from the distributor at the initial visit, indicating at least that the home visit was inoffensive. Low parity urban women accepted pills at a high rate (68% among those with one or two births); 43% of comparable rural women did so. Regarding spacing, 55% of urban women desiring more children accepted pills; 32% of comparable rural women did so.

"Acceptance" of supplies offered at the doorstep can of course mean little, and much depends upon continuation and prevalence measures, even if crude. At the second visit, approximately four months later, 90% of urban pill acceptors at the first visit said they were continuing to use them (80% rural). Among over 100,000 women visited twice, prevalence inquiries produced the following:

Percent Using Contraception

	<u>At first Visit</u>	<u>At Second Visit</u>
Marrakech City		
Pill	36	54
All Methods	49	65
Rural Sector		
Pill	8	37
All Methods	11	45

Note: Condoms and IUD's, the other two methods offered in the program, were each used by less than 2% of the women visited twice.

The second visit was useful, producing a substantial number of additional acceptors and helping to motivate earlier acceptors, thus probably improving continuation.

Two further results were significant. (1) The sex of the worker/interviewer was not an important variable: males did as well as females, a surprising result. (2) Concerning future resupply, three-fourths of urban women said they would like to obtain further supply through a local dispensary, whereas only one-fourth preferred continuing to receive it from a household visitor. Rural women preferred the reverse, with two-thirds wanting resupply through household visits and only one-third at dispensaries. This may reflect the greater distances to dispensaries in rural areas.

Cost-effectiveness was judged favorably in this project. A large factor in this was the use of the standing personnel of the health ministry who in rural areas were already involved in regular visits to the villager. There is of course a real cost when additional duties are assigned to current personnel in terms of opportunity costs, through interference with pre-existing responsibilities, unless the personnel were under-utilized. Even where they are busy however it may be decided that benefits to the population will be enhanced by a shift to alternative functions. In the expanded project (below) a combination of health and family planning duties was used.

References

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VDMS Expanded Project (To 13 Provinces)

Time and Place: 1982 (3 provinces), 1983 (10 provinces) --

Institution: Government of Morocco, funding support from USAID.

Objective: To implement on a large scale household distribution backed by local dispensaries.

Research Design: No control group. Monitoring over time through service statistics and partial survey information (to be confirmed).

Intervention: Itinerant nurses make five visits annually to homes, offering: orals and condoms, with referral for IUD and sterilization; ORT; referral for immunization; iron folates; weaning food. Nurses in local dispensaries give back up.

Results: The 13 provinces include 40 % of Morocco's population, and public acceptance has appeared to be good as the program has expanded. Intermediate activities have been impressive: 2300 itinerants trained, 800 mopeds delivered, 455 dispensaries/health centers included. In the 3 provinces that started first, preliminary estimates are that prevalence rose from approximately 25% to 40-50% (depending on the province) over the first year.

Remarks: This important project suggests that household distribution in a conservative Moslem setting can work, using the established health infrastructure with adaptations to extend outreach.

Reference

"Project Evaluation Summary" for USAID assistance to the Government of Morocco, January 1984 (need permission to cite).

TUNISIA

Political Party¹

Time and place: Initiated November 30, 1965, in two rural provinces.

Institution: Destourian political party.

Objective: To test whether the party's support would augment the practice of family planning.

Research design: Pretest.

Intervention: In the province of Beja a family planning team made periodic visits to rural areas. The Destourian party coordinated the publicity, and meetings were run by local party leaders to discuss family planning and to announce the impending visit of the team. In another province, Le Kef, clients were transported from rural areas to the central regional hospital in government vehicles. The support from the Destourian party was similar to that in Beja.

Results: The number of IUD insertions increased tremendously in both provinces, much more than in Tunisia as a whole. Acceptance in rural areas was excellent, indicating that the support of the political party was helpful.

Problems/remarks: This experiment was notable for the time it took place because it stressed the national rather than the personal benefits to be derived from adopting family planning.

