

Population and Reproductive Health Oral History Project

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Grace Eburn Delano

Interviewed by
Rebecca Sharpless

October 7–8, 2003
North Wales, Pennsylvania

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Narrator

Grace Ebum Delano (b. 1935) is a nurse-midwife who has been involved in Nigerian reproductive health programs for many years. Mrs. Delano is the executive director of the Association for Reproductive and Family Health in Ibadan. A CEDPA graduate and protégé of Peggy Curlin (whose oral history is also included in the Project), Delano is the 1993 recipient of World Health Organization's Sasakawa Prize.

Interviewer

Rebecca Sharpless directed the Institute for Oral History at Baylor University in Waco, Texas, from 1993 to 2006. She is the author of *Fertile Ground, Narrow Choices: Women on Texas Cotton Farms, 1900–1940* (University of North Carolina Press, 1999). She is also co-editor, with Thomas L. Charlton and Lois E. Myers, of *Handbook of Oral History* (AltaMira Press, 2006). In 2006 she joined the department of history at Texas Christian University in Fort Worth, Texas.

Restrictions

None

Format

Seven 60-minute audiocassettes.

Transcript

Transcribed, audited and edited at Baylor University; editing completed at Smith College. Transcript has been approved by Grace Delano.

Bibliography and Footnote Citation Forms

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Transcript

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Sharpless Today is the seventh of October, 2003. My name is Rebecca Sharpless, and this is the first oral history interview with Mrs. Grace Eburn Delano. The interview is taking place at her daughter's home in North Wales, Pennsylvania, where she is overseeing the birth of a new granddaughter. And I'm so grateful that she's taking the time for us while she's here from Nigeria. She is the co-founder, vice president/executive director of the Association for Reproductive and Family Health in Nigeria. Mrs. Delano, thank you so much.

Delano Oh, you're welcome.

Sharpless What I'd like to do today is start at the beginning. Tell me a little bit about your family and growing up.

Delano Thank you very much. My name is Grace Eburn-Oluwa, née Samuel. Eburn-Oluwa in the Yoruba language means "God's gift." I was born on the thirteenth of November, 1935.

Sharpless So Samuel was your family name?

Delano Yes, Samuel is my maiden name. I was born to modest parents on the thirteenth of November, 1935. And so I will be sixty-eight this year, but people call me "sweet sixteen" (Sharpless laughs) because I think age is in

the mind.

Sharpless I think you're right.

Delano Because I work with youth, and with others as well, you really have to ensure that you come to their level to be accepted, so they say "sweet sixteen." I've only just been promoted to "sweet fifteen" (Sharpless laughs) because the sixteen is now getting older. I always feel younger within me.

Sharpless That's right.

Delano Anyway, jokes aside, I was born in Lagos and my mother had me at a very old age. She experienced a succession of infant mortality. I was one of those children that was referred to in the local language as *abiku*. The concept of *abiku* in Yoruba culture of southwest Nigeria means a particular child dies and is born into the same family again and again as long as it continues to die. My mother had infertility problems when she got married in 1912. But after waiting for six years without getting pregnant, she then decided to marry another husband, even though her first husband liked her so much. The man had a polygamous family and she felt she could not produce a child for this man. The other wives made life unbearable for her and she felt uncomfortable and had to leave.

Sharpless [Uncomfortable] with the other wives.

Delano Yeah, since she did not have any children. A childless woman is looked upon as a witch. So she got married to my father in 1918. And again, she waited for another four years before she had her first baby, a stillbirth, in 1922. In 1925 she had my brother David Ibikunle. Then there came two other children who died before they were a year old, and then she finally gave birth

to me in 1935. There was a ten-year age difference between my brother and myself. I will talk a lot about my mother because she was closer to my brother and me than our father was.

She was a very caring, loving, kind, generous and highly industrious woman. Although not educated, she empowered herself and decided that not going to school would not be any barrier to achieving success in life. She was a model of a woman achiever, a women leader to the core who loved sharing her experiences as learning process for others. She decided together with my father to teach herself to read and write, starting with a Bible study class. Her ability to read and write was further enhanced by attending Sunday school. She found solace in the word of God through reading the Bible and caring for other people's children. Because of those children she cared for and brought up under her roof even [before she] had her own children, other people were unaware that my mother did not have a child of her own, as she was fondly called Mama by all the children. When she eventually had my brother, he was considered as just an addition to the other children in the family.

When I was born, it was believed that I was the re-incarnation of the dead children. I was *abiku*. But it was childhood diseases that were the problem and was responsible for the high infant mortality rate she had. Eventually she had me at the old age of forty-four. She said she was most uncomfortable and embarrassed to be seen [pregnant] at an advanced age. Initially, she was not even sure she was pregnant. She thought she had fibroids or fluid in her abdomen. She went into hiding to avoid answering embarrassing questions about her bulging tummy. And embarrassment

prevented her from going to the hospital when she went into labor. She still did not believe she was in labor. She however went into the room with my father beside her. She said she felt the urge to push down, which she did and with a big push there came this little girl.

Both looked at each other with an exclamation: Oh my God, this is a gift from God. And that was how I got my name, Ebun-Oluwa. *Ebun* means “gift.” *Oluwa* means God. So, Ebun-Oluwa means “God’s gift.” My parents thought I was a miracle child. For my christening at the church, I was given the name Grace of the Lord.

Sharpless

Your parents were Christians?

Delano

Sure, they were Christians. My father was also a judge of the customary courts in those days. He worked in Kaduna, the northern part of Nigeria, and for so long. He was there until he died in 1952. My father was the leader of the Yoruba community in Kaduna, while my mother was the leader of the female Yorubas. Whoever would be coming to the northern states would automatically see my parents. They were very accommodating, generous and caring to a fault, bringing people into their home. You [would] think that our house was a transit lounge. That was how we were brought up, to be accommodating and kind to others. I must have taken so much after my parents, because if you visit my home today you will find many children living with me. At any given time, I have at least about six, at most about twelve children in my house. And during holidays, friends’ and relatives’ children stay with my family. We live together as one family. I see this as a god-given role I can be passionate about.

My mother sponsored quite a lot of children to [attend] school. She might not have been very rich but she took delight in helping other people's children. Being brought up in Kaduna in the northern state of Nigeria, I mixed with people from other parts of Nigeria. I could speak Hausa, Igbo, Nupe and Kukuruku languages fluently. However, when I moved to Lagos at the age of thirteen, with nobody to speak with I lost my [ability to speak] Igbo, Nupe, and Kukuruku.

My mother was very ambitious and very innovative, always thinking of new things to try her hands on and always willing to transfer her skills to others. She was very active and very vocal, two of the traits I got from her as well. In fact my mother I would say was a born leader and I think that was how I developed my leadership trait and willingness to help others to make it in life.

Sharpless

So, what was your mother's name?

Delano

My mother's name was May Olaitan. *Olaitan* in Yoruba means "wealth that never ends." My father's name was Daniel Idowu.

My paternal grandmother had three sets of twins plus two single births after each set of twins. She had thirteen children in all. Out of thirteen children, only four survived: three boys and one girl. In Yoruba culture the twins and the children born after them have special names. The first twin is called *Taino*, meaning "the first to taste the world." The second twin is called *Kebinde*, meaning "the last to come." A child born after a set of twins is called *Idonu*, "the devil behind the twins." A child that follows the child after the twins is called *Alaba*, meaning "child who has come to draw a line of

demarcation.” So out of the first set of four children only the third child, my father, survived. Out of the second set of four children, only the second of the twins survived, named Kehinde. Out of the third set of twins plus two others, only the fourth survived, named Alaba. The last child to come was a girl, who also survived. My paternal grandmother died at the delivery of the thirteenth child, named Enitan, which means “historical child [whose story will be told].”

When we give a child a name, it must have a meaning. My mother’s maiden name was Durojaiye, which means “stay alive to enjoy life.” The naming of a child is very significant. For example, the name Durojaiye is an appeal to a child whose parents have had high infant mortality to please stay behind to enjoy life. It may interest you to know that my mother’s elder sister died at the age of 110, and her younger sister died at age ninety. So in my mother’s family they lived very, very long.

Sharpless

Let’s talk about your childhood.

Delano

My playmate was my brother. Because there was a gap of ten years between my brother and I, I was like an apron string around my brother’s neck. I was really a tomboy. Rarely would my brother not take me with him wherever he went. So he had to carry me around on his neck. I did things that boys did in those days: playing football, boxing, et cetera. I did not see myself as doing things that girls would do. I was always wanting to do things that he was doing, rather than things that girls should do, because I was always with him.

The first primary school I attended was a mixed school, United Native African School, in Kaduna, in the northern state of Nigeria, from 1940 to

1944. I then left the mixed school for an all-boys school called Government School, in Kaduna, in 1945, under a headmaster called Mr. Salako, a very strict teacher who [was forced to admit] the first two girls in the school. I was such a determined and adventurous child. I was not in a hurry to leave school as I was enjoying it. I was prepared to be placed in any class as long as it was the school of my choice. I remembered telling my mother that I would want to move on and away from home to another school to experience how other children live away from their parents. I also wanted to avoid being pampered and spoiled. My mother agreed. So I moved to Lagos at the age of thirteen to stay with Mr. and Mrs. George at 8 Moleye Street, Yaba, Lagos.

Sharpless

How far was that?

Delano

In those days we had to travel by rail or road for three days to get to Lagos from Kaduna. Now you can travel by air for only one hour and fifteen minutes from Kaduna to Lagos. As I moved to Lagos to stay with the George family, the family also decided to send two of their children to stay with my mother. I was enrolled at the Ideal Girls' Modern School, Moore Road, Yaba, Lagos, in 1948. The school was founded by the late Mrs. Dedeke, one of the educational reformers who, along with other women, advocated for improving the quality of female education, and established a girls-only school. Ideal Girls school was what you will call a mid-level secondary school.

In my third year in the school, I took the common entrance examination. I was one of the first three candidates who scored the highest marks, hence I was entitled to federal government scholarship, which I was awarded to use in

any secondary school of my choice in Nigeria. I then left Ideal Girls' Modern School in 1951 for the New Era College, Surulere, Lagos, another all-girls school, where I was nominated as the class prefect.

Sharpless

What does the class prefect do?

Delano

Under the supervision of the teacher the class prefect coordinates the affairs of the class. She must be brilliant, smart, assertive, respected, have leadership qualities and is expected to assist the class teacher to keep the class in order. The prefect is expected to ensure that assignments are carried out and submitted on time. Furthermore, a class prefect is expected to be a role model.

And then I had a classmate who was my school daughter, named Abimbola Eko, now Mrs. Abimbola Egberongbe. Both of us became a nurse/midwife. We got married to men who went to the same school and were also classmates. I was like a surrogate mother to my school daughter and I was expected to advise, guide and mentor her. Though we were classmates, I was older. She was brilliant and we both competed with each other academically, sharing the first and second positions. It was a healthy competition.

After three years in the school we both decided to move to a mixed school of boys and girls. She moved to Ahamadiya High School in Lagos and I moved to Abeokuta Grammar School in 1953. That was where I met the man who later became my husband. He was the one who was asked by my late cousin, Henry George, who also was an old student of the school, to deliver my letter of interview to attend Abeokuta Grammar School. When I

informed my mother of my [transfer] to Abeokuta Grammar School, she was very supportive because she was very appreciative of the values of education. She did not have such opportunity but was prepared to ensure that her children and other people's children were not denied the golden opportunity to be well educated.

The Abeokuta Grammar School that I attended was one of the best schools in the country, under the leadership of late Rev. J. Ransome-Kuti, a renowned educationist and a disciplinarian. He was the father of late Professor Olikoye Ransome-Kuti, a pediatrician and onetime minister of health, as well as chairman of the Primary Health Care Agency in Nigeria. His younger brother, late Fela Anikulapo, the popular musician and activist, was my classmate. Professor Ransome-Kuti died in 2003 in London at the age of seventy-four, while attending a WHO meeting.

Back to the Abeokuta Grammar School days—it was one of the schools that was highly rated and regarded as a school for future leaders. Students were groomed to excel in life, to appreciate values such as honesty, commitment and dedication to the service of their fatherland.

In 1956 my brother [asked] my mother to send me to England for my nursing training. I left for England to train as a nurse/midwife. My reason for wanting to be a midwife was based on the reproductive history of my family, especially that of my mother, who had infertility for twelve years, wasted pregnancies, and high infant mortality. Her lack of information, coupled with no access to reproductive care and counseling might have been responsible for the misconception, delay and agony she went through.

[My mother attributed the deaths of her infant children to] the work of evil spirit rather than to preventable childhood illnesses. This was another major reason for the choice of my profession. I wanted to contribute to a reduction in infant and maternal mortality by correcting misconceptions, using such tools as education, counseling, provision of quality maternal and child health services, which would eventually contribute to reducing maternal and infant mortality and morbidity. I must say that my mother was lucky to have survived high-fertility unsupervised pregnancy and labor at age forty-four in those days of high maternal mortality and morbidity.

So I left Abeokuta Grammar School in 1956, when I was almost twenty-one years old, and traveled to England in the United Kingdom for my nursing and midwifery training. I had my general nursing training at the Lister Hospital in Hitchin, Hertfordshire, between 1956 and 1959. Hitchin was a beautiful countryside—I hope it is still so. It is about an hour and a half by train from London. It was very close to Luton and Cambridge.

After I completed my general nursing training I moved on to Princess Royal Maternity Hospital in Huddersfield, Yorkshire, for my part-one midwifery training, and from there moved to Duchess of Kent Maternity Hospital, Uxbridge, for my part-two midwifery training. I still remember the day I took my first delivery: the nineteenth of February, 1960. They were a set of twins, and it was the happiest day of my life. I felt fulfilled, excited and proud of myself. They weighed five pounds, four ounces, and five pounds, six ounces, respectively—both boys.

After qualifying as a nurse midwife in 1960, I decided to undergo a

specialist training to enable me work in the district, outside the hospital settlement. This I cherished most as it gave me the opportunity to provide care to women who preferred home delivery, away from the regimental, hospital environment. I got my training at the Institute of District Nursing at Chelsea and Westminster in London, where I graduated as queen's nurse.

In the performance of district nursing duties, the nurses had to ride on bicycles with their nursing/midwifery kit strapped on the back of the bicycle in a basket. District nurses in those days wore a navy blue coat with a matching hat. They were posted to specific districts to work and were expected to reside very close to the district. It was quite challenging. I must say that I was quite happy being there, for the community people who would not go to the hospital for care.

It was during my queen's nursing that I discovered that there were quite a number of Irish women having many pregnancies. And for you to be able to deliver in the district, you should be able to assess that the woman is not at risk. And for someone who had had quite a number of babies, they are really women at risk.

Sharpless And they should be in hospital—

Delano Exactly.

Sharpless —and not depending on the midwife.

Delano [And at the time] I said to myself, There must be ways that these people can space their children if they would want to have a non-risky pregnancy. So I decided that there must be somewhere where there's a course on family planning. So I attended eight lectures at an institution in Euston, London. All

we were taught in family planning was the use of the diaphragm, because that was what available then.

Sharpless In the late 1950s, yeah.

Delano So that was how my entrance into family planning started, in England, in 1960.

Sharpless It sounds like in your growing-up years the child mortality rate was such that family planning was second to child health.

Delano Yes, it was. Our mothers and grandmothers did express their concerns quietly or secretly. My mother told me a great deal about traditional methods of pregnancy prevention. If time permits, I will narrate the history of traditional family planning as I was told by my mother—may her soul rest in peace. But my entrance into family planning started when I was in England.

Sharpless With all these Irish women?

Delano Yes, when I attended the lectures on family planning, when they taught us how to space [pregnancies], between '59 and '60. I attended eight lectures, for which I paid two pounds.

Sharpless (laughs) Eight lectures, two pounds, and diaphragms.

Delano Two pounds, yes. This was a lot of money in those days for a district nurse. But spending it on a course to save the life of mother and child was worth it.

Sharpless So did you go back to the Irish women and tell them about diaphragms?

Delano Oh, yes. My reason for going for the lecture was to acquire knowledge and skill that would enhance the services I was providing and prevent complications.

Sharpless How many other Africans were in training with you?

Delano

There were four other Africans with me while I was at the Leicester Hospital in Hitchin, Herts. There were two nurses from southwest Nigeria who were the first two Africans to be accepted for nursing training at this Hospital. They were Mrs. Victoria Funmilayo Nwandike, née Adeniji, and Miss Ajike Oyedele, who was my brother's friend's sister. It was through her that my brother got the information of the training. These two were in their final year when I arrived at Leicester Hospital. They were brilliant and well respected, and they paved the way for other Africans to be accepted into Leicester Hospital. I arrived with another Nigerian woman, Clarrise Yeside Macorroh, now Mrs. Coker. Yeside and I eventually became good friends and we are still friends today. Two other Nigerians joined us when we were about to leave. Their names were Theresa Mbamali and Macelina Igwe, both from the southeast of Nigeria.

Sharpless

What did your mother think about your moving to England?

Delano

She was very happy. It was a dream come true, what every parent wished for; to send their children abroad. She had always told me that right from childhood that she knew I was going to excel in life, and be an achiever. She said that I was a gifted child. My mother paid for my trip to England, as well as for my brother's and my education. She was in the lucrative kolanut and textile business, exporting her kolanuts to Ghana and then the Gold Coast. Hence she could afford to fund my trip. She was also a philanthropist. My mother was the type of woman who worked hard to help with the family expenses. She did not bother my father to ask for financial assistance. On my trip to the U.K., I must acknowledge the role my brother played to ensure

that I achieved my goal of becoming a nurse/midwife. He persuaded my mother to provide the funds, while he did all the planning.

My brother David Ibikunle was a retired accountant. He was the one who got the information about the nursing program from a friend of his, the late Mr. Oyedele, whose only sister whom I had earlier mentioned had also been sent to Leicester Hospital.

Sharpless

Let me turn the tape right quick.

Tape 1, side 1, ends; side 2 begins.

Delano

I went abroad really to see what I can do to help my people back home. And whilst I was abroad, my husband of today, who came to call me to go to the school where he, too, went—we went to the same school. We went to England the same year. It wasn't planned. His father sent him to England, and my parents sent me to England. He went to England to read law. And so, we met in England, and we courted.

Before we left home we were courting, but the type of relationship we had was the relationship of looking forward to how to help each other to succeed in life. And when you talk about a sexual relationship—that wasn't part of our own thinking or our relationship. We saw each other like brother and sister, and so this friendship developed gradually until we got to England. We were looking after each other. He was looking after me. And I cannot even say if he proposed, but it just happened. But we courted for eight years before we got married on the third of April, 1960, in England. And then I came back home in 1961.

Sharpless

Okay. Did the two of you come home together then?

Delano

No, he came home before me, and then I joined later. So I came home in 1961. And I had my first baby on the nineteenth of January 1962. And so, that was how the two of us met in England. We got married in England in one of the churches in Notting Hill, and my guardians were British ladies when I was in Hitchin Herts. In those days, they will attach you to a family, so I was attached to the Williamses. They looked after me in England. And so, when I was going to get married, he gave me away. And when I was getting engaged, they were there.

And I made a lot of friends when I was in England, because there was an organization known as East and West Friendship Council. Joining the East and West Friendship Council broadened my horizon. I was able to travel extensively around Europe. All you had to do is to tell them that you want to travel, and then they'll bring down the map. And you can go around anywhere, and then they will attach you to a family. You will describe the type of family you would want to stay with, either a singer, historian, comedian, and so they attach us to various families, families with children. And this was how I spent my days in England.

Sharpless

How wonderful.

Delano

Oh, yes. Learning how the English actually lived, because I went there to learn about the ways of living. And, of course, the British Council, too, was there helping overseas students. So, these were my days in England. I traveled extensively. There was no place I did not go to. And we made friends, and I'm happy to say that even with the friends we made, we are still relating. And their children, two of them, have come to Nigeria, and our own

children, too, went to England to stay with them. And so we have continued to develop. My husband—

Sharpless Now, tell me about—Nigeria became independent while you were in England?

Delano Yes.

