
INITIATIVES INC. presents
**REPRODUCTIVE HEALTH
INTEGRATION ISSUES**

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Reproductive Health Integration *Issues* is a new publication of Initiatives Inc. designed to support the integration of reproductive health into the portfolios of organizations currently addressing other development concerns. In quarterly installments, *Issues* will address the complex programmatic, managerial and evaluative questions that arise in planning and implementing RH integration strategies.

Why issue *Issues*? The newsletter is a by-product of the USAID-funded SEATS Project, Reproductive Health Integration Initiative (RHII), which promotes the integration of reproductive health services into the portfolios of non-governmental community organizations (NGOs) to improve the quality, quantity, accessibility and sustainability of family planning and related health services for underserved populations. The underlying premise of RHII is that integration provides a cost-effective and efficient method of reaching women and men with the tools to help them make informed choices about their pregnancies, ensure their reproductive health and help their children to survive.

In integration workshops and discussions with implementing agencies, key questions have been raised about how, where, when, by whom and what aspects of Reproductive Health should be promoted. RH Integration *Issues* will begin an exchange addressing these issues and present successful examples of RH integration into other development sectors.

Why concentrate on NGOs? The road to sustainability: The role and magnitude of donor assistance have changed over the past decade. International and bilateral aid agencies have stressed the need for donor-funded recipients to develop strategic partnerships with indigenous organizations to foster local capacity to plan, execute and sustain development strategies. Government organizations and local NGOs, in more difficult to reach areas, are the main links to sustainable programs.

Historically NGOs have played a key role in the social and health development of the communities in which they serve. Trusted by their communities, NGOs are often able to reach people that government programs cannot due to logistical, cultural or economic restraints. Building on their community links, NGOs are in a unique position to offer these underserved populations contraceptive and reproductive health services. Ultimately RH integration is mutually beneficial to NGOs and their clients: NGO programs have greater impact and clients receive better reproductive health care.

CBD Programs: Is There a Formula? In Reproductive Health, Community Based Distribution encompasses a wide range of innovative uses of existing community networks to provide non-clinical settings for contraceptives and related health information. From village volunteers, to market women, to social marketing, to workplace programs, CBD strategies expand the reach of RH interventions.

Using community volunteers as providers of service is not a new concept. Yet organizations considering adding new responsibilities onto the volunteer's workload, as often happens in integrated service delivery, must analyze important issues: When does overload occur? Can volunteers maintain loyalty without receiving payment? In lieu of monetary incentives, what has encouraged volunteerism or longevity? Who are the most effective volunteers? How can monitoring and supervision be more effective? How do you measure effectiveness?

Responses from an array of RH specialists have revealed there are no secret recipes but a variety of means based on local conditions that help CBDs to meet the needs of their clientele. According to a study in Africa conducted by the Population Council¹ comparing CBD models, it is the consistency within a program rather than the type of CBD approach chosen that is the strongest indicator of its success. Examples of such 'mixed model' approaches that have proven to

be less successful include blending a top-down bureaucracy, e.g., local government association program, with community volunteers as distributors or diluting a market vendor approach by substituting NGOs, local government administrations, etc. as distributors instead of using the existing traditional trade organizations. Other key components of building effective programs include involving the community at the planning stage, providing quality and regular supervision sessions and timely and appropriate resupply of commodities and ensuring that the program is a part of a larger family planning service system.

Encouraging Recruitment: Strategies to encourage CBD recruitment and longevity must be in tune with community and organizational structures. Although providing a monetary incentive usually results in better performance, in countries where government policies prevent charging for contraceptives, payment to volunteers is often infeasible. Volunteers must be motivated; non-monetary incentives include special ceremonies to initiate or honor volunteers, raising their status; providing emblems, satchels, umbrellas, boots, or bicycles to identify the worker or make the job easier. Choosing community members who are going through a lifestyle change freeing them for extra work, such as those newly retired, has been successfully promoted by Pathfinder International. Recruiting CBDs from among existing volunteer, or community spirited networks, e.g., religious or political groups, with strong traditions of volunteerism has been shown to be effective in Kenya. In contrast encouraging volunteerism in a situation where all other workers are paid professionals is difficult to defend and ultimately, sustain.

Why do Women Volunteer? A 1992 study by CEDPA found that women gained non-monetary rewards from their CBD status. The training, rewards from helping other women, enhanced social status, improved family relationships, heightened impact on family decision-making, were all cited as reasons for enjoying their jobs. Remuneration increased their job satisfaction but was not the sole reason for their decision to remain agents.²

Involving the Community: Noteworthy schemes to encourage a sense of ownership on the part of the community include ensuring volunteers are community

members; encouraging community selection of volunteers; mobilizing support for in-kind contributions, such as assistance with domestic or agricultural chores to free up the worker's time for health rounds; or providing space for mobile clinics. Assisting local community organizations to plan and implement schemes rather than forcing a top down approach to strategy development builds commitment to the program.