Comment: This trial is one in which the principal political party lent its name to family planning work in rural areas, coordinating publicity and running meetings by local party leaders. The point of interest is that, apart from the various ways in which information and services can be delivered to a population, the signals they get from respected leaders and powerful institutions around them can have significant effects, both in producing normative change and in stimulating actual response to programs.

Reference

Population Council, "Tunisia: The Role of the Political Party". *Studies in Family Planning* 13:5-6, August 1966.

(Above text taken from Roberto Cuca and Catherine S. Pierce, *Experiments in Family Planning: Lessons From the Developing World*. Baltimore Johns Hopkins Press (for the World Bank) 1977, pp. 232-233).

Tunisian Contraceptive Retail Sales Project

Time and place: 1976-1978

Institution: Syntex Laboratories, Inc. and the Office National du Planning Familial et de la Population (ONFPF) within the Ministry of Health of Tunisia. Funding from USAID.

Objectives: To increase the availability of oral contraceptives and condoms through retail shops and to promote their sale through public advertising.

Interventions: The activities originally planned for this CRS project can be summarized in three main categories: information, distribution and economics.

a. **Information:** The plan was to disseminate improved medical information on oral contraceptives and condoms to pharmacists, doctors and perhaps other medical personnel. In addition, the products were to be publicized directly to the consumer by advertising through mass media, point-of-purchase and other advertising methods.

b. **Distribution:** The goal was to improve the current commercial system of distribution of orals and condoms through pharmacies and to initiate distribution through general retail outlets.

c. **Economics:** The project was to establish a retail sale price affordable by the poor and sufficient enough to provide a profit incentive for all merchants along the distribution chain. The system was eventually to become economically self-sustaining.

Results: An evaluation was conducted a year after the project began. The results are summarized below.

- o The greatest progress had been made in improving the information on orals and condoms through existing medical and pharmaceutical channels. Actions included a medical seminar, detailing work with pharmacies, movement toward an improved brand name and packaging.
- o The distribution system of contraceptives through pharmacies did not work well. Pharmacies experienced delays in delivery; sometimes they did not receive what they had ordered or ran out of stock altogether.
- o There was a major controversy and little progress in publicising orals and condoms directly to the consumer. The evaluators noted that the need for good advertising was little understood and greatly feared by the ONFPF officials.

- o There was little progress as far as making orals and condoms available outside pharmacies and clinics throughout general retail outlets. The prospects of progress on this did not look good at the time of the evaluation. Some carefully controlled experiments were planned to test the public reaction to making condoms available in some retail shops and vending machines. However, the ONPFP was unanimously opposed to changing the distribution system for orals because it would require removal of the prescription requirement. The commercial sales and advertising was also strongly opposed by the medical profession and pharmacists.
- o Achieving economic self-sufficiency was also judged to be remote.

In general, the evaluation did not find the project to be operating as it had originally been conceived. This was in part attributed to the unwillingness of the ONPFP, a government organization, to let private organizations or other programs to operate independently as in a CRS project. The program was therefore constrained because the contractor could not take any action without prior approval from ONPFP. Moreover, the basic assumptions of the Syntex CRS project, that "oral contraceptives and condoms would be made available through retail shops and that their sale would be promoted by public advertising" were eventually opposed by the GOT.

The change in attitude by the GOT on the distribution of orals appears to be the result of pressure by politically powerful pharmacists and physicians. At the time of the evaluation, then, the GOT was basically not sympathetic to "the idea of a well-publicized, non-medical, non-pharmacy distribution project," despite their initial support and approval of the contract.

On the basis of these findings, the evaluators recommended that AID should renegotiate the contract with Syntex in consultation with the GOT or reduce the scope, time period, and funding, to achieve those objectives which the GOT is prepared to implement and to eliminate activities which the GOT presently opposes".

References

Altman, D.L., P.T. Piotrow, 1977. "Evaluation of Contract AID/pha-C-1143 Syntex, Tunisia. Report and Recommendations", USAID.

Family Planning for Couples in Rural Areas (Le Planning Familial Par Le Couple en Milieu Rural) (PEPC)

Time and place: 1977-1979, three districts within Jendouba governorate: Fernana, Jendouba, and Ain Draham. Population: 144,000. (MWRA 15-44: 18,727)

Institutions: Tunisian National Family Planning and Population Office; technical assistance and funding from USAID.