Sharpless How much did that change things in Nigeria? I mean, was it different when you came home?

Delano When I came home during the independence we were young. We were not all that interested in politics. It's only education that would encourage you or push you to wanting to learn about politics. But it was just one of those things. There was independence, and so we all rejoiced. And that was really—things were okay, no problem. [When] we were under British [rule], it's only those who were in politics, whose parents were interested in politics, that would learn more about politics. In those days, it wasn't things that children or school children would talk about. We were all busy reading about how you want to make it in future, rather than looking at how the country is going to be governed. That wasn't our cup of tea.

Sharpless So, when you came home it didn't seem different?

Delano It was—when we came home things were there. Then there was the university hospital. So, I came home, again, as I said, in 1961. And—

Sharpless Um-hm. Okay, and then you were going to tell me something about your husband when I interrupted you.

Delano Well, I got married to my husband, and I was well loved by his family. I was accepted not as an in-law, or sister-in-law, or daughter-in-law. Even his

brothers, sisters, they call me their sister. They saw me as—I am that type who is so open. I'm very accommodating. I bring people closer to me. I'm easygoing. I'm all over the place, and I want to enjoy myself, and I feel that I should make people to do likewise. So, even if you are locked up in your shell, I'm that type who will bring you out of your shell. And if I could help, I would help.

Sharpless

That's a wonderful gift.

Delano

And even if I cannot help, I will find a way of making a difference in your life so that you will—if I make it in life, I want you to be like me, and even be better than I am, so this is my major problem. I've made it, and I want people to be able to make it. So anyway, I got married to my husband, who qualified as a lawyer, and he came back quick, came back home early, and became what we call a town counsel. He worked for the government in the department of public prosecution. And he, too, decided to rise in his own area of specialty. And then he got his promotion, and later on he became a judge. And not only a judge, but a chief judge of the high court, until he retired two years ago. And so, that's my husband, the chief judge of the high court.

Sharpless

When you decided to come back to Nigeria, then, what did you want to do? What vision did you have for yourself on how you would take your path?

Delano

Now, my vision before I left was that I was coming back—my mission was to improve all the healthcare services because, based on the story I've told you, quite a number of children must have died. And I was not in the profession, so I could only talk about my own parents. And growing up

made me know that they had problems, and she must not have been the only one having problems.

And so, my mission was to go there, go abroad, go and find out how the Europeans were doing it, and come back home to see how I can improve the lot of my own people. The idea is to come and improve on the healthcare services of Nigerians. My mission then was to reduce infant mortality rate, and quite a number of mothers would have died, as well, so that was my mission. It was when I was there doing nursing and midwifery that I got to know the reason why mothers were dying, and why children were dying. So I really learned a lot, because I wanted to know about it. I was anxious to know about it. When I was doing my nursing, people saw this in me, that I was always in a hurry, wanting to learn, because I always had the impression that I may never have the opportunity to come back. I was always in a hurry to get as much as I could, so that I can take it back to my country and help.

When I finished my studies and I was to start my health visitor's training, I just decided that with my being a queen's nurse in the district, I could just go and start delivering babies. So I came back to Nigeria in 1961, and then I started work. I came back in November 1961. My baby was born in January 1962, and I started work in March at the University [College] Teaching Hospital through another friend of mine that we met in Lagos. Her name is Idowu Akinwunmi, and she then was the secretary to the matron of the University Teaching Hospital, Ibadan. University Teaching Hospital happened to be the very first university in Nigeria, and so I was very, very lucky when I got appointment there.

I went for an interview when my baby was born was only forty-eight hours [old]—that was when I got a letter that I should come for an interview. And so I went for this interview. I had only just come back from England. When I talk, [I am] very appealing, very accommodating, and I'm very forceful. And so when I sat down, and I was being interviewed, they said, Do you have children? I said yes. How many? I said, "One." How old? I said, "Forty-eight hours." They said, You've got the job. (Sharpless laughs) So, I went back to the hospital to my baby, and then we were discharged on the sixth day.

Sharpless (laughs) Oh, my goodness!

Delano So, that was how I started at University College Hospital, Ibadan, as midwife.

Sharpless How did you decide to go to Ibadan?

Delano Well, why Ibadan instead of Lagos? My husband was based in—his parents then were in Ibadan. And so, when I got back home, he had job at the judiciary, but he's in [the] department of public prosecution. My husband worked for the government all his life, and so he was based there. And that was how I decided to now move to Ibadan, and that was where we have settled up to today. So, that was how we moved to Ibadan, yes. [In March] 1962 I got this appointment as the staff nurse at the University Teaching Hospital in the maternity unit, and I took off.

Sharpless Okay, at the time that you took the job in March of 1962, how did the hospital in Ibadan compare to the ones that you had been in in England?

Delano Well, when we are talking about the University Teaching Hospital—it was manned by the British, so the head of department was Professor Lawson—

may his soul rest in peace—a real disciplinarian, and very articulate and highly intelligent. Most of the doctors we had then were all foreigners. You could see that the ideas that we were all practicing—if you have trained in England, you will really want to go to University Teaching Hospital, because what you have learned abroad is what you are bringing in. Except that all the sophisticated things that you use there may not be 100 percent available, but they are nearly 100 percent.

Our style of doing things [include] discipline, posture—the way you do things were really how they did it in England. So we actually brought back what we trained in England to do, and that was how we operated. It was just like being back home, coming from England and coming to the teaching hospital. I prefer to work in the teaching hospital instead of the state hospital, because there they were too disciplined, so that you just have to provide quality of care. So that was how I started at the teaching hospital.

Sharpless

Now, how did the university hospital compare to the state hospital?

Delano

[At] the teaching hospital, you had professors, high intellectuals working at the university, and then there was a teaching department. There was school of nursing, school of midwifery, so you could see that the standard must be very high, whereas in the state hospital, that is second level. Then you have the third level that is primary healthcare, which is even lower, so that standard would start reducing. When it comes in terms of referral, the primary was sent to the secondary. The secondary was now sent to the tertiary. So this was the setup.

Once I was in the teaching hospital, I was in charge. I worked in the

labor ward, I worked in the lying-in ward, I worked at the postnatal, I worked at the antenatal. We were rotating. It was during my time in the labor ward—we were very hardworking and very committed. And it would be a sin to find a baby dying when you are taking delivery. We were never in a hurry. We were so much concentrated in wanting to see a nice baby, and when you start taking a woman into labor, you want to stay with that woman to actually see the outcome of that delivery. And even if you have to go off and the woman has not delivered, immediately the following day, you will dash there to go and see the baby—the outcome. You dash at once to see the baby first, so that you will be able to go and see the mother to say you have seen the baby.

We had what we called the premature units then, or high-risk unit, or resuscitation unit. If the baby has been transferred, then you will go and see the baby, so that you can take the news. But when you are a midwife, it's the joy [of] helping a woman who has carried a baby in her, and it's like magic—something you cannot see, and you're all waiting for that day to come. And then when the baby now comes out alive, and you help the woman to deliver the baby, and you now carry the baby and you say to the woman, "This is your baby." And that smile on your face that you are sharing with her gives a feeling of joy, a feeling of fulfillment, a feeling of satisfaction that you helped to do this. You helped to look after this pregnancy, and at last she has now delivered. And that was why I wanted midwifery. I wanted to see the joy radiating on the faces of mothers, and I'm happy that I did that successfully for thirty-two years before I left the university and moved on. I started in 1962. I left the university in 1992. Now, how did I start family planning? I

think I've finished with my—

Sharpless

Okay.

Delano

So it was when I was working in the midwifery unit that my potentials got recognized by the consultants, and I was always there for women. If they could not speak English but if perhaps they could speak Hausa—because they knew that I could speak Hausa, I was always being invited by all the consultants. So I became so popular among all the consultants in the various units. We had three units: the unit of Professor Lawson, the unit of Professor Ojo, and the unit of Professor Hendrickson, or Professor Fullerton. And for each unit they would say, Go and call Delano, Go and call Delano, especially if they have Hausa. And so, this was how I was rotating, and everybody wanted to see me work with them. Each weekend I will come and give mothers a bath. I will come and do their hair the native way, and help them to pierce [their] babies' ears. It was just a joy to work. And so, during that period, maternal mortality was very high, and it has not even decreased up until now. It's even getting worse rather than improving, and so we have a problem.

Sharpless

Now, at a place like University Hospital, was the maternal mortality high?

Delano

Well, don't forget that the hospital would look after those that are referred, and—

Sharpless

Okay. So, they were in bad shape when they got there.

Delano

Exactly, because from primary to secondary, from secondary—and then they directed us there. You could not just send anybody to the university. The doctor had to give a letter of referral. It's not just walking in.

And so, in those days, you had terrible anemia, and that was when they started exchanging blood. That was the first time we would see blood being exchanged. Some of them would have been dead before arriving or (unclear). And so we started including nutrition. [There were] lots of stillbirths, because mothers left it too late. And, of course, there was the culture, too, especially where they think that you have to [deliver the baby] at home, because your mother did it at home, and so you, too, should do yours at home. And by the time they decide to bring the women, they would have had obstructed labor. And coming in [to the hospital], it's sometimes [the decision of the doctors] to save the life of either mother or baby. So, you could see that at times it was a hopeless case. But the few that got registered at the university, and got looked after, made it. But it was during this period that we started talking about family planning.

Sharpless Um-hm, and one more question. You must have been pretty rare with your English training.

Delano Oh, yes. I spoke in English. One thing again that attracted the consultants to me was that I had a way of speaking, and they could not believe if I was a Nigerian or a Jamaican or a Trinidadian. And I know that. I was told that they had [an] argument [about it]. Then we had the English matron, and we told them that I was a Nigerian. And all of them said, no, I couldn't be a Nigerian, because—

Sharpless Your English was too good.

Delano —my intonation was so different. I told you I went to England to learn. I told you I wanted to mix and I was—staying with English people, I learned

their ways of doing things, because that was the reason I left my country. So, I did not go there to make Nigerian friends. I went there to make English friends, because I left Nigerian friends at home, and I knew I would be coming back to them. So I really learned a lot. That really helped me a lot in my life.

And so when I got back I was doing things the British way, because I was British trained. And I'm glad that I was. My talent was not allowed to be wasted. I was a clinical instructor to assist medical students. I was in the antenatal. I was allowed to talk to the women. And one thing that I really appreciated was that I was allowed to use my initiative, and those doctors came to trust me because I was genuine. I'm not blowing my trumpet. I knew that I was good, and they knew that I was good. And so I was really encouraged to bring the goodness out of me and use it.

And this was how I fell into family planning, although family planning was not part of the program in the university until 1965, when late Professor Ojo, O. A. Ojo, decided to introduce family planning to Nigeria. Family planning started in 1956. I mean, the idea came in 1956, with Pathfinder Fund. They are called Pathfinder International now, (unclear) when they came from U.S. And what happened was that quite a number of people had been procuring abortion, terminating pregnancies, because they did not want it. They did not know what to do, and quite a number of people died from the process of having unsafe abortion.

Sharpless

How were abortions done?

Delano

It was in a very, very crude way. Some of them would use caustic soda, some

of them would use—they would drink herbal tea, and some of them would use a chewing stick. There's a stick that we chew—Africans like cleaning their teeth with a stick. Well, there's this chewing stick in one part of Nigeria in the west, and that was used by traditional healers for women in labor. They gave it to really increase contraction, and when they knew that it could increase contraction, they started using it for abortion. And all they had to do was to chew that stick, and that would really contract the uterus and expel the fetus. That was one.

The other one is to use heavy binder to really compress the baby to come out. And so they would tie this heavy binder around the abdomen, and it's like really suffocating the baby, and so the baby would come out. And some would use enema. It's the liquid that is made, and you now use the funnel. Enema is supposed to be used to clear the colon, the rectum, but they will now use it for the vagina. And then they will mix the concoction, either water with lime—and then this blue. You use blue to actually brighten your clothes when you wash it

Sharpless

Okay, bluing, yeah.

Delano

But they now use it. I've even been told now that they sniff it, and that it's even like one of the drugs that people use now to [get] high. But those people use it to procure abortion, so some of them will drink blue or pour it into the vagina. Another thing they did was to use a candle, and in the action they will push a candle inside the vagina, but then it will puncture the Pouch of Douglas. And by the time they know it, the gut is out, and rather than succeeding in procuring abortion, it has killed both the fetus and the woman.

And there were so many horrible things that they used in those days. And some of them, the schoolchildren, would use them—knitting pins to really dilate the cervix. But in the attempt, they just went in, because they had no clue about the anatomical structure of the uterus, so they ended up by having this problem. So, these are a few of the problems we had.

Sharpless Did you see many of these women who had attempted abortion at the hospital?

Delano Oh, yeah, quite a lot. Even when I was at university, student midwives, student nurses will procure abortion. I know of one that became a tutor, and had to have a laparotomy for so long because she kept having a repeat. Anyway, in 1956, when Pathfinder Fund in USA heard about the problems they were having in Nigeria, some women—the well-to-do women who came together in society and decided to cry out about—because two of their children died from abortion, and these are children from well-to-do families. When it was happening to those that were not well to do, nobody heard about it. But now when it has happened to them, they now decided to cry out that—come over to Macedonia and help. And this was what prompted Pathfinder to send delegates to Nigeria to help.

Tape 1 ends; tape 2, side 1, begins.

Sharpless This is the second tape with Grace Delano on October the seventh. You were saying that when it was the poor girls getting abortions, that was fine. But when it was wealthy, that was something different. Could you say that again, please?

Delano Yes. Well, when the rate of criminal abortion was getting so high in Nigeria,

especially in Lagos, those who were really dying were the very, very poor. But when it now happened to the children of the rich, that was when people decided to now cry out. But you could see that it's an issue of the poor getting poorer and having babies and the rich getting richer. So, when it happened to them, they now cried out that something must be done, because two girls died from procuring abortion. And so, Pathfinder Fund came, and they now had what we call Marriage Guidance Association. And it was being manned by top-notch [people] in Nigeria like the late Mrs. Abimbola Awoniyi, who was the very first female obstetrician/gynecologist; Lady Manuwa, who was the wife of one of the high surgeons; the late Lady Oyinkan Abayomi, the very first African chief judge in Nigeria; and Lady Alakija. These were wives of the aristocrats in the country then, and they were the ones that came together and started guidance counseling with the hope that perhaps it would help to reduce the birthrate, and ensure that women would know what to do when they have children. So they were the ones who cried out, and of course the late Professor Adeniyi Jones, of the university.

And so, when they came and they discussed, that was how Pathfinder introduced family planning to Nigeria in 1956. In 1959—I'm sure that date must be right—that was when Planned Parenthood—it was not called Planned Parenthood, it was Family Planning of Nigeria, something like that. It was later on that they changed their name into Planned Parenthood Federation of Nigeria. That was how it started, with Professor Adeniyi Jones providing services in the community. But then at the university, Professor

Ojo in 1965 now decided to start family planning in Nigeria. He was provided with the Lippes Loop.

Sharpless

Um-hm. With IUDs.

Delano

Lippes Loop, and a method called M211. The M211 was M-shaped, like this, a metallic IUCD with a string at the bottom. The Lippes Loop helped even to solve the problem of Asherman's Syndrome for those with infertility, but it's not in use now. It's like an S shape, the Lippes Loop. Professor Ojo was provided with this Lippes Loop and M211 by Pathfinder and the Pop Council so that he could use it for research in the hospital. And that was how Professor Ojo, in 1965, decided to start trying out the Lippes Loop and the M211.

I was in charge of the midwifery unit in the clinic, and for him to be able to get the cases, we had to give a talk. What it meant was that when we [spoke with the women] during the antenatal [period], [we talked to them] about family planning. He now recruited one of our staff, who was an old woman. Mrs. Sokoya was her name. She was a part-timer. By then, we were not allowed to help Professor Ojo, because the university did not believe in family planning. But Professor Lawson got him this material and said, "You want it, you take it. You are son of the soil because (unclear) Africa."

And he was interested, so he decided to champion the cause, but then he was [required] to do it alone. He was not given a staff from the university, and so he had to appoint a lady part time. The program would start at four o'clock. Why four o'clock? Well, usually, the antenatal clinic will run from morning until two to three, and then at four o'clock we have finished,

although we should close at five. So what it meant was that when we finish clinic at two, the part-timers would stay and start working with me. Those of us who were interested had already started. We were doing it because we were just interested, and so that lady and myself would start talking to the women—coming for postnatal, coming to antenatal—about family planning, and that was [how] he identified my interest in family planning.

So I told him that all the knowledge I had was on diaphragm, and nothing else, not on any other method. And he said at least I had an idea. So we were giving them talk. Then we would recruit. We call it recruitment. We would recruit, and then he would do the counseling. We would help him to fill the papers, but I was doing it unofficially because I was not meant to work in family planning. But the clinic was in my unit, and I was in charge of that unit. Even the lady that was helping him was under me. So, because I was interested and I was in charge, I could help because it meant assigning people to go and help. And that was how Professor Ojo started family planning in 1965, [with the] Lippes Loop and M211.

Sharpless Now, when a woman would come in before she had her baby and you would say to her, “You know, you don’t have to have another baby anytime soon if you don’t want to”—is that the kind of thing you’d say?

Delano Well, one thing is that when it comes to—it’s only now you talk about counseling. Nobody knew what was really counseling in those days. It was education. Educate the woman. Just let her know that having too many babies together was very, very injurious to her health, and letting her know that if she tries to space, that would help. And so, spacing for a longer

period, even without using the traditional method, now that there are other things that she could use to reduce complication. So, these were the things we will talk [about]—and that there were methods that you could use, and that your gynecologist who actually assisted you with your pregnancy was there and will be able to help.

And it depends on whom you are talking to, it depends on how you introduce it, and it depends on how you accept it. If you are the type of a woman who is running a clinic and you are highly respected and recognized as a friend of the people—you have to be friend of the people. When we were there, some of them would bring clothing to give to the women. If they have problems, we will be there to help, and so some of them saw us as their family, not just as a nurse. You were looking at a concerned—not [just] a professional—a concerned human being.

Sharpless

More like a friend.

Delano

A friend, so the majority of us who were working in those days, we were more like friends to our patients. And at the market they will shout and say, Hey, Mama. Those were the things you enjoy. Then they will ask you, Do you think I should do it? And if you say, “Yes, it’s good for you.” Are you sure? If you say yes, they will do it. With counseling now coming in, we have improved. But before then, it’s like telling them, It’s good, it’s good. I know it’s good for you, and just go and do it. So they would do it.

So this was what we were doing in those days, and recruiting clients for Professor Ojo. We started a project called Ojo Ibadan. That was the name of the project, Ojo Ibadan. And then he had quite a number of forms he was

filling, to find out the acceptability of the IUCD, a new contraceptive device, on African women, because most of the research conducted before then [was] conducted overseas. But this time around he wanted to see its efficacy, its acceptability amongst Africa. And being conducted by an African made it so unique, because it is their own son who is doing it on them. It's not any foreigner who has brought in any foreign ideas.

So this was how Professor Ojo—may his soul rest in peace—the first African obstetrician/gynecologist, who was my mentor, decided to invite me to team up with him to introduce family planning to the country. So, that was how it took off. Now, how did I decide to become fully involved with family planning? He now asked the university to allow me to come on [reassignment] from the university to the project, because it was now going to be a project.

Sharpless

And this was in the mid—

Delano

In 1970, to be precise. So in 1970, I was now asked to leave the department, the maternity unit, and go and assist Professor Ojo in setting up a family planning clinic. And we were now to run what we call a postpartum program. It was called a postpartum program. Why postpartum? They wanted to see if family planning would be accepted in an integrated setup. And why an integrated setup? Because we were dealing with maternal mortality and infant mortality, and the only way you can actually get your clientele is catching them when they are pregnant and when they are delivered. And so, we wanted to see if using that approach would increase acceptability, would change the attitude of people who did not see anything good in family

planning, because they thought it was foreign. So, the postpartum program now took off, with Pop Council providing us with the IUCD and oral contraceptives, Ovral, Norgestrel, and IUCD.