Improving Effectiveness: Other ideas for improving the effectiveness of the work of CBD agents include: publicizing the agents and their services; providing heightened training with refresher courses on a variety of RH issues, including the ability to recognize STIs to allow hygienic recommendations or eventual referral; directing efforts toward adolescents; enlisting men as agents to reach their counterparts³; creating career ladders for CBDs. Providing adequate training to supervisory staff on both technical and communication aspects of the job and scheduling regular supervisory sessions improves CBD performance.

To increase usage of CBD services, it helps to research existing community gathering patterns and couple CBD activity at these popular sites, e.g., workplace, markets, teen centers. CBDs are found to be more useful when they provide more than just information or referrals such as offering several contraceptive method options.

Areas to explore to help with recruitment and program sustainability are limiting the term of volunteers to encourage participation and reduce volunteer burn-out; and assessing the impact of having the CBD obtain supplies directly from social marketing outlets, eliminating the need for elaborate resupply schemes and enabling the CBD to gain personal income.

In summary, there is no ideal CBD model; political, cultural, social and economic variables influence the program. Importing CBD models without regard for local conditions, such as community needs and desires; community participation; or political and administrative backing is a prescription for failure. Continual evaluation and monitoring is important to determine whether the program is effective and what areas require revising. Most importantly, CBD projects cannot stand alone; they must be part of a complete RH system, including referral and supply backup systems.

Experiences from the field: PATH's Healthy Start (HSCS) Program in Sumbawa, Indonesia integrates FP and antenatal care into its USAID-funded Child Survival Program through a team approach. Using Family Planning Program Funds to support this pilot project, *PATH's Carib Nelson* reports that ...The HSCS Program uses health workers to deliver health services to newborns, pregnant women, and postpartum women. Initial neonatal home visits are made by village midwives in the first week of the infant's life. She is teamed with a village FP worker who identifies potential acceptors and provides FP counseling while the midwife delivers FP services. PATH's program facilitates cooperation between the village health workers to extend outreach services. Using early pregnancy home visits as the initial contact, women are counseled about FP and pregnancy and urged to visit the clinic for antenatal sessions. At the clinic both the midwife and FP worker meet with the women. The midwife stresses the importance of ANC exams, TT immunization, iron supplementation and nutrition while the FP worker counsels mothers of children brought in for immunizations and prenatal women seeking antenatal care. A 6-week postpartum home visit is conducted jointly by the midwife who schedules contraceptive service meetings and FP worker who provides FP counseling. At the same time the infant is examined and the mother is encouraged to bring the infant to immunization sessions. The village team approach has been successful in reaching most 6-week postpartum mothers and recruiting about 1/3 as new acceptors. This study has helped to demonstrate the appropriateness of linking CS, MH and FP activities, activities which had been artificially separated in Indonesia's health system. The local FP department has been so impressed with the project's results that they are providing funding and expanding it to other areas. For more information contact: Carib Nelson, PATH, 11th Floor, Tifa Bldg, Jln, Kuningan Barat no 26, Jakarta 12710, Indonesia or cnelson@cbn.net.id

Resources:

Population Reports
Population Information Program
Johns Hopkins School of Public Health
111 Market Place, Suite 310, Baltimore MD 21202 USA
www.jhuccp.org

Family Health International
PO Box 13950, Research Triangle Park, NC 27709
www.fhi.org

Internet Connections

REPRO-HLTH-L is an interactive forum for discussion of reproductive health issues. To subscribe send a message to: listproc@info.usaid.gov stating only subscribe repro-hlth-l (your name).

Other links for RH information:

<http://erc.msh.org> (FP Manager's Tool)
<http://www.basics.org> (Child Survival)
<http://www.reproline.jhu.edu> (RH)

Issues welcomes contributions:

Send short articles, comments and suggestions to initiatives@worldnet.att.net or mail to: Editor, RHI Issues, Initiatives Inc. 276 Newbury Street, Boston, MA 02116

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Footnotes:

¹Phillips, J., Greene W., 1993. Community Based Distribution of Family Planning in Africa: Lessons from Operations Research Population Council Africa Operations Research & Technical Assistance Project.

²Kak, Lily P., Narasimhan, S. 1992. "The Impact of Family Planning Employment on Field Workers' Lives: A strategy for Measuring Empowerment: Working Paper Number 1, CEDPA, Washington USA.

³Chege, J.N., Askew I., 1997. "An Assessment of Community-Based Family Planning Programmes in Kenya." Population Council.