Objectives: To develop a cost-effective system to increase the availability and use of modern contraceptive methods in rural areas. To compare three variations of home visits, resupply methods, and service combinations.

Specifically, the project was designed to examine the following issues:

- The minimum number of family planning distributors needed to assure full coverage of the eligible population.
- The most appropriate mix of interventions.
- The effectiveness of one versus two household visits.
- The relative impact of a "family planning only" delivery system versus an "integrated" one, as regards family planning outcomes.
- The feasibility and acceptability of different contraceptive resupply mechanisms.

Research Design: Three experimental areas and three matched control areas. No pre-survey. Limited information gathered in the home visits; a one-year follow-up survey in Fernana; a 1979 contraceptive prevalence survey covering Jendouba governorate.

Interventions: Different delivery systems were introduced in each of the three districts. Initially all married women aged 15-44 in all three districts were visited and offered family planning information, as well as free supplies of contraceptives or referrals for surgical methods. In Jendouba district this was the only household visit. In Fernana, a six-month follow-up visit was made to determine contraceptive use, provide additional motivation and free resupplies, and recruit new acceptors. In Ain Draham an integrated family planning/maternal and child health (FP/MCH) household delivery system was tested. During the first round of household visits a number of health interventions were added to the family planning activities, including height and weight measurements of all pre-school children; detection of diarrhea and certain eye, skin, and parasitic diseases; advice on pre- and post-natal care; and vaccination referral. The responsibilities of the canvassers were expanded in the second round to

include distribution of Neo-Sampoon foaming tablets and packets of Oralyte oral rehydration salts to each household with pre-school children. Due to a supply shortage, however, distribution of Oralyte oral rehydration salts was limited to only two districts within the Ain Draham delegation. A special campaign in which the PFPC driver distributed condoms to interested husbands was also added during the second round of visits in this area.

A permanent contraceptive resupply system was also tested, following completion of household visits in each district. Field workers from the Preventive Health Service were asked to distribute contraceptives during their regular biweekly visits to designated meeting places in three districts. In Jendouba and Ain Draham, the acceptability and feasibility of employing social assistants from the Ministry of Social Affairs and district administrative officials (called omdas) as resupply agents were also tested.

Medical follow-up by the OB/GYN who served as project director was also established in each district. He made weekly visits to selected locations (generally schools) in each district during which he provided gynecological examinations and treatment of side effects, as well as reassurance and motivation for women using contraceptives. This program served as an additional follow-up and resupply mechanism for family planning acceptors.

Results: A total of 3078 new family planning acceptors were recruited in the 30 month period of the project. These new clients represent approximately 50 % of women at risk of pregnancy who were contacted in these three areas. The highest percentage of new PFPC acceptors, approximately 57 %, came from Fernana - the district with the lowest baseline prevalence rate. Slightly more than a fourth of the PFPC acceptors were from Jendouba where only one household visit was made and the contraceptive prevalence rate was already quite high (33 %). The lowest level of contraceptive acceptance (16 % of all PFPC acceptors) occurred in Ain Draham. This has been attributed in part to the fact that canvassers in this area had less time to spend on family planning activities because of their added responsibilities with health interventions (Maguire, et al. 1981).

The household distribution campaign sought to recruit those women who would not otherwise have adopted methods through regular program channels. In order to evaluate to what extent this had been achieved, PFPC acceptor levels were compared with regular ONPFP (National Family Planning and Population Office) acceptor levels before and after the project was initiated. For each year of the project, PFPC recruited a significant number of additional acceptors over the regular national ONPFP program. In 1977, for example, an additional 60 % were recruited by PFPC activities in the three project areas. However, in 1978 and 1979 the relative increases in number of new acceptors attributed to PFPC activities decreased to 34 and 14 % respectively.