Sharpless Oral contraceptives?

Delano Yes, oral contraceptives and IUCD. So, we were to have two categories of people. There were the postpartum acceptors, and there were the immediate, [which] meant that you have it immediately after delivery. The postpartum meant that you have it six weeks after delivery. And so, we kept that record of immediate acceptors and ordinary acceptors.

Sharpless But you had to have just had a baby to get it? It had to be women who had just delivered.

Delano Well, we were given a room within the antenatal clinic, under the obstetrics and gynecology department, to run the program. I was given a room, and I was interviewed by Professor Ojo, who was in the university, Dr.—he is now Reverend Adenuga, who was in the state hospital, and Dr. Adesina, who was in the primary. So, the three of them now teamed up to start postpartum program in Nigeria. But before then, Dr. Adesina was working with Planned Parenthood [at] the state [level]. And so, we were now asked to start the program at the teaching hospital, [combining] the tertiary, the state hospital, and the primary [levels]. And I was employed now to coordinate those three units.

So what it meant was that, for the program to really succeed, you must have about 150 women accepting family planning every month. And so you really have to intensify your advocacy, your propaganda, your promotion, so

that women would have it. The day I was going to attend the interview, I was taking a delivery, because I just said, "Leave me with my women." I was up there. I will be doing both.

And so, when we did the interview, they said it was I they wanted, so I became the nurse in charge of the first University Teaching Hospital [program in] planning in the country. The program was funded by Pop Council for three years. And after three years, we would have demonstrated the need for family planning to be integrated into the hospital, and that the university should then be prepared to take it all, and have us as a staff, rather than me being paid under the project grant. So, after three years—because I knew that the success of that type of a project [relied] on the acceptor rate, what I did was that I started campaigning. The problem we had then was that they thought family planning was alien, and no one would want it. And I had to make a case that family planning was not alien, and that was how my mother came in. I went to my mother to find out.

I said, "In those days, when you were still having babies, was there something called family planning, though it was not called family planning? Were there methods that women use when they did not want to have babies, or they wanted to take a rest, or they wanted to space?" My mother said, "A lot." Then I said, "Tell me [about them]." So she [told] me all the various methods that were used in those days. So, what I did was that I now decided—

Sharpless

Okay, you're showing me a chart of traditional methods of birth control: rings, pendant, armband.

Delano

I now decided to ask my mother, and my mother said, “Oh, yes. They had what you call invisible method, and they used quite a number of methods.” So, I told her that in the English hospitals, they have the pills. My mother said, “Yes, they had something you can drink, and either you will drink it as herbal tea, to prevent pregnancy, or you will eat it as a food, which will be dished out to you by the medicine man to prevent pregnancy. Or you would even take it [to a] circular route [intersection], to be eaten by spirits on your behalf, and that you will put the concoction in a calabash, and then leave it on a circular route where all roads meet. And then the spirit will come there and visit it and eat it on your behalf, because the medicine man would have [made an] incantation [with] your name, and that this was what you wanted.” So she said that was oral.

Then I said, “Now, they have what they call injection. How did they do that?” “Oh,” she said, “simple. What they did was that they would do scarification with a blade, a sharp knife, and how long you want it for [would depend on] the number of incisions you have, but then the medicine would have been prepared that will now be rubbed on that incision. And then it gets absorbed into the bloodstream, and when it gets absorbed, it worked, and then that would prevent pregnancy. So, it’s usually done at your spine, at the back.”

Then, I said, “What about something to cover the mouth of the womb?” “Oh,” she said, “Oh, yeah, they use that, too.” Then she told me that there’s lemon, that the flesh of the lemon, it’s very medicinal itself, because they drink it to procure abortion. Then you will scoop out what is in the lemon,

and [she said,] “You know that thing that is”—she was trying to describe the cervix—she said, “You know that thing that [sticks] out in your vagina? You now use it to cover it, because when that thing is [sticking out, the lemon will go in]. So, when you cover the cervix, you won’t [become pregnant].”

Sharpless

So, you use half a lemon?

Delano

Half a lemon. Then she said, “The other thing you can use is a rag. You just push it in. And you can dip the rag in vinegar, or in blue, or in salt.” That would act as a spermicidal. Then there are some herbs that you will grind or pound, and then you will plug it into the vagina [and] that would kill [the fetus]. Other things they used: you invoke the spirit. You have this little idol, little baby, a wooden doll in the corner of your room, that could be used either for someone who is looking for a baby, or for someone who is not looking for a baby. Another one was using charms either around your neck, or around your waist, or armband. And she said, “Those things we had made from the skin of a leopard or a tiger.” They were fear[some] animals, and children coming from heaven will be so scared of those things that when you have the armband, or you have the ring, or around the waist, you will not get pregnant.

Then she said, “With a ring.” I said, “With a ring?” Then I remembered the copper T. Most of them were made of copper. The ring had an effect for how long you want it for, and when you don’t want to have it, you can throw it away. Then she told me of one that they used for adolescents, and she said she nearly used it on me. But then she said it occurred to her that she only had two children, and that I was traveling. If she should die whilst I was

away, that would be the end of me. What was this method? It was a padlock. They will invoke your spirit into the padlock, and the incantation was that it should lock up the passage to your Fallopian tube, so that you will never get pregnant. Then they lock it up and keep the key somewhere. But the problem [is], if the woman or the parents who kept the key should die, that would be the end of that child, and the child would never have any issue. And she said she thought of it and said no.

Then there is an invisible one again. It's a feather. They put it on the ground—usually this is done for adolescents. When the adolescent crosses this feather, then an invisible barrier is created in her vagina, and so a man will not be able to penetrate. Then there's another one used on women who are [engaged in] infidelity. What they did was that the man would have this [invisible object prepared by an herbalist], and would put it [on the ground], to prevent the wife from having an illicit love affair. The man who climbs on this woman will die. Or, when the lady crosses what has been put on the ground, and has an illicit love affair, anybody who mounts that woman will start having a fit. And they called the medicine Do Not Climb Me, *Magun*. *Magun*, which means “don't climb.” That is, don't climb the woman. And any man who climbs the woman to have sexual intercourse will [have] fits three times. The first one, he will go into spasm. He will jump. If he should jump a third time, he will die, and that's the end of him.

So, this was the method that my mother taught me. So I said good, and I decided to mount these methods, those that I could mount, on charts. When I started using it, my idea was to let people know that my point of entry—

when I'm giving a talk, it's going to be on African methods. I have to talk to you about how Africans feel about child spacing, and lactation, and so on and so forth—the methods we were using. Then it would gradually [move] to the scientific method. But first the question would center on traditional methods, so that we would discuss that a lot. [The women would] ask me questions. My mother had taught me this, so I would answer all the questions.

And then I had the other [chart] mounted, the scientific method. Then I would start the comparison, and then I would talk about how it worked, the efficacy, is it injurious to health, the availability, the acceptability, was it palatable to test, and the routes that it's given—administration, and so on. And so, I would now start comparing the two. And when I finish comparing, then I would ask the question, "Which one do you think you would want, the one on the right or the one of the left?" And then they would say, Oh, yes! Give me the one on the right, and this is [what I want]. So, you could see that my style of getting people—I did not force them.

Even before Gada(??) came in telling us that you have to ask, you have to talk, you have to explain, we had used this method. You have to understand your people when we are going in anywhere. You really have to know their culture, and it's by so doing that your entry into any program would be hitch-free. If I want to recruit people, I use that style. I become part of them. I want to learn about yours. It's only when I've finished learning about yours, then I will ask if you want to know about mine. Then they will say yes, and so we will be able to compromise, and this was how I started using the two

methods.

And when I give a talk, I do it with music. I introduce songs into family planning. First I started this song (singing in Yoruba):

Feto somo bibi, Feto some bibi Ki aye re ko le dara

Moti feosi temi, lot feto si tire, feto some bibi haye re

ko le dara

which means,

Go and plan your family so that your life will be better.

You will have a better life to lead.

I have planned mine, so go and plan your family

so that you will have a healthy life and a better life.

And so then everybody will say, Yes, I want a better life. Yes, I want a healthy life. So I would start my talk at the teaching hospital, because I was there with some nurses. We recruited more nurses. It was leadership by example. You have to watch me doing it, and I sweat, I jump, I dance. I would sweat whilst doing it, and I would be enjoying it, and the women would be clapping. So they named me Mother Planner in Nigeria. (Sharpless laughs) In the hospital, I would go to all the wards: maternity, antenatal, postnatal, including the clinic.

Sharpless

So, you started at the hospital.

Delano

Yes, it started in the hospital, but then the other two sites—because the research was in three sites, tertiary, secondary, primary, so I had to go there, too. There were nurses there, but I had to teach them how I do it, because I was having lots and lots of clients, and what I did was that we would go out

to start talking. When we go out, we go to market. We go to builders' sites. We go to the ministries. We go to anywhere there's immunization, either [at the] government or primary [levels]. Just name it—anywhere I find women seated. And we will say, The program is going on now. [You will receive it as soon as] you get there. No one will keep you waiting. Before you say, **Hey??**, they are beside you. Before you say, **Hah??**, they have attended to you. And before you say, **Ooh???**, you have left the place. So, they [would call me] Mama Hah(?), Mama Ooh(?), Mama Woo(?).

But [with] all my followers, I mentored them because I enjoyed what I was doing. And they, too, did likewise. So, we will send clients to the university. And then, for the primary, secondary, I would be there again, talking. And how did I make my entry at the secondary?—because you could see that the system was quite different. We were organized, and they were not all that organized. But that did not mean that I should run them down. The idea is to make a difference. See what you can do. So I become their friends, because I was coordinated.

Tape 2, side 1, ends; side 2 begins.

Sharpless

Okay, when you go to the secondary clinic.

Delano

When I go to the secondary setup, the idea is that we all know that you cannot compare the teaching hospital with the secondary. The ways of doing things [there are] quite different from the way they do things in the teaching hospital. It's not that they are not disciplined, but the lifestyle, the technique, the approach, the (unclear), the prevention [were all] quite different. The style of dressing, not just naming. I think I was a community woman from

the word go, and I would fit in anywhere, and so I fitted in there. Fitting in was getting to the clinic, [where] I would greet them, I would ask them what they are doing. And if they were weighing babies, I would start weighing babies with them. I would start recording with them. If they were looking at pregnant women, I would help them do it, so that we would do it together. Then they would say to me, Come and give your talk, and we will follow. And, of course, whoever was competing with me, you have no chance because they would say, Delano is here. Carry on. And so, I would give the talk. Then I would say, "In the evening, they are starting here. So, you can come at four o'clock. But before four o'clock, you can go to the teaching hospital." Then I moved to primary, and I did the same thing. And that was how I became so popular.

Another thing that helped was that I was the secretary general for the Professional Association of Midwives of Nigeria. By being the secretary of the midwives, what it meant was that any hospital would know Delano—any program. And so, I decided to involve them on all the programs we are doing. So that was the tertiary, the secondary, and the primary. Dr. Adesina was running the primary, the other doctor was running the secondary, and Professor Ojo was running the tertiary. Staff strength started from one—that was me—and then it increased to three, and then from three to eight, until, [when] I left the place, we had thirty-two staff. Then Professor Ojo decided to now send me to Downstate Medical Center so that I would be—

Sharpless

In New York.

Delano

—in New York—so that I would perfect what I was doing. So that was how

I came to Downstate Medical Center, to attend a trainers' course in family planning. And I remember when I was there, I would phone him to say, "Let's do it this way. Why don't we—" Then he would say, "Listen, Delano, why don't you come back home and bring the brain of New Yorkers with you, so that we can start adjusting?" Because I would say, "This is how they are doing it here, and tell those girls this is what they should do at the clinic." And so, when I got back, he allowed me to use my talent.

Sharpless

What did you learn in New York?

Delano

In New York, I learned about family planning, because I told you the only training I had, except Professor Ojo giving me on-the-job training, was [with the] diaphragm. But now, I had to go to New York to learn family planning, because they were running a four months' family planning training for service providers, nurses, and doctors. We were taught how to provide all methods, including IUCD, injectables, diaphragm, pill, oral contraceptives—all the methods that were available, except we were not allowed to do sterilization.

So we went through all the methods, and I became a very knowledgeable person in family planning. It's one thing to be asked to go and do something, but it's another thing for you to be interested in wanting to learn. I was so interested, and I felt that that was another opportunity. I would never have that opportunity to return that way. So that opportunity I did not want to slip through my fingers. Everything I could learn I learned. Every corner I could go I went to. Just name it, everything I could take back home with me I took them back home with me—materials, models—that would really enhance my

performance at home. I wanted to compare myself with America. I really wanted to do things the way they were doing it. I've always wanted what was best for my country, and each time I had opportunity to travel, I always went back to make sure that it would have a multiplier effect.

Sharpless Um-hm. Now, was this when you were still in your three years of funding from the Pop Council?

Delano Um, '72—yes. That was when the Pop Council—

Sharpless Okay, so you were still working on your acceptor rate.

Delano Yes.

Sharpless So, how—

Delano The acceptor rate went to 360, because the promotion was so high, and bringing in more traditional methods, it took time before nurses got to know why I introduced the traditional—it was I who introduced the traditional methods in the country. They thought that perhaps I was selling it. No. I was making a case with traditional methods that family planning was not alien. So, now that I had opportunity to be [conducting the] training, I had to be telling them that I was not selling traditional methods, I was just making a case, because it's when people know that things they had used before—because I always say it was true: what the traditional healer invented, the scientist improved on.

And what they have done is to make it noninjurious to health, easily available, palatable, and affordable and safe and effective. That was what they had done, because herbs are herbs, and it's herbs that pharmacists would use to actually produce this. So, they just needed to be convinced that nothing

was alien, and then the acceptability went up. And so, it got to a state that Planned Parenthood even thought that we were stealing all their clients, because they would come to our clinic. You would be accepted with open hands. I was very strict—strict in the sense that you must not ill-treat your clients. When they come, they must be attended to.

And so, up until today, all the staff that I groom, they poach on our units, to come and take our staff to international program. Even about two months ago, they've just poached on us. They've taken two, and they are all taken to donor agencies. There's no staff that worked with me that would go and work with NGO. They are all accepted in international [organizations], because they are well groomed. They are [up to date]. I have a big library. Every now and then you must update your knowledge. And patients should be treated with care and respect. They should come first in your life, and your point of entry should be dictated by the people themselves. You must identify their need, and even though you have your own vision and you have your mission, it takes time for people to accept your vision, and they have their needs. So, you just cannot push yours on them. Even if you are donor driven, there are ways of doing it so that it would be fifty-fifty, a little bit of this and a little bit of the donor, because the donor, too, has an agenda.

So, this is how my girls work. And so, this was how the Pop Council project worked for three years. Then we got an extension for one more year, and it was the university that got the extension, not the secondary or the primary, because now they really wanted to institutionalize family planning in the country. So, they give us one more year, and after that year, the

University College Hospital now decided to accept family planning, and so we were now put on their payroll. And by then I had gone to Connecticut, the fourth year, I went to Connecticut to learn [about] training of trainers.

Sharpless Let me ask you one more thing about the Pop Council project. When you got the acceptors, did you have plenty of supplies of contraceptives for them?

Delano Oh, yes, for projects. For projects all those things would be there, yes. And they were free.

Sharpless They were shipping them in from the United States?

Delano Oh, yes. Contraceptives were not available in the country. They all came from the United States. So they were there to be used. And another thing that was happening then was that we were asked to request consent from the husband. So you can imagine the problem women had. The protocol said they should obtain consent from the husband, and we did. But then we finally discovered that when you are talking of African culture, some women could be very clever. We made a mistake. We did not ask for the wedding photograph. We did not ask for wedding certificate, and we did not say, Bring your husband. And so, when the women—you know, with education you can make a difference. And when we embarked on mass and intensive education of women, they were knowledgeable. They became informed. They now knew why they have to space, even though culturally their husband would not want them to, because they did not understand. Then we were not targeting the husbands. We were just looking at the women.

But we were able to let the women know that excessive childbearing was

highly injurious to their health. And so, if we asked them to bring the consent, they would bring the consent. And what they were doing was getting any man on the street to just sign. And so, we got to know. But what it proved was that women, if they are educated, they know what to do. That's one. If they are empowered, they know what to do. That's two. It's not that they were being deceitful, but when you talk of human rights, it was wrong to say that the life of the women was in the hand of the men.

And so, we obtained the consent. They were signed, but asking that they should bring the consent from the husband, that was what that study said. And so, the women, later on, would say, When we were doing the evaluation, that was how we got to know that you wanted it. And, of course, we fooled you, because we wanted to stay alive. We didn't want to die, because the husband would rather have us dead having babies. And so they will refuse to sign. They got either a child or someone else to sign. One thing that [made us] happy was that they themselves signed, which was most paramount. But the husband issues—[it] was during evaluation that we got to know about that. But then, I'm happy to say that family planning started from that end.

Now, to make sure that the program was accepted—it was only accepted in the urban, and not in the rural [areas], so I now decided that it was about time we started going to rural [areas], because we were having many complications still coming in from the rural [areas]. And in the rural [areas], that is where about 70 percent of the population live. And if they live there, and know the facilities were not available—[or] were available, but they were not being run daily, and even if they were being run daily, they were ill-

equipped to actually cater for complications. And so, family planning was not there, and they have never heard about it.

So what did I do, again? I just decided that I was going to identify one area in the rural with a population of 89,000, and just go there and start preparing them for the future, just in case family planning would be more available to us, and we will move into the rural [areas]. So, I was giving a talk, and that was how I had opportunity to attend [the] Ravenholt program in Tunis.

Sharpless

Okay, so, USAID had a program in Tunisia?

Delano

It was Ravenholt that was doing dissemination of the findings of its household delivery of family planning. That must have been in 1978. So, when I had that opportunity, Ford Foundation—but before '78, let me deviate a little. Before '78, you know I had gone to Downstate Medical Center. I had gone to Connecticut.

Sharpness

No, actually, we didn't talk about Connecticut because I cut you off. What did you do in Connecticut?

Delano

Well, in Connecticut, I went to learn about training of trainers in family planning, preparing us to start training people, because there was no family planning curriculum in nursing, in midwifery, in medical school. It was just one of those things. So when I came back, Ford Foundation, [from] 1973 to 1976, decided to fund family planning training under Professor Ojo at the University Teaching Hospital. It was eight weeks for nurses, two weeks for doctors, and two weeks for social workers. So we had doctors, physicians, non-physicians, and social workers. With that training, I was now prepared to

come and help Professor Ojo. Professor Ojo was giving the didactic, and I was giving the practical.

Before they came down for the practical, I would help prepare, because they would spend six weeks with me downstairs in the clinic. The didactic was taking place in the classroom upstairs. So, for six weeks I had to get a program ready for them. And the training I had in Downstate Medical Center and in Connecticut really prepared me. I actually went [out into] the world to do it. And so, with that training, I was now able to be providing the practical aspect to those coming down. And that project was '73 to '76, where we trained nurses who had graduated. Nurses who had graduated were trained, and then doctors who had graduated were trained. Then we looked for those who were helping in the clinic. We now made them a social worker, although they didn't have the—we trained them to be able to do a little bit of counseling, a little bit of home visit, and a little bit of helping with recordkeeping. So, the ideas that Professor Ojo and myself had, we brought [them] back. It was during that period that we used those who were trained to go back to the state hospital, and so on and so forth, [to] start integrating family planning.

Now, Planned Parenthood was then running the family planning [programs] in most secondary hospitals from two o'clock until evening, because they were not given space from morning until evening. But in their headquarters, Planned Parenthood was running a daily program there from morning until evening. They call it Planned Parenthood Federation of Nigeria, but the University Teaching Hospital was running this.

Then we had Dr. Lakero in Lagos. We had this hospital. They call it baby factory. It was called Mercy Hospital, and they deliver babies like pigs, like chicken, every day. So Dr. Lakero decided to start family planning in Lagos Maternity Hospital. They call it Mercy Maternity Hospital. So, that was how Lagos and Ibadan started providing family planning. And, of course, Planned Parenthood now decided to spread. They now became Planned Parenthood, instead of Family Planning of Nigeria. They graduated and became Planned Parenthood, and it spread. And they are affiliated—

Sharpless

They were affiliated with the international organization?

Delano

IPPF, International Planned Parenthood Federation, and I was one of their advisors until about a few years ago. Anyway, so that was Planned Parenthood.

But then, my mission and the idea I wanted was that family planning should be integrated, and it should not be the program that is just provided from two o'clock until six o'clock. And so I started to champion the cause of getting the hospitals to integrate family planning into their existing services. But that did not come until I went to Tunis. Now, it was when I was at Tunis that I met Allan Rosenfield. (laughs) And I met Fred Sai. Okay, so you can see now where the meeting—that was when he did a dissemination. Then he talked about taking the program—

Sharpless

“He” being Ravenholt?

Delano

Ravenholt talked about taking commodities, family planning, to rural areas, from house to house. By then there was a young doctor who had joined Professor Ojo. That's Professor O. A. Ladipo, the founder of our NGO. So,

he now came from England and joined Professor Ojo at the university. Ojo was invited to Tunis, and Ford Foundation sponsored him to go to Tunis. And Ojo decided to ask me to represent him. I felt so elated. I said, “Me, a nurse, go and represent you?” He said, “Yes, I know you can do it.” So, I went to represent Ojo at Ravenholt’s program. And then, Ford Foundation decided now to fund Ladipo. The two of us were working under Ojo. We were in Tunisia.

And during the presentation I said to him, “We can try this approach in Nigeria. If we’ve been having a problem getting family planning accepted, why don’t we try the community-based approach?” And he said, “Are you sure we can do it?” I said, “Of course.” When I make up my mind to do something, I go for it. I always know there may be a yes or a no, but you don’t give up. Then, fortunately, Allan Rosenfield—during discussion we were just talking at coffee and so on—then he came in, and I don’t know how it happened. Columbia University was interested in looking for an African country where they would develop their skill and mentor them. So we said we could try it in Nigeria. Then Columbia said, We’re interested, we will work with you. That was how we started working with Allan Rosenfield at Columbia University.

And so the very first community-based program in Nigeria, introducing family planning, but in an integrated approach, took off. We got fund[ing] from AID, through Columbia University, and then they asked me, Where do you want to operate? I said, “I’ve been giving a talk in one of the rural areas, but no service has been provided. Now we can start with them.” But they

would not accept family planning alone, because maternal and infant mortality both were very high. What [the women] said was, We will not stop having babies until we have living children. If you can bring us something that will stop the children dying, we will accept you.

Then I said, "Tell me. What was responsible for the death of your children?" They said they would have diarrhea and they would die. I said, "One. What else?" They have fever and they die. I said, "What else?" They have cough and they die. I said, "What else?" When they have a wound, they die. I said, "Well, those were preventable causes. If I bring in preventable causes program, I want you mothers to stay alive to look after their children, because if we make the children to stay alive, we don't want you to die, because they need you to look after them." They said, Yes, you just keep the children alive.

So, I've been nursing that program for years, and I had the opportunity in Tunis. And so, I said to Professor Ladipo, "We will go to this area. It's virgin territory." No one had been there before. "Let us go and introduce CBD [community-based delivery]." And Allan Rosenfield said, "Yes, we're interested." They would look for funds. So, we got the proposal. We got back. We told Professor Ojo, and he said, "Go ahead. You can be the deputy director." That's Ebum Delano. "And Ladipo, you can be the director. I will deputize and coordinate, because I know the terrain."

So that was how, through Columbia University mentoring us, providing all technical assistance and financial assistance, we started the very first community-based program, but integrated with it was maternal child health

and family planning that was taken to the rural area, a population of 89,000. We now train 171 village TBAs— traditional birth attendants—and voluntary health workers to provide services to eight different villages around those areas. But we attached the programs to primary healthcare, so that it could serve as referral points to them.

So the first family planning program took off in 1980 in Nigeria, and it was successful. We operated through Columbia University, and the staff were trained. We put together training manuals for them, and then in 1980 to 1984, we finished with them. Then the government decided that they were taking it over. So the government of Nigeria in 1984 took over the community-based program that we hatched when we were in Tunis, integrating family planning to MCH [maternal and child health]. Now, how did we get them to integrate into secondary? We said—

Sharpless

Let me change tapes.

Tape 2 ends; tape 3, side 1, begins.

Sharpless

Okay, so the government took over the community-based health.

Delano

Yeah. Why did the government take it over? They discovered that it was one way of getting healthcare services closer to the masses. But, you see, we went in with family planning. They wanted maternal child health. So we had to compromise, because using maternal child health was a very good approach to actually increase acceptability, if the reason for doing it was not population, but trying to reduce maternal and infant mortality rate. That was what we had preached in the past, and it worked. And so with this training. Then there was a period, in the area where we were working, that the

government introduced free healthcare services, but it was not working. So, ACDD?? was a blessing in disguise. How? Because we were running a program that should be self-sustaining. The people we trained were being provided with commission. They were not employed by them. It was a community-based approach.

I don't want to go into the history of how we got them and the processes we used. But recruiting them was very vital—getting the right type of people paving your way and making your entry in such a way that it would be a community-based owned program from the beginning, getting them very much involved. And using languages they would understand made it acceptable. And that was where my very first book in family planning—in Yoruba, north of this—the very first one was written, because I was going to rural areas. I wanted them to be able to read it, and know that family planning was not alien, and that what people are talking about family planning was all myths and rumors.

So my very first book was called *Guide to Family Planning*, but this was an improved one, in the local language. And this was what I give to them first to read, and reading it was very easy, and made our entry there very easy. I'm happy to say that during that period, we were able to reduce maternal mortality rate. How? [There were practitioners known as] doctors in the rural areas, but they were practicing without using the information they got handed down to them by their grandmothers. [What we did was] to get them to improve on the services they were providing. We decided to use them because they were already there, and they were the only ones known there.

And so we went there and let them know that we were not coming there to stop them doing the job, because they were the only ones available. We were just coming in to help them improve on what they are doing, and to get them to know their limitations, be able to transfer, and be able to ensure that they collaborate with the nurses. And so, they embraced it.

But we now said, You will keep a commission [for each] treatment. And so, on family planning they were keeping a commission of 50 percent. On minor elements they were having a commission of about 30 percent. Why 50 [percent]? On family planning, it was subsidized. On minor elements, it wasn't subsidized, but they will be able to replenish their stock. So, that was what we did. The medicines were there every time anybody wanted it, so when the government got stock and they had no drug they would write a prescription to the woman and say, Go and get me Levaquin and so on. So, they will now take it to the TBAs and the voluntary health workers. That was how the government solved [the problem], because it was a godsend to have free help in that program. This was another program complementing what they had introduced politically.

And so, the government in Oyo state decided that they will embrace family planning. And Pathfinder decided that they will now build what we call a CBD unit within the ministry of health, and it's the first CBD unit in Nigeria. It's in the ministry of health, and this was where they coordinate other projects that are not ministry oriented. But what we did was that all those nurses in the ministry were now sent to—those who were involved with CBD—were now sent to Columbia University for training. And about

twenty-one of them went for the training, apart from those who were in force from the university. So, this was how the relationship between ourselves and the university and the government started. And up until today it's so strong. They even think that we are ministry staff. And so, the CBD unit started. In 1984, they took over the CBD unit, and we decided to start the market-based approach. So, that's the introduction on CBD.

Sharpless

That's great.

Delano

But before I close the chapter—when I got back from Connecticut, there were controversies on IUCD, especially the Dalkon Shield. And then there was the rumor that they were going to stop sending it to Africa. When you look at the IUCD, especially the Lippes Loop, it had no hormones in it. It was just a little IUCD object that stays in the uterus. The problem you could have, maybe heavy bleeding, which we refer to as menorrhagia. I used it for fourteen years because I could not use hormonal, because I had migraines. But then with these controversies, there were plans to stop sending it to Africa. And some people went around saying that they were trying to dump things that would not be used in America to Africa.

So, my first book on—a clinical manual—on IUCD was now written, [and] I wrote it so that it's self-instructional. Self-instructional material teaches someone what to do, teaches them how to carry out good counseling, how to carry out good selection, how to carry out infection prevention. I have used it for fourteen years, and I made a case that we would prefer to be using it instead of—though the other method, mixed method, could be there, but this is one method that had not been in it. Then,

another thing—the IUCD, especially Lippes Loop, was useful for women who had their lining of the uterus stuck together. The Lippes Loop was used. We call it Asherman’s Syndrome, where the lining of the uterus would stick together. So, they now use the Lippes Loop really to actually help the women to open up and create a gap so that they could get pregnant. And if it was so useful to us, why would anybody want to stop it because of their political issues? So, I wrote that book, and the book became so useful. And there’s no school of nursing, midwifery, health technology [where] you won’t find it. And then UNFPA [United Nations Population Fund] funded it so that it went round. Now, the story of this, in 1988—

Sharpless

The Guide to Family Planning?

Delano

Yes, why did I write it? We had started family planning, and some of us had been going around talking about family planning. But there was no policy on family planning, and there was a need to have a policy, especially now that, through CBD, we’d been able to get the government state hospital to integrate family planning. We started training, and some of the nurses are now back. So, we moved the idea that state hospitals should start providing family planning services. And the reason we gave was that if we were in the rural areas with the CBD, they would be referring cases. And it would be nice to refer to the state hospital from the primary, if they had problem.

And so, the first family planning clinic was opened in Ibadan, and that was what paved way to other hospitals nearby having it. Tomorrow we will start talking about how we started increasing number of health workers, and how we integrated family planning into school of nursing and midwifery, and

how we started the market business approach. I decided that if there was going to be a policy—this was headed by late Professor Ransome-Kuti—people should be prepared with information. And fortunately, the UNFPA country rep, in 1988—I now approached her [and told her I wanted] to write a book on guide to family planning. If people read about it, they will understand, and when we are talking about policy, they will know what we are talking about. And if we are talking about using a method to prevent pregnancy, they will know what it was all about.

And so they said I could write it. And fortunately, a publishing company, Spectrum, decided that they would take the printing over, on the one condition there is a market for it. So I wrote it in Yoruba, in Ibo, in Hausa, English, and French. Having it in all these languages, UNFPA now decided to buy this, and then gave it to all the states so that people were able to read about family planning, what it was all about, and how they can use it. So, this is the second edition.

Sharpless

The book called *Guide to Family Planning*.

Delano

Yes, and the third edition will be coming out. I've just finished a third edition. I've updated it because now you have HIV/AIDS, you have breast cancer, you have sexual dysfunction, you have—what else have I put in? I've put in sickle-cell anemia. They want to know about sickle-cell anemia. They want to know about [these] other issues. The next edition I've just submitted to the publisher before I came. But what brought about the writing of this book was the policy. I wanted people to be well informed about the issue of family planning so that the misconception and the myths they had about

family planning would be dispelled, because ignorance is a disease. When people are well-educated, they will know they're right. They will be able to take the decision based on informed choice. This was what motivated me to write it, and so that was how it started.

Sharpless

Well, this is wonderful, and I've thoroughly enjoyed it, and we'll go again tomorrow.

Tape 3 ends.

End Interview 1.

Interview 2**Sharpless**

Today is October 8th, 2003. My name is Rebecca Sharpless, and this is the second oral history interview with Mrs. Grace Eburn Delano. The interview is taking place at the home of her daughter in North Wales, Pennsylvania, and it's part of the Population Pioneers Project.

Okay. We had, I thought, a great outing yesterday where we got you well into your career as a nurse-midwife, and when we left off you were still working with Dr. Ojo with the University Hospital, doing all sorts of different things. And I think we said today we would start out talking about the market-based approach that you adopted in your work.

Delano

Thank you very much. We reviewed the various approaches to delivery in family planning in the country, and we decided to use innovative approaches to ensure the acceptability and availability of family planning services. And what actually prompted us to start looking for other ways was, after the policy in 1988—

Sharpless

And what you're talking about there is the government—the national—

Delano

—the policy on population. And that was when the late [Health Minister Olikoye] Ransome-Kuti, who died just few months ago [2003]—he was the only one who had the courage to come up with a population policy. All the while, people were dragging their feet for one reason or the other, and so politically we did not have much support. I would want to call the support we had before then sort of lukewarm, rather than an aggressive and progressive and highly participatory type of support. That was not all that forthcoming.

But then when Ransome-Kuti was made the minister, he decided to use maternal mortality rather than looking at population, because we discovered that maternal and infant mortality had continued to rise. It went from 800 to 3,000 per 100,000 births. And right now, rather than coming down, it's still going up. So he decided that if the men were not forthcoming, he would want to use another strategy, based on the life of the mother and the baby. So he came out with a policy of four children per woman. [The policy of] four children per woman was well embraced by everyone.

But then some of us thought of a polygamous family. If we are thinking of improving on the quality of life, are we doing justice to a family by saying four children per woman? The woman could have four and stop. But then the man who is in a polygamous family, if he has six children, it could mean that he could have six times four, which would be twenty-four. And when you look at twenty-four, think about the economic status of that family. The poverty is staring at everybody. Those of us who are midwives and were really advocating for reduction in maternal mortality, we welcomed [the four-children per woman policy]. At least it was something coming forward at last that really gears people to start thinking about the effect of high fertility, not only on the mother [and the child but also on the nation].

Then, of course, we had the Rapid [Assessment Methodologies]. The Rapid now came forward to tell us the effect of high fertility on health, high population on the economy, on agriculture, on education, on the economy of the country. And so, with the policy now [in place] of four per woman, and, of course, the Rapid presentation going on in every circle, we were able at

least to have family planning accepted to certain extent. One thing we were happy about was that at least the woman will now be able to have a rest. But then it has to be backed up with quality of care, because even if you say four children per woman, and the quality of care is not there, then it's a major problem.

Sharpless Now, when you say four children, that's four living children or four births?

Delano Well, you are now coming out with another dimension. Are we saying four births or four children? Well, it was silent on that. It just said four children per woman. And—

Sharpless So, if you lost two, then—

Delano Well, the hope [was] that with aggressive education, information, and availability of family planning, women would now be better informed, their children would be better looked after. The program for infants would be more intensified. The immunization program would be more aggressively implemented, so that at least the six killer diseases [of] children, one would have a solution to that, and these children would stay alive.

As I said earlier on, the premium that Africans pay on children is so high. They would rather die from having babies than to stay alive not having a child. We have a proverb at home that says that (in Yoruba), *Omo laso me*. What that means is that a child is the cloth that you cover your body with, that gives you shelter, that protects you, and gives you honor and glory. This is what it means when you say a child is the cloth that you tie around your body. And with that adage, Africans would rather have children.

So, four children [per woman] meant that the health sector had to ensure

that you start a program that would provide quality of care. When you are talking about quality of care, it's talking about the right to information, the right to privacy, the right to confidentiality, the right to availability of method, the right to affordability of method, the right for the woman to be able to choose the method she wants, and that includes mixed methods. So if we have to look at those elements that make up quality of care, how can we implement it? This was how we now started various training programs, and looking at various approaches, and thinking of how can we institutionalize family planning so that it will now be seen as part of health, rather than as part of population. And of course that was where the Cairo program came in right on time. I will come back to the Cairo [program].

Sharpless Yes, I want to talk about that. Could I ask you a couple of questions, though, about—

Delano Go ahead.

Sharpless You mentioned the polygamous families. How common is polygamy in Nigeria?

Delano It's very, very common. It's very, very well accepted, culturally accepted—

Sharpless What effect do you think that has on women?

Delano Well, when you are in a polygamous family, it means that the husband is going to have so many mouths to take care of, and there's tendency for the men to want to neglect their duties, shirk their responsibilities. And some of them now see themselves as just there to provide babies to the women, and it is their headache to look after the children. And that is why some of the children are not really well cared for, because if you have so many mouths to

feed, believe you me, you can see that the quality of care would not be there. But it's accepted religiously. It is accepted culturally.

Sharpless

Yeah, when I was talking to Nafis Sadik, she told me that in Pakistan, one of her clients, her patient's husband, said, "So what if my wife dies? I'll just get another." How much did you run into that kind of attitude in Nigeria?

Delano

Well, I will say that was careless talk and having a nonchalant attitude to human life. It's an unpardonable sin, and I don't think any man should be allowed to get away with such a statement, because if he could say such a derogatory statement, the woman should then be able to say too that if he dies, she, too, would be able to pick up another man. And I think the women should pick that up, and let [men] know that they are not machines, they are human beings, and when you marry, you don't actually marry for the sake of procreation. You marry for love, and, of course, your culture does say you should replace yourself. But that's not an indication that a human being, especially men, should think that the woman is only there to produce babies.

And that was why we included male involvement in our program, too, which was one of the strategies we used. An African man, if he means it, he will not open his mouth to say it, because we have another adage (in Yoruba), *Ki eru eniyan meji ma di eru eniyan kan*. It's a prayer that means, "May it never happen to my family where the [responsibility] of two people will now become the [responsibility] of one person, because the strain will be so much that he will not be able to cope." With that adage, you can see that an African man will not express himself in such a careless way. He will keep quiet, even if he's going to have another wife, and that is as far as polygamy is

concerned. But one thing is that it is the law. It is the law. Bigamy or no bigamy, everybody keeps quiet about bigamy. Once you have a child for a man in the African set-up, the child is accepted. It's not looked at as illegitimate child. The law accepts that any child that is born by any man should be catered for.

But what did we do with our own men—if I may divert a little—we discovered that some of them were not readily coming forward to give their consent to their wives accepting family planning for one selfish reason: the fear that [women] would become promiscuous. The men did not want their wives to have a [contraceptive] method that would not expose them, because without a method, if a woman engages in illicit affair, it will result in pregnancy. But now that she has something that will protect her—that was their fear.

And so, we had to allay the fear of the men. And how did we do this? We embarked on male involvement. Male involvement meant training voluntary health workers who are male, who now start talking to the males themselves. This is a sort of a peer program. That is, the men to the men, the women to the men, and then vice versa. We then decided to identify communities who we could use as promoters [of] healthy living, rather than just promoting family planning. Their role is to promote healthy living, to promote reduction of maternal mortality, and then to advise and inform and educate and encourage. When you have encouragers, then you motivate. So people are now being asked to go out to their communities, to churches, to mosque, to gatherings, and start educating the men on the health benefits of having a

[smaller] family—rather than having high fertility, reducing the fertility. And letting them know that when you have children too early, it's a problem.

So we are now advocating that girls should actually get married after age eighteen, even though there's the Islamic law. Eighteen is not too early. Then, to give an interval [between children] of at least two and a half years to three. Then, that they stop having children when they are about age thirty-five. But if there are some who suffer from infertility, family planning comes to play a very major role to help the infertile couple, too, to be able to have [children]. So they should not say family planning has just been there to stop having children, because it's helping those who cannot have [them]. So we are talking about not too early, and the interval, and that they should stop at not too many. And not too many means that we're asking them to stop at four.

But we've laid emphasis on health, rather than population. Why? According to [common belief], if you have land, what is your problem? [There's enough] for everybody. But they have not looked at the other indicators. So you have to educate them that if you have too many [children], it would affect the health—not only the health of the mother, but we are now laying emphasis on the health of the father, too—the health of the children, and then the community. We discuss the involvement on the nation and community last. We let them look at the implication of too many children within a family, on the health of the mother, and the father. The mother will be able to develop herself. She will be able to breastfeed. And the children will not die from childhood ailments, because diarrhea will be

eliminated. Then she would be able to even start developing herself, and she will be able to contribute to the upbringing of the children. So, the adage that says, “God forbid one of them would die and leave the responsibility to one person alone”—we now use that. These are a few things that we have used. And then the males started talking to others. What we did—

Sharpless Can I ask you one question, though?

Delano Yes.

Sharpless One of the things about family planning, though, is that when a woman can control her own fertility, she begins to control many things about her life.

Delano That’s true, because—

Sharpless And how do men in Nigeria respond to that?