Acceptor levels in the three districts with PFPC activities

were also compared to the three comparable "control" areas with no PFPC intervention. During 1977 and 1978, the peak activity years of the program, there were differences of over 100 % in acceptance levels between PFPC and non-PFPC districts (Maguire, et al., 1981 p. 26).

With regard to method preferences the pill was the most popular method among family planning acceptors (57 %). However, a continued strong interest in tubal ligation was also found: close to a third of all MWRAs contacted accepted a referral for tubal ligation. Method preferences also varied by district. The pill was most preferred by acceptors in Fernana and Jendouba, at 64 and 60 % respectively. In Ain Draham only 35 % of acceptors chose this method and over 50 % preferred sterilization. IUDs were more popular in Jendouba than in the other two districts. This has been attributed to easier access to clinics offering IUD insertions in this area (Maguire, et al., 1981). The distribution of Neo-Sampon and condoms in Ain Draham resulted in a higher level of acceptance of these "secondary" methods than in the other two districts.

Table 1
TRENDS IN CONTRACEPTIVE PREVALENCE,
PFPC DISTRICTS, 1977-1979

Districts	Percent Using			
	First Visit	Second Visit	Follow-up Survey	CPS
Fernana	16 ^a	28 ^b	28 ^c	23 ^c
Jendouba	33 ^c	-	-	39 ^c
Ain Draham	24 ^a	26 ^b	-	29 ^c

^aRate among currently married women aged 15-44 visited in the household canvass.

^bEstimated rate among currently married women aged 15-44 visited in the second canvass based on an assumption of 100% continuation among women already contracepting at the first canvass and the rates of use among first canvass acceptors.

^cRate among all currently married women aged 15-44 in the district.

Source: Maguire et al., 1981, p. 23.

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The greatest change in contraceptive prevalence occurred in Fernana where initial use levels were lowest (16 %). Thirty months after the initial household canvass, 23 % of all MWRAs were using family planning as measured by the survey. In Jendouba the impact of one household visit was less impressive; prevalence was already higher, and rose only from 33 to 39 % in 14 months. In Ain Draham with two household visits in 10 months, prevalence increased from 24 to 29 %. (See Table 1) After one year, the acceptance rate in Ain Draham (integrated delivery system) (69 %) was only one-third that in Fernana (family planning only) (18 %).

Moreover, these findings contradict one original hypothesis of the study: that family planning acceptance and use rates would be higher where contraceptives were offered in the context of other MCH activities (Maguire et al., 1982, p. 29).

A closer look at continuation rates suggests weaknesses in the resupply and referral systems. In Fernana, 468 women were referred for contraceptive sterilization at the time of the first household visit. Data from the second household visit, however, showed that only 30 % had actually obtained a tubal ligation. For most women the long distance to the appropriate health facility and lack of transportation appeared to have been "insurmountable barriers" to adoption of an IUD or tubal ligation as a contraceptive method (Maguire et al., 1982, p. 100).

In addition to these barriers, many women were not well-informed about where they could obtain pills, foam, and condoms after the initial household visit. "One of every five women who were not contracepting at the time of the Contraceptive Prevalence Survey (CPS) did not know where to obtain a modern family planning method. Among most users in rural areas who expressed an interest in taking the pill, two-fifths were unable to name a source for that method. In addition over half of those who knew a source considered it difficult to get there" (Maguire et al., 1981, p. 31). On average, the special resupply mechanisms lasted only one year and were no longer functioning at the time of the CPS. These results point to the need for permanent resupply points in the community, together with sustained information and education activities as well as an effective referral system if newly achieved increases in contraceptive use are to be sustained.

The PFPC proved to be a relatively low cost model as compared to other FP/MCH pilot projects in rural Tunisia. The overall cost per family planning acceptor was \$32. In Fernana, where the greatest increase in contraceptive prevalence was achieved, the cost per new acceptor was \$9 (Maguire et al., 1982). The inclusion of health interventions during the last year of the project in Ain Draham resulted in a 13-fold increase in cost per new family planning acceptor. However, even with this added expense the cost per acceptor for PFPC was two-thirds lower than the cost in PFAD, Tunisia's first contraceptive distribution experiment (Maguire et al., 1981).

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