Delano One thing with Nigerian women is that they are so highly industrious. You will find quite a number of them at the market selling things, although most of them may not be able to read nor write. But if they had had opportunities, some of them would have become professors. But because they did not have opportunity to go to school—well, it’s a disadvantage. But at the same time they’ve been able to actually make ends meet. They go out every day. They want to be seen doing something, and they are not the type that would want to be locked up in the house.

So family planning, according to the women we interviewed, has actually come to improve their life. Two, it has made them healthy. Three, it has made their own children healthy. And they are now able to forge ahead and be like some of us, trying to advocate that they should plan their family. And four, it makes them feel like a responsible person. They can now contribute

to development—not only development for the nation, but even within themselves, because they can even pursue other programs. Some of them started going to school. Some of them started to go to university, some into polytechnics. And even if they had had it before, the advantages of education that was integrated into the program made some of them to now want to be like those of us who are educated. So some of us are role models to them.

Sharpless

That must be scary to some of the men, though.

Delano

Well, what we have done, again, is that if you start education, you can eliminate some of the problems that were responsible for non-acceptance of family planning. When people don't have information about the why and the how, then there's tendency for them to read wrong meanings into your motive. This is why I wrote so many books. What I do in my life is that I just look at the situation. And if the situation is about breastfeeding, I use breastfeeding as an approach to bring in family planning. If it's on prostate cancer, then I now write a book on how [men] can carry out genital self-examination. You can have it done in the family planning clinic, and they will be able to teach you how to identify your problem, which is an advantage. Then if it's cancer of the breast, one of the advantages of family planning clinic is that you will be taught how to perform breast examination very early. You will detect it, and then you will have solution to it before it is too late.

Integration is one way that I have found very, very useful in introducing family planning. Make it an integrated program. Let them see the benefit, that in one spot I can get so many services without having to look for it. Another thing it does when you have integrated [approach], especially for husbands,

who are very, very jealous of their wives, and who are always suspecting [them]—[when] the woman comes to an integrated program, nobody knows what she's there for. She may be there to collect a tablet, but then in one spot she can have so many services. And it saves time. It's very economical.

Some other people look at it from another angle, that it is very costly. But really it is not. It depends on managing a program, planning it with the people, managing it effectively, and ensuring it is a participatory type of program whereby you are all there to plan together. And when that happens, programs can be run effectively and efficiently. So this was how we were able to find a solution to the problem of the male, because they are now highly involved.

And then we now started a program in the army. We went to talk to the army boys. We started a program in the churches, usually [during the synod], when all the vicars come together, and we would be asked to come and give lectures. There was a whole day so that they would be free to ask questions. And of course we have it written in such a way whereby you quote passages in the Bible, and quoting passages in the Bible would enable them to see the reason why you should plan your family. So that is the men.

Now how did we win the community? This was where the market-based [approach] came in. When we finished introducing the community-based approach in the rural area, it was accepted, and the government saw it as a very good pilot project. One thing we are happy about is that all the pilot projects that we have embarked on—when I say “we,” I mean late Professor Ojo, Professor Ladipo, who is the president of my organization, and

myself—we always plan with the people. And when we plan with the people, we sit down with the government, because we want a project that will be replicable. And so, if we go and look for funds to start a pilot project, we involve everyone from the beginning, so that by the end of the pilot project, they have learned about it. They now want it, and they would want to replicate it.

So, this was what happened with the CBD [community-based delivery] in the rural area. It became a model for replication, which was now integrated into primary healthcare in the country, not only in Oyo state. With the help of Ransome-Kuti and Professor Ojo, we were able to now have this program replicated in more states.

Now with the market, what prompted us to go to the market? The women's organization known as the Committee on Women and Development was set up when they were trying to empower women in the country to start taking responsibility for their own health and development. That was when we were planning [for] the Cairo [conference]. So with that program, they would normally go to recruit women to start a program on development. And usually they go to the market. But the problem they had in the market was that the women told them that quite a number of their children were dying, and they wanted hospital built within the market. So they approached us. I was at the university then. This was in 1984, '85. They approached us that could we ask those who started program in the rural area to help them build a hospital in the market. So we thought that there were quite a number of hospitals all over the place, and they were not being well

managed. And the more you have, the more problems.

So, we said to them, Don't you think you should take your destiny into your own hands, and start what the Red Cross were doing many, many years ago, and the Girl Guides—providing some care, and being educated to do it, rather than building a big hospital? That would be cheaper, [and would involve] quite a number of people participating. So they bought the idea that we should start what we call a market-based maternal child health and family planning program, for treatment of common ailments, within the market.

We then began organizing with them. Then the late Mrs. Florence Remilekun Akintunde, a nurse-midwife, was made the program director. And then another lady who was a chairperson of the Women and Development Program—she, too, is dead now—Mrs. Saiyose. And then we had Mrs. Ajoke Feyisayo, who was then the overall chairman for the state. Then we had late the Mrs. M. Ajose Harmson—she, too, is dead now—who was actually in charge of women and development in the country. So when they approached us at the university, we decided to talk with Columbia University. This was another request that was coming in, and could we take it over. Columbia University decided that they would look for funds, so that we can start a market-based project.

There were 440,000 stalls in thirty-nine markets within Ibadan City. Ibadan City is in Oyo state, [which has] with a population of about four million, but they have the largest market in the western state. So we decided that in the thirty-nine markets we would train 365 women and men who were selling things in the market. And the criteria for selection [were that] they

were interested, they would want to participate, and they have the time to spare. There would not be monetary incentive—it has to be voluntary. And they would be able to carry out health education, and they would be willing to ensure the continuity of the program.

So with this laid down, we now identified the women, and we gave them fifteen days training on maternal child health—not delivery, but referral, treatment of common ailments. The common ailments were the few killer diseases, preventable killer diseases of infants: malaria, diarrhea, cough, and, of course, treatment of wounds—and then education on immunization and referral, and looking after women who are antenatal, and so on. So with this training, they were happy to take it over. They were all willing, and they accepted it because that was the first time we were training people in the market. So we gave them kits, and with the kits they now started a program within the market, providing family planning, referring clients to the nearest hospital. Cases were now referred promptly. Children with problems [were also treated].

And then we developed various songs that would help them remember what they were given. For instance, for the treatment of malaria, we taught them the regime, and it was (singing in Yoruba)—

Sharpless

That's the tune to "Ten Little Indians"! (laughs)

Delano

Exactly. (singing) "One little, two little, three little Indians." So, we used a tune that their children were familiar with. [We sing the treatment song. The antidote for malaria is ten tablets. Anti-pyrexia is eighteen tablets. Anti-histamine, or anti-itching, is three tablets. To increase appetite is seven

tablets.] You can see that the technique we use, the methodology of training, [encourages] women to learn and participate. And, of course—

Sharpless

Let me turn the tape.

Tape 1, side 1, ends; side 2 begins.

Go ahead.

Delano

And, of course, family planning was really embraced. They actually came out with the adage (in Yoruba) *Omo bere osi bere*, that is, “Many children, many miseries.” Another is *Osan ki a bi okansoso oga yato si egbegberun ti won yoo je eru*. [This means, “I would prefer to have one child who is a master than thousands of children who are slaves.”] This is one of the various adages that they use when promoting family planning.

Sharpless

Now, would these market-based clinics then have a supply, for example, of oral rehydration medicine?

Delano

With the oral rehydration part, Ransome-Kuti decided that he would prefer a salt/sugar solution, because you don’t need to go and buy that from any chemist. So they have that in their kits. They had everything in their kits so that they were able to provide services. And that project—we collaborated with the local government, with the ministry, which is the secondary. That is the university working with the secondary level, and the secondary level working with the primary level. And so, the three tiers of the government work together to implement the market-based program.

Sharpless

How was Columbia involved with this?

Delano

Columbia was a mentor. Columbia assisted us in getting the funds. The funds actually came from AID. We worked together, and that was how the field on

market-based [programs] was put together by Columbia. And it has been found very, very useful, especially in medical schools, on how to use various approaches in reaching the masses. And I want to say at this time that, based on [that] program and approaches that we [have used] in improving healthcare delivery in the country, Professor Ladipo and myself got the Sasakawa Award for our contribution to improving healthcare services in the country. And we went to the assembly in Geneva to get the award. And we were—

Sharpless That's from the World Health Organization?

Delano Yes, we were the very first Africans to get the award, and we felt very happy that what we were recognized. The government took over the market-based project in 1989, and you could see that the pilot project became a model in the rural [areas].

Sharpless And that's exactly the way it's supposed to work.

Delano Exactly.

Sharpless Just exactly, yeah.

Delano Exactly. Handing over, handing over. And then the immunization program, too, improved, because women will now mobilize people. They will even come to the market so that they can have the immunization. This is where community involvement plays a major role, when you are thinking of a program. That should be a program of the people by the people themselves. When they are involved, they see that [they have] ownership, and so the resentment, the hostility [is] highly reduced.

So, when people say, Ah! we [went] there, but they didn't accept it, you

should find out what happened. What was their entry point? How did they manage their entry point? Were the people taken for granted? What we should all try to avoid is taking people for granted. No matter how knowledgeable you are, you must try to come down to the level of the people. Use the language they will understand, and if you are very, very explicit with your information and you get them better informed when you are taking off, your program will be accepted, and they will do it themselves. So, this is the history of the market.

We now decided to institutionalize this program, because we've been running helter-skelter, I would call it, from one spot to the other within the community. But you need other people who [are] knowledgeable. We should be handing over the baton. We should not be seen as doing it alone, because we were just a drop in the ocean, working in Oyo state, which was one of the thirty-six states in Nigeria. So we decided that this program should be institutionalized. As I said, in 1973 to '76 Ford Foundation started training graduated nurses, doctors, and social workers. So, Pathfinder Fund now decided to come in and fund the training program in the country. But before then, late Professor Ojo, myself, Professor Minkler(?) from Berkeley University, and Dr. Morasha Morasha (?)—we were asked to go around to institutions, universities to see if what we started at the University of Ibadan—integrating family planning into the existing clinic—if the same thing could be done [elsewhere]. So we now moved on, and we taught [at] sixteen universities in the country.

The idea [was] to identify the need of the university, to educate them

about family planning and its usefulness when it is integrated, and about how it could play a very useful part in decreasing maternal mortality and infant mortality—to identify personnel who were interested in wanting to implement the program, and would be willing to implement it, to identify a team who would want to work together—rather than an army doctor, army nurse, bringing everybody together as a team, because everyone is important.

And with this we now moved from University of Ibadan to another university. It's called University of Ife. Then we left University of Ife. We went to University of Ilorin. Ilorin again is between the south and the west and the north. Then we moved from Ilorin, and went up north to Professor Fakaye?? in Ilorin, Doctor Banbushe, and Doctor Odejida?? in Uunife. Then Doctor Epuinpu?? and now Doctor Shitu?? has taken over in Ahmadu Bello University in the northern state. Then I've forgotten the name of the other doctor in Maiduguri. We taught at sixteen universities, and picked these universities as strategy points in the north, in the east, in the west, so that they can start.

I was now made a temporary country rep by Pathfinder, although I was working at the university. We were able to get a proposal written, send it to Pathfinder, and Pathfinder Fund—but is now called Pathfinder International—now decided to fund these programs in all the universities, so that they can start replicating what we did in University of Ibadan, in the department of OB-GYN.

The only university that decided to integrate it into the community health then was University of Ife, because they had a program called O-4, and this

program was being funded by [an] obstetrician-gynecologist who did not want competition, and he personalized the program. And we felt that for a program of such nature, everybody should be involved. We would prefer to have it in O and G, but when he was being difficult, it was now transferred to community department at the University of Ife.

Another university that started double implementation is University of Lagos. They had it in department of OB-GYN under Professor Osage??, and Professor Isa?? had it in the community department, and Professor Ransome-Kuti had it in the family health community unit, so that they were the three running the program. The late Professor Ransome-Kuti was a pediatrician, but he actually played a major role with Ojo in the promotion of family planning in the country. So, then we went to Jos under Dr. Wright??. Then Professor Otuba?? took over. And that was how we were able to spread the tentacles. And then we went east to Professor Ochukuedebele??, an obstetrician-gynecologist. Simultaneously these programs were going on.

Then we decided, Why don't we try an institute, one of the churches? So we moved to Eyeno??. Eyeno Hospital is an Anglican set-up. But this time around, we now introduced laparoscopy to Eyeno, and this was done by JHPIEGO [Johns Hopkins Program for International Education in Gynecology/Obstetrics]. So, that was how we were able again to move and work with the religious group. And so, the training of laparoscopy came under JHPIEGO, the integration of all the other methods under Pathfinder Fund. And—

Sharpless

Was that the first time sterilization had been introduced?

Delano Well, sterilization was introduced long ago, but on request through a major operation where you will cut the woman open. We called it laparotomy. But this time, it's now using the—

Sharpless The tiny—

Delano —endoscope and the tiny—yes—to do it.

Sharpless Much less invasive.

Delano Yes, and this was how we now set up the first outpatient endoscopic clinic at University Hospital. So, again, it's to promote sterilization. And now that we have institutionalized it in the university, Pathfinder came in to start training graduated nurses, and graduating nurses. We had to start a pilot project, because the nursing council did not give it a thought. Nobody gave it a thought. And we felt that if we want family planning to be institutionalized and be part of health, it has to be in the curriculum of school of nursing. It has to be in the curriculum of school of midwifery. It has to be in the curriculum of school of health technology. Health technology was no problem, because that was Ransome-Kuti's baby. He started that program, so it was incorporated.

But for the nurse-midwife, it had to be done, and this was how Pathfinder decided to let us run a pilot project. Six thousand dollars was given to us then that we should embark on the training. And what we did was that those who were leaving the—we are now calling them graduated—don't forget that we have trained the graduated, now the graduating—we now started a program within the university credentials (unclear), Ibadan, under the principalship of Mrs. Rachel Babalola. She, too, is retired now, but

she was so much interested. She gave us all the support, and so we started collaborating with the fertility research unit in the University College Hospital, Ibadan, under Professor Ojo and Professor Ladipo.

And so, these nurse-[midwife]s, when they are about to finish their one-year program, they will now come in for six weeks to the family planning unit. And so, we will conduct the six weeks' training and the six weeks' posting. And we started giving them certificates. With this certificate, when they qualified, they had an edge over other midwives trained in Nigeria, because they now had two certificates, one for family planning and one for midwifery. So they were getting jobs.

So, the other nurses now protested that they, too—the student midwives—they would want to start such a program. What we were trying to do was to prove a case that it would not increase the time, the duration of their training, that it could be easily integrated within the component of midwifery, because when you look at family planning, most of the topics were really associated with obstetrics and gynecology. It's looking at the reproductive organs, and when they are giving them lectures on reproductive organs, it would be given once and for all. And when they are talking about complications, how you can prevent complications, family planning comes in. So, it wasn't anything extra that would be involved.

Anyway, we did the pilot project, and were now able to put together a good report to let them know that the nurses, the midwives, did not spend extra time when they were training. With this in mind, that was how JHPIEGO came in with Connie Husman. Connie Husman used to be at

JHPIEGO. She has now left JHPIEGO, but she's still very active. And so they brought a grant and asked us to run a workshop for the principals of school of nursing, school of midwifery, and school of health technology, so that we can now present our findings. And with these findings, we decided the training would take place in northern state, where we have [found] problems, and get them involved with the planning.

And so we had this workshop. She had her findings of how it was integrated, how it did not harm their studies, but rather enhanced their studies, and how they are really in demand when they looked for a job, why people want them more than those who did not have it. So with this in mind, the nursing council was there. We started putting heads together to write a curriculum for school of nursing, school of midwifery, and health technology. And I'm happy to say today that family planning has been integrated into school of nursing, school of midwifery, and school of health technology.

Whilst waiting, we thought that there were other ways we can really ensure that people are trained, professionals are trained, because that would be the major barrier. If they are not well trained, they would now start [spreading] rumors, misconceptions, misinformation. So we encouraged states to start schools of family planning. The first school of family planning in the country was started by Mrs. Maku?? at Ogun State [University], which is again in the western part of Nigeria. And Pathfinder Fund readily gave the support. The other one again was started—I'm happy to say that now they have a school which was built by USAID later on. The other school was

started in Oyo state. That is still running. So, those two schools are still running, and the other nursing schools and OB-GYN departments at the universities are providing the services. So you can see that we've looked at the tertiary [level of care]. The tertiary [would transmit the knowledge] down to the secondary, [and] the secondary would now provide services to the primary. So we were now feeling more comfortable that we have trained quite a number of people.

What else did we do? These materials came out so that it would enhance training. That is the material—

Sharpless The clinical manual—

Delano The clinical manual on IUCDs. Then *The Guide to Family Planning*, [which] it was written when the population policy was coming out, [and became] very handy as the reference material for anybody. Then Bob Hatcher came in with *Contraceptive Technology Africa*.

Sharpless Okay, he was at CDC [Centers for Disease Control and Prevention], right?

Delano Oh, yes, CDC and Emory University. But it was CDC and Michael Dalmat, Professor Sai—

Sharpless Professor Fred Sai?

Delano —Grace Delano, myself, yes. We now went to Ghana. You know, that was where we went to put heads together to put together *Contraceptive Technology Africa*.

Sharpless I want to talk about that, because that's been crucial. How much work was there at this point? How much work was there across Africa? How much were you thinking about work in Nigeria? You mentioned you were going to

Tunis, you were going to Ghana, you were going to South Africa.

Delano We'd gone to Kenya, Egypt.

Sharpless So, you were all over. How extensive was the dialogue, then, between the different countries of Africa and the work—

Delano Now what was unique, again, based on the experience that I had in Nigeria, I was now recruited by JHPIEGO to go to Ghana to see if it can be integrated in Ghana. And with one doctor, [Winifred] Ogundehin—she's a professor now in the school of nursing—the two of us were asked to go and carry out a needs assessment of how family planning could be integrated into the school of nursing in Ghana. So we now taught Ghana, Kumasi. We went around. We went to Cameroon, we went to Sierra Leone, we went to Gambia. And going around like this, they were all looking at a woman who has done it before, a woman who can really tell them how it worked, and—

Sharpless That would be you.

Delano Yes, that was me. And so, they were eager to actually see, come face to face with someone who has done it, and they were able to ask questions. How did you manage it? How possible was it? What were the problems you envisaged, and how did you cope with the problems? And so, going around, we now wrote a report, and we got a grant to assist Ghana to start the integration. And I think the lady was Mrs. Kankan. I cannot remember.

So when we were in Ghana, for the training to take off, I insisted that before we start any training, all the commodities must be on the ground, because it's worthless starting a program and then waiting ages for the commodities. The problem we had in Ghana was that they had not gone to

the port to offload the commodities. And I pushed buttons, but whilst I was pushing the buttons I was teaching the others how they can carry out their advocacy, how you can twist people's fingers around, how you can be a good ambassador, how you can be a good promoter, how you can negotiate, and how you can get things done. Even if you have to use your money, don't worry. Whatever you use will be coming back to you, and the way it's going to come is that you would have achieved what you set out to do.

So we waited for a few days, and then things came in. We were able to get the commodities, and the training took off in Ghana. So when it took off in Ghana, we moved up on to Sierra Leone. Then we move up to Gambia. Then we move on to Cameroon. And this was how that lady and myself were able to go around those places. Then, while I was in Mauritius to assist in conducting training, they got to know that I [had written] a book on intrauterine contraceptive devices. So I teamed up with another doctor at the human reproductive program that was a unit organized by Dr. Ojo—and these trainings were organized periodically. And it's still being organized up to today. But myself and someone else teamed up to conduct training in Mauritius for people that were brought from all over Africa to come to that training. So, in my little way, these were the things I've done with the institution.

But then you may be wondering, How did I acquire all this knowledge? I kept updating my knowledge. For instance, I said I went to Downstate Medical Center. That gave me training on family planning. Then I went to Connecticut University under Mrs. Derosha??. I don't know if she's still alive

now, and that was training of trainers. Then I went to CEDPA [Center for Development and Population Activities]. That was where I got empowered. CEDPA develops women. CEDPA makes you really think of yourself as a human being, and brings out the potentialities in you so that—

Sharpless That was—

Delano CEDPA. That was Peggy Curlin, and you know Peggy Curlin was involved in a CBD program in Bangladesh. She was the first one to do hers in Bangladesh. That was how I met Curlin, in CEDPA in Washington.

Sharpless But how did they do that?

Delano They started running management programs for women, and I was with Symkya. I was one of the first two Africans that were—especially Nigerians—that attended that program—

Sharpless At CEDPA.

Delano —and I was management. We won. Women in management won. And with the training I got there, it made me to be more determined to really want to go home and actually help not only women but people. It made me very determined to provide everything I could within my power to improve on reproductive healthcare in the country. It made me to improve, to start thinking—CEDPA told us that you can think big, but go and start small. So, with that philosophy, I was thinking big.

But all those ideas—I decided to divide them in such a way that at the end of the day, I was able to implement everything I had in mind. And so, when you are talking of your mission—my mission really has been accomplished. Even right now I can say that I came, I saw, and I conquered.

I was able to make a difference. I was able to have a change. I was able to change attitudes. I was able to get the people to change their behavior, and I was able to really get them. It's not just you doing it. It's stepping it down so that other people—it would have the multiply effect. CEDPA did that. So, with the management training, I was now prepared for the world. And that was how I went to the first Women's Decade meeting in Kenya in 1980—I think it was '80 or '85, the first women's conference that was held in Kenya.

Sharpless

Oh, in Nairobi, yeah.

Delano

Yes, in Nairobi. Yes, I was there, and I was supported by—one thing that CEDPA does is that when they train you, they ensure that they follow you until they can say to themselves that I can throw her now to the world, and she will be able to make it. They will monitor you, they will encourage you, they will give you everything it takes so that at the end of the day, you will say to yourself, I am now prepared to [pass on] my training to others.

So with all this training, I now decided to intensify my training, intensify my advocacy. I not only got empowered, but more knowledgeable and more competent, and I could speak anywhere. It doesn't matter. I could approach anybody, and I'm never scared. There's nowhere I cannot talk, and I have that courage to speak out. So I went to Nairobi for that.

Sharpless

Let me change the tapes, and let's talk about Nairobi.

Tape 1 ends; tape 2, side 1, begins.

Okay, this is the second tape with Grace Delano on October 8th. Okay:
Nairobi.

Delano

So Nairobi was where we all went to discuss the issue of women, and to start

planning strategies on how we can make sure that the problems that women were having all over the world, especially with their reproductive rights and services, were given to them. And I'm happy that I was one of those who went. After I went to the Nairobi, then I went to Cairo, then I went to Beijing, but if CEDPA had not decided to follow [up with their] alumnae, some of us would have been left aside. And so there's continuity. And fortunately, those of us that were really groomed by CEDPA, we can be reckoned with all over the world. And we have been good ambassadors. We have actually helped the needy. So I was at Nairobi for the first meeting of women of the world. Then, of course, I went to another one in Rome, Belagio, where they brought together women leaders of the world. We met again under another umbrella, bringing in all women of the world, so that we could discuss issue of women.

At Nairobi, what I discovered was that there were some people playing a fast one on Africa. When we were thinking of improving the healthcare of the underprivileged, especially in the area of family planning, there were some people trying to undermine the intelligence of those African women, and these were religious groups. The religious groups were out, and they came mostly from Australia.

Sharpless Were they Christians?

Delano Yes, and they were there to promote natural methods and having more children.

Sharpless Oh yeah, the natural family planning people.

Delano They were there advocating that they've had thirteen children and that there

was no reason why Africans should be told to limit the number of babies they have. And unfortunately, they brainwashed some of the medical doctors in Kenyatta hospital who were religiously inclined, telling them so much rubbish about family planning—how women were forced to [use] methods, how they were given injections and pretending that they were giving them immunization, how they would not examine them, and they were given hormonal methods. And unfortunately I happened to be there, and I was posted to the rooms where these workshops were going [on]. We were strategically located.

This is one thing that CEDPA taught us. Wherever you go, find out what is going on and make yourself useful. You are not going to be an antagonist. Rather, you are going to be there to correct the situation, and we are going to do it in such a way that, at the end of the day, you are going to be a friend of everyone, rather than an enemy of everyone.

Sharpless

And I can see you would be really good at that.

Delano

So anyway, I hear this propaganda about the crying fetus, that family planning was destroying the fetus. So I decided to follow them to every room, every room with the crying fetus. And then they would give their lecture, and I would now answer back. The lady that presented herself looked very poor, very wretched, a terrible of example of a healthy woman whom they were trying to use as an example. And I said to her, “I only have three. And look at you. You have had six.” I said, “Compare yourself. I’m not being nasty. You are being brainwashed.” If anyone had said, Look at your uterus—

And then, unfortunately for her, I had a condom. And while she was talking away, I was blowing the condom. And I held the condom, and went to the front to ask the question, “How many times does she think that you can be pregnant, that a woman’s uterus can hold [another] baby? Does she know what would happen to that uterus? It’s like this condom. [Pretend] this is your uterus,” and I started blowing it again. I inflated it, and I said, “That’s your uterus expanded. That’s your uterus expanding with each baby, and you can notice it’s getting thinner, it’s getting thinner, it’s getting thinner.” And before they could know where they were, it went, Boom! I said, “That’s your uterus, and you are gone.”

I said, “Don’t be misled. These white people standing there, they are not telling you the truth. In their country, some of them have used family planning. They have one child, they have two, and they are progressing. Africans are backward. We have to move with time. Women are relegated to the background. When you keep on having children, your health will suffer, economy will suffer, education will suffer, the nation will suffer, your children will suffer.” And with this, they got so scared. So each time they noticed I was around, they would leave the scene. And my duty then was that I was going to destabilize them.

Then a doctor now got up to say that she had noticed that they do not examine women before they give them injections. And I said, “You are an African woman. I feel so ashamed to be an African today. Hearing it from you, and you call yourself an obstetrician-gynecologist? Even if you have been brainwashed to come and make such a statement, you should know that

ethically [what you did was] wrong.” And if this should be heard by the obstetrician-gynecology [association], I told her, her certificate would be withdrawn, because she should not have taken part in a project that did not examine women. And if she had been doing it, and she did not stop it, then she had failed. And so this was the issue of Kenya. And that was how I left Kenya.

And everybody started recognizing this woman who was talking about family planning, because I have seen the goodness of family planning. I’ve seen the benefit. But there are some people who, ridiculously, would want to just run a program now because they are not well-informed for one religious reason. And the crying fetus had nothing to do with the woman trying to prevent pregnancy. Then I said, “Listen. A woman will not procure abortion if she’s allowed to use the best method, the most effective method, and she was not forced to use a method that was against her choice.” I said, “Give her the opportunity to be educated.” So this was how we left Nairobi, and the battle continued. I reinforced my program. I went back home and disseminated the information to women. So, that was Kenya.

Now when I went back home, I decided that I was going to bring all women together and start a program. That was how the MacArthur Foundation in 1989 decided to give us funds that we had under the project of USAID, that is, the United States Agency for International Development. We were able to recruit volunteers who could provide services. And if we could form ourselves into an organization, a nongovernmental organization, whilst I was at the university, then we could identify other organizations who

are CBOs, that is, community-based organizations. Bring them together, mentor them, empower them, and let them start providing services.

So, again, through Columbia University and Dr. Eugene Weiss—we are still working together up to today—and Allan Rosenfield, and then Goroush and a few others now helped us to get a fund from MacArthur Foundation in California. And so, with that fund, we now identified thirteen CBOs within the country. And the thirteen CBOs, we now strengthen them, we mentor them, and bring them together to form an organization. They mobilize the people themselves. Then we started training of trainers, training of the providers. And under the umbrella of these identified organizations, we were able to train their people in thirteen different places, so that they could start providing integrated maternal child health, treatment of minor ailments, and family planning.

Sharpless Now is that ARFH you're talking about?

Delano Yes, this was how the Association for Reproductive and Family Health [ARFH] was established at the University College Hospital, Ibadan. So I was coordinating it as the vice president, and then Professor Ladipo became the president, but we were still in the university. I was coordinating the fertility research unit within the department of OB-GYN, still doing training, providing services, doing research. So it was research, service, and training. And at the same time, I was coordinating the Association for Reproductive and Family Health.

Sharpless Which is the thirteen CBDs.

Delano Yes. So the Association for Reproductive and Family Health was given a

room within OB-GYN. We employed nurses for that program, and we had program for fertility research. But we worked together as a family, and that really broadened the horizon of the staff.

One thing unique about the approach of Professor Ladipo and myself, which Professor Ojo handed down to us, was that your staff should be well trained. They should have continuous updating to provide them with materials. And at this time, I really want to appreciate the contribution I had from Columbia, from Bob Hatcher in CDC, because I had *Contraceptive Technology*. A lot were now distributed freely from Pathfinder Fund, which provided commodities, and they used my house because I was their part-time country rep until Bisi Olatokunbo was appointed as the country rep. But before then, I was helping Pathfinder in the country, looking after those various universities and services. They brought in equipment, and they used my garage to house those equipments, the commodities, so that there was no institution that did not have equipment and commodities, so that services were uninterrupted. But we kept strict statistics, and the statistics were going up. The impact of the program was felt in all the universities. So with this in mind, leaving the university and the government, I now moved on to community-based—

Sharpless Okay, can I back you up for just a minute—

Delano Yes.

Sharpless —and ask—tell me about Bob Hatcher and *Contraceptive Technology Africa*.

Delano Okay. Now, the contraceptive—in those days, there were no books on family planning.

Sharpless Except what you had—you had written some.

Delano It was Bob Hatcher really that gave me the urge, the courage. And when you meet Bob Hatcher—Bob Hatcher is someone who can move mountains. And he writes—even the little book I wrote, I got the ideas from him. And one thing with me is that when I get ideas, I go back home to see how I can use it and simplify it. And he writes extensively. He has written quite a number of [books in the series] *Contraceptive Technology*, focusing on adolescents, focusing on STI/HIV, focusing on various issues that have to do with reproductive health.

So with *Contraceptive Technology*, we were invited, as I said—myself, Bob Hatcher, and Fred Sai in Ghana and Michael Dalmat from CDC—and so we met, but then there were other contributors who chipped in. We found the book very useful, and it was like a Bible to me. And they made it available so that everyone coming through our institution at the University College Hospital Ibadan fertility research unit would automatically be given [a copy] of *Contraceptive Technology*. And all the universities, too, were provided with the materials I ordered for them. So, the idea of writing, I got it from Bob Hatcher. That's one.

And then the reason, again, why I started writing—I must tell you this story. We conducted our research—I'm a nurse-midwife—and when it was to be published, I was told that I was an ordinary nurse and that I would not need it. And I felt hurt. I worked so much on a program, and then telling me that I would not need it, because I was not going to apply for professorship post. I now decided that I was going to teach them a lesson, that they forgot

to add few letters to the [word] ordinary, and that was “extra.” And I decided to let them know that. I am not an ordinary nurse but an extraordinary nurse, and that was how I decided to write this book. Fortunately, it came at a time when there was controversy, and I was happy to have Pathfinder Fund. The country rep that now took over said—I told her that they called me an ordinary nurse, (Sharpless laughs) with everything I have put in. I now want to tell them that I have a lot to offer the people, and no one should be named ordinary.

Sharpless

This is your IUCD book, yeah.

Delano

That’s it. So the first book that I wrote, Pathfinder Fund funded it through this first country rep, Bisi Olatokunbo, on condition that I distribute the book free, and then ask for comments. And after [receiving] the comments, I should write another one, based on the comments, on the evaluation. And I said yes. The books were distributed freely all over the country. And when I did that, the report that came with it improved on it.

Now when this one came out, I had another problem. The problem this time was that UNFPA [United Nations Population Fund] said I should distribute it to all the schools of nursing and technology, and then midwifery and medical school. Then someone decided to stop the circulation (unclear) paid for. So what I did was that I kept writing to all the schools that UNFPA had made books available for you, go and collect them. And on the third letter, in annoyance, the officer in charge had to distribute it, and had to apologize for holding the books.

And I asked him, “Why did you hold it?” He said because I had written

Guide to Family Planning, [and] he wanted other people to start writing. I said, “One way that you can encourage people is when people write, you encourage them and distribute. And when others see that books have been read, it will encourage them, and they will join.” I said that was one way. So, this was how. And I said, “Listen. I was trained by CEDPA, and CEDPA said, ‘Don’t give up.’ I don’t give up easily.” So, this was how this got circulated.

Sharpless

You obviously have an enormous capacity for hard work. How did you manage to raise four children while you were doing all this?

Delano

Well, thank you, again. I want to thank my husband and my family, and, of course, we have what we call extended family in Nigeria. You can see I’m here helping my daughter. Others would have been here, but they were not given visas. And [in an] extended family, you are there to help your family. I told you that my mother used to have other people’s children in her home. And so my house is always full of children. Having children was no problem. Everyone [helped] to look after the children—my husband was there, and everybody. So it’s matter of trying to plan your program in such a way. And if you are a manager, and you have been trained in women and development and women in management, you should really know how to manage your own home before you know how to manage your organization.

So, based on my training, and even based on my own ability to want to do things myself, to want to improve myself in life, I was able to cope. But I didn’t have problem with my children whatsoever. They were not neglected. They were all well read, all of them. And one thing is that they follow the

trait of—my mother did this, my mother did that, and I must do it. So everybody wants to excel. So that is the training, and family planning. Now, MacArthur—

Sharpless Okay, well back—yeah, go ahead.

Delano So, with the MacArthur Foundation, we were funded for five years. And after that five years, we produced a beautiful material on five years of MacArthur's project. And we even produced a film, *Where They Live and Work*. For the first program of three years, we were mentored by Columbia. Then after three years, we were now asked that Columbia should wean us, that we were now prepared to stand on our own. So MacArthur Foundation funded us for another three years.

Sharpless They funded you directly.

Delano Directly for another—this time around we now went out to other communities. And the communities we went to—we identified twenty-one other NGOs, and the twenty-one other NGOs now identified others, and we had about fifty-six. With the MacArthur Foundation, we identified seven NGOs. The seven NGOs worked with twenty-one others—three, three, three. And the three, three, three identify others, making fifty-six CBOs. So, it was seven, then fourteen, then twenty-eight, and then fifty-six. So, with this, we were now all over—

Sharpless I'm sorry. Are they NGOs or CBOs?

Delano There's the nongovernmental organization, which would be the head. Then there's the community-based organizations, which are based within the community. So, being based through the NGOs we identify, we strengthen

them. And through them, they now identify CBOs, and the CBOs, they strengthen them. This was like handing down. We conducted various management training to start off with, supervisory skill training, then training of trainers and training of the agents, training of promoters, and male involvement. It was reproductive health. This was post-Beijing, after we have now gone to Beijing.

Sharpless This is after Beijing, okay.

Delano Yes, we have left Cairo. We have now gone to Beijing.

Sharpless Yes, oh, yes.

Delano Well, we left Nairobi. We went to Cairo. Now, with the issue of Cairo, some of us helped—

Sharpless Yes, let's talk about Cairo, yes.

Delano —to write the position paper for the country, because the government was not aware that there was—or they were not really actively involved. Let me deviate a little. We now went to pre-Cairo conference. Again, thanks to CEDPA, that identified some of us that they had been grooming. We met by chance in New York, pre-Cairo. And it was when we were at the conference and listening that we looked for a representative from Nigeria. No one was on the seat to occupy the chair. So we decided to form a coalition right there, because for us to have a voice heard, for us to be able to speak, we have to tell them that we were representing Nigeria as one. And so a few of us came together, NGOs, and this includes the Association for Reproductive and Family Health, Women's Health of Nigeria, WHON, Girls Power Initiative, COWAN—COWAN is Country Women of Nigeria—and one more is a

sociologist. So the five of us now decided to hold a meeting, and to now march to the embassy in New York to find out why there was no representative at that crucial meeting. And they gave us some information.

We were not pleased, so we decided to start working together. Fortunately, we were supported. All of us were supported by CEDPA, but we just met by chance, and that was how we decided to design a strategy on how to go back home and use the coalition. Right there we decided to give it a name. So, we call it CONOHPD—Coalition of Nongovernmental Organizations in Health, Population, and Development. So the five NGOs now formed a coalition, and when we got back to Nigeria, we wrote a report, and we sent it to the ministry. Then we now looked for funds. Fortunately, again, we got a [grant]. I think it was either MacArthur Foundation or—what was [Joan] Dunlop's program, I'll think of it in—

Sharpless

International Women's Health Coalition.

Delano

International Women's Health Coalition assisted us, and so we now started planning for Cairo. We were going to get the government to do something, so our coalition assisted the government in writing the position paper. But before we did that, we all went to our different states, and we mobilized all the women.

In my state, I was in charge of the B Zone. I mobilized them, but I had to divide them into two: those who could speak English and those who could speak the local language. So I held two different workshops, telling them about the Cairo plan, what we all planned to do, and asking them for their views and their ideas of what they would want us to present in Cairo. I put

mine together, and the others put theirs together in their various states, and we invited religious leaders. Every organization got represented, and this was how we assisted the government to prepare a position paper. But we did not stop at that. We now conducted a mini research of the perception of people: what they felt, how they felt, what they would want done. We compiled it and wrote a book.

So when we got to Cairo, we held a small meeting. We brought women together to share this meeting. We assisted them to get sponsorship, so some of them came to Cairo. And so, the government representative came to Cairo, we were recognized, and this was our contribution to Cairo. Now, leaving Cairo—

Sharpless What was the most important outcome of Cairo for Nigerian women?

Delano The most important was that we were more enlightened. We were better informed. We were able to present a case in a united front, even though the government was dragging its feet because of the Holy See. We were able to let them know that we wanted family planning because we're there, and the issue really boiled [down to] abortion.

Sharpless How powerful is the Catholic Church in Nigeria?

Delano It depends on the state where you are. If you are in the eastern state they are powerful, but even then we have pressure groups there who were actually making things work. And under the MacArthur Foundation, we were able to get a group in the east under the Soroptimists in a village called Ogbaru. Then we were in another part where Catholic were very strong, and that is in Isialangua??. In Isialangua we used a Youth Corper—you refer to it as the

Peace Corps—we used a Youth Corper who had worked with us in the south, but now posted to that state to work with a women’s group. Then we now move to Rivers state. We move to Delta state—you know, Rivers, and Akwa Ibom. We were working with various NGOs under MacArthur Foundation.

And so we brought out the book on *Where They Live and Work*, and then a film on *Where They Live and Work*, about how women providing services, education, advocacy, about women’s empowerment, male involvement, and getting them to start working together to see that there’s a need to improve the quality of life of the masses. So, when I get back, I’m going to send you some of the publications so that you can see it.

Tape 2, side 1, ends; side 2 begins.

Sharpless

So, the government was responding to the Holy See then, and you had to—

Delano

Well, the government did not respond to the Holy See, but you have the Holy See on one hand, and you had the Muslims on the other hand. One thing that we have come to appreciate when you are working in reproductive health is that politically there may be silent acceptance. You can do your thing as long as you don’t make noise with it. And even if you make noise, you have to make it in such a way that whoever happens to be there when you are making your noise, you would approach the issue in a more mature, political way so that it will not develop into hostility. You must have a style of approaching issues, and when you have that style, you can actually weather the storm, and this is what we have done. It’s knowing the right type of people to approach, knowing the right approach to use, and identifying the

right climate when you will really hit the nail on the head. And when you do, before they know where they are, they have said yes, and you have to move like lightning. I believe [you have to] strike whilst the iron is hot. When there's a need for it, just go in. Don't leave it until tomorrow because once you do that, then it will be overtaken by events.

So, when we have a program, we move fast. You have the idea, you move fast, and then you identify people that you can put in strategic places and make sure that they give the right type of information that will be backed up with materials that will guide them. The trick we have, or the strategy we have used, is that we write it in Yoruba, we write it in English, we write it in Ibo, we write it in Hausa. Simplify it. My style of writing is simplicity. I don't use jargon English. I come to the level of the masses, and those who are highly read, if they want to read my book, they can read it. But I want to reach out to those who are really in need, and this is why they call me, again, the media call me Obera Yatata??. Obera Yatata means a very nice woman, one of the best women. Obera Yatata is an adjective that qualifies a woman who is good. And the market women call me Mama Planner, Yetu??. So, whenever there's something going and they want me to speak, you will hear the boys say, Yetu, Etu, Etu, and that is when I will come from behind and speak. That is the Etu. Anyway, with the Holy See we all went back. And we were all going out in one voice—

Sharpless

This is after Cairo.

Delano

Yes, so all the organizations—we were all performing excellently in various areas. What we did was that we wanted to conduct research to find out

perceptions of women after Cairo so we [would be] prepared for Beijing. And so again we conducted the research, and it was on the perception of women on (unclear). I will send that to you. Just remind me, because we published a book which we circulated.

Those of us who went out with a mission wanted to see how we can get the government involved, how we can get the people better informed and participate, and how we can all come back to make a difference. And I want to tell you that we all made such differences. There's the lady in Kuwait??. She's very powerful where she is. The lady in Juan??. although she's now in WHO, but her project is still going on—the Girls Power Initiative, targeting and empowering women and youth and girls. And I'm looking after reproductive health, and this was how we have managed to work together and are still working on the coalition. We are the only coalition that had worked together harmoniously without problems, and we were able to bring out two research materials. We did not overshadow each other. Your ideology in your various organizations you can carry it on. But then when we come together, we come together as a team, and we go back to work with the communities to empower them, and this was how we prepared for Beijing.

Then we went to Beijing, and I presented a paper on my experience of five years with MacArthur Foundation. MacArthur Foundation funded us for ten years, but for those ten years we were able to mentor other NGOs, develop the capacity of various NGOs, and we are happy to say today that there's no—if you look at the various areas, you divide Nigeria into four, even if you are looking at the geopolitical zones—you will see Association

for Reproductive and Family Health, or fertility research unit, or Ebun Delano and Ladipo and Ojo in all those places, either in the university, tertiary, in the secondary, and so on. Whenever committees have been set up either locally, nationally, we are always being invited as members of the taskforces.

Right now I'm the chairperson of the taskforce of the USAID-funded project on community-based [delivery programs]. Professor Ladipo is the chairman of Reproductive Health, and I facilitated and coordinated the writing of the national reproductive health and family planning book—my training manual for TB and voluntary health workers to be used in the country. That came out last year just before Professor Ransome-Kuti died, and was the first time that we came out with an illustration on standing order??—but using pictograph—on the standing order for TBs and voluntary health workers. They are the latest now, and they are the ones to be used nationally.

Sharpless TB—tuberculosis?

Delano TB is traditional birth attendants.

Sharpless Oh, okay, not tuberculosis

Delano Voluntary health workers are VHWs.

Sharpless Okay. Traditional birth attendants.

Delano So there's a national training manual now which I coordinated for the government—that was last year. We can now move on to—under the MacArthur Foundation, that was how we worked in the riverine areas. In the riverine areas, we trained the communities. We call it *Where They Live and*

Work. Healthcare services are not available. Again, through MacArthur Foundation, we were able to identify NGOs, the National Council of Women Society, [which] is an umbrella for the country's women organizations. Again, with MacArthur Foundation, we will identify them, we will give them seed grants, and with a seed grant we will train them so they can train others. So, with that services were being provided on the lagoon, on the sea, in canoes. And we made the film of *Where They Live and Work*. Now, that is working in the riverine under MacArthur Foundation.

Sharpless Now, you're saying "riverine," right?

Delano Riverine is—you have to go through marshy areas.

Sharpless Okay, so isolated?

Delano Isolated, lagoon, in swampy areas, and you can only get there—

Sharpless By boat.

Delano —with canoes. Not speedboats, canoes.

Sharpless Canoes.

Delano Yes, so this was what they used, and then—

Sharpless So, these are the people who are at the back of the back, kind of.

Delano Exactly. Disadvantaged. Our program really is to go to disadvantaged areas where the government has not been and to use it as catalyst to create awareness on the magnitude of the problem so that the government would be there. And so we were able to promote family planning, which in actual fact had tremendous effect on reduction of a maternal and infant mortality. But using this community to take their own destiny into their own hands made them actually let the government know, Come over to Macedonia and

help us. And it's not only in the east—most of the cities. So, under our organization, we have covered twenty-six out of thirty-six states in the country, and so you will notice our tentacles in every state. The other states we have not covered, we may be there training and mentoring, bringing [people] in. Another thing we do is that we encourage NGOs to come and learn from us, so they send their staff to our organization, and we groom them.

Sharpless

How much have groups from other parts of Africa come to see you?

Delano

When we were running training in the fertility research unit—that's when you will have the Africans coming—but under Association for Reproductive and Family Health.

I will now go on to the youth program. That is when we had the West Africa Youth Initiative. Now, I have talked about the various approaches we have used starting from the university whereby we promoted the ideology of integrated family planning into the university and then established training program. Then the training program graduated, and then we started laparoscopy training. And in that university, nurses were trained not only to do insertion but to do Norplant as well. So nurses do implants. We now train people in implants.

So, moving from the university, I now went to the level of secondary, whereby the government in the hospitals were encouraging integrated family planning. Then I went further to ensure the integration of family planning into the school of nursing, midwifery, and health technology. And then we provided various materials for them. We now move to the community

whereby we integrated it into the urban, into the rural, and it became a model. Then we went to the market and used the market-based program, and it became a model and we handed it over. Then we decided to go to the riverine area, so that they can work by the seaside in a marshy area where governments are not available. Another thing we did was that we provide consultancy services. And being one of the alumnae of CEDPA, I was appointed as their consultant to work in three states in the country. And this time around, I requested that I should use another approach, using a moving railway. Do you call it railway?

Sharpless Railroad, railway, yeah.

Delano Okay, railroad. So, CEDPA got a grant and was working with National Council of Women's Society, and—they now posted me in Lagos, Odun?? state, and ocean state??—the National Council of Women Society. But then in Lagos I worked with the railroad organization and trained what we call—they are like the Red Cross, but they are not Red Cross. They are another organization that provide—

Sharpless Disaster—

Delano First aid.

Sharpless Um-hm, disaster aid.

Delano Yes, first aid. And so, we now introduce the idea that they should move with the railway—I will remember the name later. We train them to provide family planning services. We provided them with kits, and so they were moving from station to station. They were on the rails, and they gave them a coach, and that was another approach we used.

But unfortunately it was short-lived, because CEDPA had a problem with the management because the director of the program left. And so they wanted to take it over, but we wanted these organizations providing first aid to take it over, and they would not want to have such a thing. If we handed it over to the rails, they would not do it. We were afraid of the bureaucracy, and they were not prepared to give it to these first aiders. And so that was how it was short-lived. But [in] the period that that program was really implemented it really made a hit, because it was the first time that family planning services would be provided in a moving train.

Sharpless You mentioned something about youth work.

Delano So now, with the MacArthur Foundation working with women organizations, after ten years MacArthur Foundation had to stop funding us. Then Ford Foundation took over our organization. And when MacArthur Foundation was funding us, we were at the university. So in 1992 I moved out of the university and retired and moved to a separate building with the Association for Reproductive and Family Health. So, now—

Sharpless And you said you were the first NGO to have its own building. Is that right?

Delano In Nigeria, yes, which we built, and we wrote a book about it because we want whatever we do to be—the same way you are writing a book now. We have documented how we built a house without getting international funding. We raised funds locally, and that was how we built the house. I will come to that later. We call it ARFH House. So we moved down to our own organization outside the university, and they had a beautiful sendoff by the university. As I told you, I started the program with only three staff, and

when I was leaving the university in 1992, I left thirty-two staff, and we funded that mainly through the project. The university only paid the salary of eight.

We were recognized as the best teaching unit. We were recognized as the most disciplined unit. We were recognized as the most committed team in Nigeria, and we were really a role model. We were called the pink ladies. We wore beautiful pink dresses, and everybody would want to be associated with us. But we were what people referred to as workaholic. We project the image of that organization, not only locally but internationally. We were called Mrs. Perfectionists because we always want things to be perfect. And what you try to do is to [multiply] whatever we learn. We always want whatever we know to have multiply effect. When I was leaving, I was given a big portrait of myself, and I was given a very, very rousing sendoff. But we're still working together.

So we moved out to a separate rented house in 1992. And in 1992 Ford Foundation—by then, MacArthur Foundation has funded us for ten years—Association for Reproductive and Family Health was born in 1989. And we were to initiate, promote, and support innovative programs that will improve the quality of life of the masses, not only in urban area but mostly in disadvantaged areas, and not [for] adults but [for] youth [as well]. So, really our mission is to set out to improve the quality of life of the masses as far as reproductive health is concerned. We focus on training, service, and research, and that organization has the staff strength of fifty-eight and we have five units.

The founding fathers and mothers were Professor O.A. Ladipo, who is the president, myself, Grace Delano, who is the vice president, and Eugene Weiss, who started with us with the CBD program—he became a special adviser—and a lawyer who is an accountant. We founded Association for Reproductive and Family Health. We have a board of eleven or twelve members and 50/50 (??), and apart from it being 50/50, one of my children is one of the trustees. And one of the professor's children is the trustee. Why have we done this? We want continuity even when we are gone. We had the vision, but we would want a program that would be there and would be like Pathfinder International with the (unclear). We'll be like Ford Foundation. Setting an NGO up is for the community, so this was how we set it up. But we have increased our trustees now, so there are six trustees in the organization, and that includes Professor Ototluring??. And then we have, as I said, eleven or twelve board members, but they are 50/50. You will find it in the material. I'll give it to you.

And then we have a set of ethical committees. They meet frequently so that the proposals that we write—they vet it themselves and approve it before we embark on any program. As I said, we focus on training, service and operations research. So we have a training unit. We have the admin and finance unit. We have advocacy and information, education, and communication, [which] you need because we design materials a lot, and we do videos, which they find useful. We have the EOR unit, evaluation and operational research unit. Then we have the youth development unit, and, of course, we have three clinics. And two of them we use as a model—model in

the sense that we want people to come and see that you can think big, you can start small, and on very little you can really make a difference. And so, they use that clinic really as a model for replication. We have a satellite clinic, and we have a youth-friendly clinic, and another clinic.

Because we do training a lot, we are recognized for training, and so people will conduct periodical training, and we provide consultancy services. Now when MacArthur Foundation stopped the grant, Ford Foundation moved in, and they have funded us now for six years. The grant came through, and this time around, we decided to integrate a program into youth. And the first youth program we had was called West African Youth. We started working with University of Ibadan. We got a small seed grant through Johns Hopkins and through Advocates for Youth in Washington to start a small program to [see]—if adolescent reproductive health can be provided to youth and if it would be accepted culturally within the community. So, we got a very small seed grant, which was for only six months, to start it at the University of Ibadan and see if we can train peer educators.

We discovered that incidence of unsafe abortion was on the increase and many girls from the university had died. Sexually transmitted infection was very, very high, and Advocates for Youth, who had experience in youth programs, gave us some tutelage. And so we were able to start working with eighty students. We now went to the university and introduce what we call MUDAAF, Multidimensional Approach to Adolescent Fertility Management. And the idea was to train them to become peer educators, and to use a small box to provide family planning commodities from room to

room to their peer group within the university. So we trained eighty of them, and the fund came from Johns Hopkins, and it lasted—I think it was two years—no, sorry, the first one was for six months.

And after that six months, we decided to mount a campaign. We had what we call a jamboree within the campus—dancing. When you are working with youth, you have to bring yourself to their level, and this was how I was called “sweet sixteen” or “sweet thirteen.” (Sharpless laughs) So, to really associate myself with the youth [we] will tie this small waistband around [our] waists and dress like them. And then we will go campaigning around the campus, dancing and singing.

And when we did it the community embraced it, because we were able to reduce the incidents of unsafe abortion in the campus. They had people to come to for counseling. They were being referred, and we did not receive any condemnation. We just thought we should try it for six months. And to our amazement, it was accepted. But we actually did a thorough planning. The planning included working with the students’ union. We made the students’ union to come together to tell us their problems. We went there [by] special invitation. And then Advocates for Youth was right on hand to help us out, and, of course, Johns Hopkins was there to provide the funds.

And so the first adolescent program in the university was started in 1992, I think it was. We will check the date here. I think it was 1992 or 1990, and again, we did it for two years. It was six months to start off with, and when we knew it was accepted, then Johns Hopkins promoted it for another two years, and that was how we went from training eighty students to training

about 440 students. And we worked in fourteen halls within the campus, and the population of the campus I think was about 440,000??—something like that. So that was how we tried working with students, introducing adolescent reproductive health within the campus. We handed that over to the university. Then we decided it was time for us to move out and help youth in need, and that was how Ford Foundation, again through Advocates for Youth, funded what we call the West African Youth Initiative, WAYI.

Sharpless Okay. Well, our tape's about to run out. So, why don't we take a break, and we can come back and pick it up there.

Delano Okay.

Tape 2 ends; tape 3, side 1 begins.

Sharpless Okay, this is the third tape of the second interview with Mrs. Grace Delano on October 8th. Okay, you were getting ready to tell me about the creation of the national youth organization.

Delano So, that was in 1995 to 1997. And this material will give you the dates.

Sharpless Yes, your vitae. Yes, I made a copy of that this morning.

Delano Okay, so this was when, in collaboration with Advocates for Youth, we started what we called the West African Youth Initiative in seven states of Nigeria and two organizations in Ghana, and it was supported by Ford Foundation and Rockefeller.

Sharpless Now, what were you trying to do?

Delano This is integrating adolescent reproductive health into the program of the NGOs, realizing that the youth are very, very sexually active, but they are not well informed. And the idea is that we should get them well informed so as

to prevent unplanned pregnancy and, of course, STI/HIV, which is very rampant. Although we brought in drugs as well, our focus, really, is on their reproductive health, and it's training them as peer educators so that they will be able to counsel their own peer group. [We] provide them with services—especially those who were in school were not allowed to provide family planning services, but they could refer their peer group to other clinics like Planned Parenthood. So we liased with them

And then apart from counseling and referral, they organized outreach activities: giving talks to their peer group about adolescent reproductive health, and how they could be well counseled and referred, and bringing them again closer to their parents so that they would understand the youth better than they have done before. We did that between Advocates for Youth and Association for Reproductive Health from 1995 to 1997. Ford Foundation supported the service delivery component, and Rockefeller supported the research component.

Based on this West African Youth Initiative, the two programs in Ghana were in Accra and Kumasi. And since then they, too, have graduated and they have actually established their own program and they have progressed. The other eight that we used in Nigeria were new youth organizations that we have formed. But what we did was that we conducted a need assessment, and from forty that we identified we picked ten. And it was out of [these] ten that we picked eight, and out of this eight those were the ones who participated. Before] the Ghana and the Nigeria program ended, we had a dissemination workshop in Nigeria and invited both governmental and

nongovernmental organizations to share our findings with them, and the idea was to ensure that it has a multiplier effect. So, the lessons we have learned: what they thought did not exist they were able to hear about. And on this project we were able to design training materials. We had Advocate for Youth, and we are happy to say that the materials have now been used in Nigeria.

Then, after the first West African Youth Initiative, we decided that we will consolidate the programs in Nigeria. So Ford Foundation decided to fund the program again for another two years on consolidation. And now from those that we have brought together, we have mentored them, we wear them, and they are now on their own and are even providing consultancy services to our organization. And Ford Foundation has now moved on to continue to fund us for another two years, and now we call it the frontier. Under the frontier, we are now moving to the north, where you have mainly Muslim-dominated areas, and identifying NGOs. The idea is to identify the NGOs, let them now work with in- and out-of-school youth so that they can start providing life-planning education. Life-planning education sets out to get the children to set a goal for themselves in life, to know their own values, to empower themselves, to be assertive, and to be able to take a right decision which they will never regret. And so, these were the projects we are now conducting in and out of school under the Ford Foundation project, which is still ongoing.

Now, in the process of doing this, the Department for International Development—it's a British organization now under the British

government—the same way you have USAID under America, you have DFID under the British—so a lady called Mrs. Fiona Duby heard about our programs, and we now wrote a small proposal about starting to institutionalize the adolescent program in the schools, rather than letting it be a stand-alone program. And when we wrote this proposal [Duby] and one lady called Bamishaye, who was then working with DFID—they decided to give us this small seed grant.

And the reason was based on the fact that parents came to our organization because they'd heard that we provide adolescent reproductive health, and we had a small clinic. Maybe we could bail them out of their predicament because two girls had died from septic abortion. Teachers in the school inflicted corporal punishment on the two girls, and they thought that was why they died. But fortunately for the teachers, a post-mortem was conducted, and it was discovered that the two girls died from septic abortion. Based on this, we now got a call from parents and teachers that if we could start a program in the school for them so that the students would be knowledgeable, better informed, and be able to prevent such occurrences.

And so, DFID decided—it was then called Department for International Development—they gave us a small seed grant for about two years, [so we could] identify four schools to use as the pilot project school. And with our experience under the West African Youth Initiative, under the Nigerian Youth Initiative, we were now more knowledgeable, more experienced to expand to other areas. So we worked in four schools, and during that period of the four schools, truancy declined in the school, children were better, they

were more disciplined, [and the] pregnancy rate declined. And even if they were pregnant, teachers were now more comfortable to counsel them and encourage them to either go and have the baby and come back, or relocate to another school if they were too shy to come back to the school.

Sharpless

But staying in school.

Delano

Yes. Drug usage, too, decreased, and that prompted us to start a small library in our organization, because when they were playing truant, they moved out, and we thought we could complement the effort of the school by bringing them in and counseling them. One way we could do that was to create a program that would encourage them to visit us. So we opened a small library, and when they came in to the library we organized with volunteers, rather than letting them sit down there and missing classes, [the] volunteers started giving them what we call tutorials, and this information spread out to everybody that we were helping. Especially children who were running out of school were now being looked after there, and we were giving them tutorials. But our tutorial was backed up with counseling and referral and service provision, and linking them up again with their parents where necessary. And those who could not afford it, we got people to assist them in buying their books and so on.

With this in mind, the government now heard about our program. We were then in a rented house. And this two-year program did wonders, so the government—we now had dissemination, and we got the teachers to talk about what happened within those two years when DFID funded the project and the impact it had on the education, on the behavior of the children, their

attitude to things, the attitude of the teachers, the attitude of the parents, and the Parent Teacher Association. They were full of thanks and praises, and so they're now requesting that [it be] expanded to all schools.

And so, from working in four schools, the government—we now came together—participatory is the word—we now came together, we had a stakeholder meeting, we shared the information, and during the dissemination of the four schools, we came out with a documentary film called *Time to Act*. And *Time to Act* actually spelled out the problems the youth were having because parents did not believe that young girls and young boys would start having sex at age ten to thirteen, and that some of them were under the influence of drugs, and some of them were having unprotected sexual intercourse, and quite a number of them [were] committing unsafe abortion. And only those that were noticed could talk about it, and those who died, nobody knew about them. But the stories filtered through, and we all came together for the dissemination of the conference, to write a concept paper to the British government to fund the youth program. We now call it life-planning education.

But one thing is that if we now wanted to replicate it in a bigger way we needed approval from the federal government, and it had to go through the National Education Council. So, to sort of circumvent that area, the government of Oyo state, where we are based, decided that it would not be a program on its own, [but] we would call it Expanded Life Planning Education. We had done that before. We were only expanding what we had done, so we did not need an approval from the government. So, with the

fanciful [name] Expanded Life Planning Education, we were funded for three years, which has now gone on to a four-year program. We introduced it into 131 schools in Oyo state—life-planning education—and establishing forty youth-friendly clinics, so that intervention was [accompanied by] education.

So, the intervention—we now used existing primary health-care center. Why did we do that? We wanted something that is replicable. We wanted something which would be possible. We did not want a white elephant's program. We did not want to start a program that would drop by the roadside, but if it's integrated within existing services it was realistic. It would be easily accepted because you will just be using the same staff. All you need to do is to reorganize so that instead of having antenatal, three or four people in one area, one can now go to youth friendly.

Oyo is the first state to start a youth-friendly clinic in Nigeria, and we started forty. We provided them with various materials, including family planning as a takeoff. We did it at low cost, in the sense that we wanted something that would be replicated, and I'm happy to say that WHO replicated it. They asked us to purchase this material the same way. It cost us rock-bottom prices to purchase the equipment. And so, they realized that things can be put together in a small, little way, if you use the right caliber of people. So, the forty youth-friendly clinics are now serving as the model for Nigeria.

Now the life-planning education has been approved. It's recognized, and we are the first state in Nigeria to run a state program. One hundred thirty-one schools are now being used. The evaluation of what we have done

within the last four years is now ongoing. The documentation is now ongoing, and a documentary, too, is now ongoing. By December, we are going to have dissemination of how the life-planning education has worked, how we got the children to set a goal for themselves in life, to know that they have a value and can identify their own values, to be able to negotiate, to be able to take a decision they will never regret, to be able now to be assertive enough and to speak out—and not only that, to be able to pass on what they have learned. What the program set out to do is to train the teachers in the school to provide life-planning education within the course system. It's a stand-alone [course, and] includes family planning, HIV/AIDS, pregnancy, "Who am I?", assertiveness, value clarification, decision-making—just to mention a few [of the topics covered]. How to beat poverty was included, because we know fully well that some of them are promiscuous, and poverty has driven them to be promiscuous. And this we discovered during the need assessment that we did, and we have a write-up on that. I will send that to you as well.

But one thing unique about it is that this program has received national recognition to the extent that teachers come from the federal government to come and learn about this program. And so our involvement with the youth has even drawn us nearer to the government. We are a nongovernmental organization that is accepted by the government, and it's not that we play to their gallery. We know what to do at the right time. We know when to say no. We know when to say yes. But they have come to appreciate that they can work with a nongovernmental organization to complement the effort of

the government. We have assisted them many years in setting up family planning clinics. This time around we are assisting them to set up the youth program that is integrated into the schools' program.

Another thing that this program has done is that we are now being used by UNICEF, and we are facilitating the UNICEF program again. What are we doing in the area of HIV/AIDS prevention? We are now being asked to facilitate. We have written three manuals for UNICEF on HIV prevention.

Sharpless

For the young people.

Delano

For the youth, but now we are targeting those who are just graduated from tertiary and are going back to the world. And when they are having their orientation to send them out to do their youth service, that is when UNICEF uses us to assist with training, bringing everybody together, and identifying some of them, training them as peer educators so that they will now be assigned to schools to go and start talking about HIV prevention. This is ongoing. Every year over eight thousand Youth Corpers are sent out. So you can see the impact of using those eight thousand to disseminate the information of HIV prevention. And of course pregnancy prevention will automatically go with it.

One thing it has done is that, rather than relying on one approach to take services to the masses, various multiple approaches can be used. Now we have targeted youth themselves, catching them young in school. Now we are even using graduates, fresh graduates, to actually reach out. In the area of HIV/AIDS, what else have we done? Apart from working with—

Sharpless

Well, let me ask you this. When did you first become aware of HIV/AIDS?

Delano Let's see now.

Sharpless Early 1980s?

Delano In the late eighties. And when it arrived really, the first lady, who was suspected to have had AIDS, said that she was attacked at the cemetery by a spirit who had sex with her, and so that was how she got the disease. (laughs) But then eventually it was discovered that really she had AIDS—she died of AIDS—that she had contracted the HIV virus.

But the UNICEF program has been going on now for two years. And then Harvard's program, AIDS Prevention Initiative in Oyo state, started about two years ago. The idea, again, is to use multiple approaches based on prevention rather than a curative [approach]—creating awareness. UNICEF mounted a massive awareness campaign, which we participated in to create awareness of the magnitude of the problem. And so, they wanted us to use the same approach that we used with the life-planning education, where we train teachers. We train the teachers, we train the principal, we train the supervisors—we call them local government education inspectors and the zonal inspector of education—we train all those categories. We train the nurses in youth-friendly clinics. We train the PHC [primary health care] coordinators so that they will be able to coordinate the youth-friendly clinic. The same way we were building the team for the school, we are building the team for the health components as well. So, they work together and they collaborate together, and they give talks in schools. Whilst the schoolteachers will go to the clinic and refer, those in the clinic will go to the schools to give talks. And the teachers now have a scheme of work. All those topics have

been integrated into the scheme that is for the school.

Sharpless So, what are you training them to—is it mainly about condom use, or is it—

Delano You mean the youth?

Sharpless Yeah, the youth. I mean, Don't have sex, and if you do, use a condom?

Delano When you are giving information, you're giving all information you need to give, and this is why you train people to be well informed. Never withhold information. The only thing we don't do in the schools is that you do not dish out the commodities, because it's against the schools' regulations. But then there are clinics where those things are really stocked where they can—they will be counseled, and those that are sexually active, if they want it they will have it. And those that are not sexually active, we encourage abstinence. But if they are sexually active, in the process of counseling them, if their attitude would change and they now want to start abstaining, that is one way. So it is better to have people who are knowledgeable and will provide them with the right type of information, with the right type of services, and—

Sharpless With a range of options.

Delano A range of options, so that they will not be misled. There are those who would not want to use methods. We do not encourage that everybody should start using contraceptives. Rather, we get you informed. And when you are better informed, then you will stop the stories of the bees and the birds, and this is what we are trying to erase.

Another thing we did at the schools is to have almanacs: pictures of sexual abuse, how to read and study, how to prevent HIV/AIDS. We are the first nongovernmental organization to actually come up with a big

illustration, flipcharts that talks about reproductive health and life-planning education, which will enhance teachers' training. Another thing we have done is that we have a big training manual that they can use. We run a system of six-three-three in Nigeria so that the secondary school can take that book—it's a voluminous one. The idea of making it one pack is that we recognize the government will not be able to produce it. So, one book for each class. We decided to have it in one. It's very compact. It means that you can teach any class when you have the whole book.

Another thing we provided for them is that we translated the manual into the local language, and because the terminologies of sexuality are difficult to translate into the local language—masturbation is difficult to translate into local language, and ovulation, and things like that. So we decided to translate it into the local language. And when it comes to evaluation, you know that whoever is using the English word is using the right word in the local language. Some of them may be reading it in English and teaching in the local language. So, to really enhance their teaching and facilitate learning, we make sure that various materials were translated into the local languages, both for teachers, for parents, and for the youth, and they are being purchased.

Then we have a small booklet, *Answers to Questions Adolescents Ask on Sexuality*, which is used for the youth as well. Now for UNICEF, we have various materials. We have a handbook that tells them how to start counseling, how to do community mobilization. So we are collaborating again with UNICEF. We facilitate that training every year, and it's now in the

second year ongoing.

We now move to HIV. On the HIV program on its own, that was how Harvard University under Bill Gates came in. And under the Bill Gates university-funded project through Harvard University, we now have a program, AIDS Prevention Initiative in Nigeria, that is called APIN. But in Oyo state it is called APIO, AIDS Prevention Initiative in Oyo state. Another beautiful thing about government working with NGO is when you come to the state where we are, you will see that government stands to benefit if they use NGO a lot. By working with us, we have benefited and they have benefited.

How did we benefit? The land where we built our office was donated by Oyo state government. Why? Because we were able to find a solution to adolescent reproductive health program of the youth. And so that we would be closer to the main road, they donated that land. They gave us hundred thousand to paint the house. They gave us materials to excavate the ground, and another thing they did was that they gave us a (unclear) so that we would be able to use that (unclear) to do the building. And then, of course, we raised funds. Everybody collected money, the market women, we all came together, the families, and we were able—and Ransome-Kuti commissioned the building before he died. So, we are proud to say that we did not get any funds from outside, and we were able to do that. So—now back to APIO.

Sharpless

Let me turn it over.

Tape 3, side 1, ends; side 2 begins.

APIO.

Delano

APIO, that is AIDS Prevention Initiative in Oyo state. The reason why I talked about [how] the relationship between us and the government has been so cordial, to the extent that we are now being invited in other states, [is that] they told us we are an organization that is reliable, that they can work with, and that we have a strategy that is getting things done. And we don't make noise unnecessarily. We make reasonable noise that is very productive and useful to the community. And so, with the APIO we discovered that we were starting an AIDS prevention program, and we wanted the government to be involved because it's the responsibility of the government. They will give the drugs—we cannot provide such things. We can only create awareness. We can only advocate for drug provision. We can only be there to back them up. We can complement their effort.

And so, to get them to do something, we decided to assist that state to put together its plan of action, which was funded by Harvard University. And so now we have two projects going on. The state government has a project on AIDS prevention and, of course, the intervention funded by Harvard University. We provide technical assistance to the government, and assist them in training their personnel and doing a little research. But we also have our own project, whereby we are working again in connection with training our teachers. We brought together teachers and students, gave them intensive training on AIDS prevention, and a way to go back as a team. Teachers in the class and their students will go back to school. We work in eighty-seven schools on AIDS prevention. Then we went to the market. Through the market we targeted the market teaching?? so that they can start

the prevention component within the market for those who come in to buy and sell. Then we targeted the private sector. The private sector are the physicians and the nurse-midwives that are providing private services, so we now train them, too, on AIDS prevention and on care. But meanwhile, in the ongoing project, we have included testing. But only a few of them are to be used to do the testing, because not all of them would want to embark on testing of HIV/AIDS. So this is what is ongoing under the APIO.

Now, what have we done to integrate reproductive health into the private sector itself? This comes under the Packard Foundation of California, working with Dawn Norrell??. Dawn was one of the team members who worked with us many years ago when she was at Columbia University with a CBD project. And we're coming together again. They now want to use another approach to see if they can use the private sector to increase acceptability of family planning through integration into existing services. But rather than say family planning, it would be integration of reproductive health and family planning into their existing services. Even if you are an ophthalmologist, you can still provide it. If you are a medical person in medicine, you can do it. If you are a pediatrician, you can do it. And if you are in O and G already, you can do it. And even if you are an orthopedic surgeon, the idea is that we want family planning to be integrated into the services.

And so we have done the first three years. Packard Foundation gave us a three-year grant, and we started the first grant by integrating it into 140 private facilities in Ogun state, Oyo state, and Gombe state—two in the west

and one in the north. Why did we choose the west? It's a fertile ground, and if we were testing a new idea—with the new intervention we thought we should use that area that we were familiar with and see how it would work. And then we can take the findings and lesson plans to go to other states that may have problem. But we decided to choose one from the north. Why did we choose one from the north? We had worked with a nongovernmental organization before under the MacArthur project, and we assisted in taking healthcare to a place where they did not have a health program, not to [mention a program in] maternity [care]. We made it possible for the government to start a health program there. And they were so grateful to us. We were the first people to be seen providing healthcare.

Since we have been able to establish our presence in that state, we now use that NGO to take the Packard Foundation to the private sector. You can see the linkage in how we are expanding. So that made it a fertile ground, because we had already formed linkage with another NGO that we mentored. And so, the 140 projects which we integrated, we trained them on reproductive health, but [put an] emphasis on family planning because Packard Foundation is on family planning. But then we integrated it into life-saving skills because life saving will automatically need family planning. So, we had fifty institutions in Ogun state, seventy institutions in Oyo state, and twenty institutions in Gombe state, bringing it to 140.

We used physician-owned clinics and non-physician-owned clinics. What we did in the program was that we started with the need assessment so that we know where we are taking off from. We had a stakeholder. After the need

assessment we took all the findings and disseminated them to the community. We brought them together to give us an idea of what their problems were using the government-owned clinic, and what were their problems using the private sector. What would they want to see done? How would they accept family planning? How would they accept other services?

So, with the information gathered—the medical doctors were there, the nurses were there—we were now able to use the information given to us to put together a training manual. We started with training the proprietors of the school in quality management. Then after the intensive management training for the proprietors, we trained the physicians on reproductive health update for ten days. Then we trained the nurses for four weeks on reproductive health and family planning. They spent two weeks of their four weeks in family planning sectors so that they will acquire the practical skills. Then we train their auxiliaries who are working under them because they are the ones that people would see when they come in. And so, there will be a better advocate than there had been before. We now identified the people within the community, two for each facility. We trained them as reproductive health promoters. So with these five people, the institution is now equipped with a team to see if it can improve on quality of care and ensure that it would provide quality reproductive health and family planning services.

Another thing we did was that we provided them with the takeoff commodities of family planning. We don't want the situation whereby they would tell us that because they live far away they couldn't get the commodity. And we wanted what they had learned, that knowledge, to be put into use

straightaway, because it's when you put it into use [that] you remember what you have been taught, and then even if you are going to make mistakes it would be very little. But to ensure that even if you are making mistake it's limited, we provided them with a small library, reference materials they can use. So, *Contraceptive Technology*—everybody has it. Then there's another one being provided by Johns Hopkins. Johns Hopkins gave me six hundred, and so every nurse and every doctor and auxiliary—it's called the essential—they have a copy. And we now provided them with a little material or directory on common words and terms used in reproductive health. That was what brought about this small little book, although there's another *Contraceptive Technology*, but we couldn't get that, so I adapted it and used that. Then—

Sharpless So, it's pocket-sized.

Delano

It's pocket-sized. Another thing we provided them was a flipchart for counseling, especially for family planning, breast examination, genital examination, and so on and so forth. So they have the flipchart, too. So, with that, and then [with] *Guide to Family Planning* in Yoruba, Ibo, Hausa, those who speak Hausa have the Hausa, those who speak Yoruba have the Yoruba, and those who would want the English, [all of them] had a copy [in their own language]. So you can see that we have actually strengthened their capacity, improved their knowledge, and encouraged them to want to work, and we backed this up with (unclear).

And we are working in collaboration with the Association of Medical Private Practitioner and Association of Nurse Midwife Private Practitioners. So, we now formed a team. Then we formed what we call advisory

committee, so that they can monitor the team's activity. We provided them with what we call an MIS, Management Information System form, because we want them to record mostly the family planning, but [we also] asked them to let us know the number of deliveries taken. Knowing the number of deliveries taken will guide us to know if it's having an impact for those who have just delivered, for those who are pregnant, and for those who had been pregnant before.

Then we backed it up with continuous advocacy. Advocacy should be continuous when you are introducing a new program so everybody knows about it. All policymakers were invited to the stakeholder so we have their approval, and so it is well embraced. We invited the kings, the emirs, and we made them to take a prominent role. One way to actually get them involved is to let them do the talking themselves, and you just do the listening and you facilitate, and that gives them a spirit of ownership. So, this is what is going on now with MacArthur Foundation. And we finished in the south. We have now moved on to the north. MacArthur Foundation has just granted us another funding. With that funding, we have just finished the training in Kebbi. Kebbi, it's a Sharia city. [Do] you know Sharia, where they brought out that women who are promiscuous should be stoned?

Sharpless

Oh, that's where that came from?

Delano

Yes. But you see it's only when you move through that there, then you will know what is happening. We were told that we would not be able to penetrate, but I'm happy to let you know that not only were we embraced, not only were we welcome, the emir of Damaturu in Yobe state has just

become our patron of our organization, and yet people will tell you that these are no-go areas.

You can penetrate any area. It depends on your approach. As I said [before], never take people for granted. Always let them know what you are doing. Talk with them and plan with them. So, we have just completed the training in Kebbi. Kebbi state is up north. The other one in Yobe state is up north, and we have completed the one in Kwara state. So those states we are training—that's forty here, forty and ten, fifty, sixty—sixty institutions in the northern state. So, now we are focusing on the northern states, strengthening their capacities and improving their knowledge and assuring that they integrate reproductive health and family planning into the existing services. And I'm happy to say that they are all doing fine.

Now, with this ongoing training, have we learned a lesson? Of course, and the lessons we have learned are what we are disseminating, and using to actually improve daily on our various approaches. How are we using it? The staff of our organization—as I said, we update their knowledge, and I'm happy and proud to say, though sadly, that when we train our girls and our staff, they come to take them away. We know they are contributing to development, but these are people that we have trained, and they look—our organization is the spot where you actually come to get staff.

Then, number two is that I have done various consultancies. At one given time, I was the country coordinating officer for JHPIEGO. I have coordinated for Johns Hopkins. I have coordinated for CEDPA. I did for WHO. I even went to Uganda for UNFPA to carry out evaluation of the

family-planning components of CBA?? I formed a team with them. I also coordinated with the universities, the federal government, the state government, and even right now I'm helping the wife of the Oyo state government to put together a strategy plan [on] how to improve quality of life, and how to help quite a number of people. I enjoy doing the job. I don't do it for money. Knowing that you are useful when you should be gives one joy. (Unclear) where we shared what we learned.

And one thing that is unique with our organization is that we always document what we do, and we have a write-up about our various approaches. We are well-known in providing IEC materials—that is information, education, and the communication and counseling materials—to the extent that they write from even as far as India asking for materials. South Africa and other African countries ask us to send them our materials. I'm happy to say that our flipchart on the (unclear) method was used in Swaziland, and Ghana is using our flipchart, just to mention a few. Another unique thing is that our organization, as I said earlier on, is grooming disciplined professionals. We are very disciplined. Wherever we are, we will always stand out clearly, and each time we approach any organization to help they will say, Ah! They are here! That's how we are known—Ah! They are here. Because until you say you are tired—we are never tired (Sharpless laughs)—because we feel that if we have the nerve to come and work, we should be there to do our very best. And we are supposed to be an ambassador to the world. When I say to the world—even though we are from Nigeria, we want to be remembered as arriving there, being there when we are wanted, and being

able to provide services. And not only just services, quality, and [transmitting] whatever we have learned and getting other people to learn from us—that is what really makes us tick and makes us unique.

I have received various awards, either locally, internationally. I'm an elder advisor, or matron, or patron. I'm not a medical doctor, but I have been [given] an award by the Society for Obstetrician and Gynecologists, which was a very unique one, and yet I'm a nurse-midwife. And also I happen to be the matron of medical students' and the nurses' association, department of demographers, and I'm always there when I'm wanted, and I'm prepared to provide services. And I'm happy to say that based on this, Columbia University many years ago gave me an honorary doctorate degree for my community-based approach. So this is why at times they call me Dr. Delano, but I'm happy to be who I am—Grace Delano, who has come to make this world a better place than she found it.

Sharpless What a wonderful place to stop.

Delano So, that is me.

Sharpless Thank you so much.

Tape 3 ends; tape 4, side 1, begins.

Sharpless I'm sorry. The microphone wasn't on, but go ahead. They gave you a small seed grant.

Delano They gave us a small seed grant to reproduce the IEC material because we were really running out of information and education booklets and leaflets. And people have come to recognize our organization—we are not a clearing house, but whatever we do produce, they are unique and they are the type of

materials that are useful to the community. As I said, we used the various languages, and so when people are organizing workshops, conferences, they always invite us to come and give them a talk, to come and facilitate, to show them films. We give out films.

So the World Bank gave us a small seed grant to organize a program for the youth, and this program was to create awareness about the adolescent reproductive health and to get them involved. And we decided to use the fund to run a mock assembly, getting the youth to go to the assembly, and letting their parents and the members of the house of assembly be the audience, to make a case for the integration of life planning into the education. And the topic was who is to blame, parents or the youth, for high rate of unwanted pregnancy and HIV/AIDS in the country. And so, they were there to make a case, and we used that fund to reproduce extra materials, which we circulated. And we used the material again to reproduce some booklets.

I have written over fifteen books as a single author, and I've co-authored quite a number of books, and I've coordinated writing of various books as well. And fortunately, I'm lucky to have either the donor agencies [willing to] support it, or the publishers themselves actually ask that I write books for them on family planning. Right now I have just updated the book I wrote in 1980, *Guide to Family Planning*, although I updated it in 1990. The third edition will now be out very soon. And apart from that, there's another book on *Answers to Questions Adolescents Ask on Sexuality*, which the publisher also has requested should be updated.

So with all these materials coming in, one can see that people are really hungry for knowledge. People want to be better informed, and people will appreciate it if they are allowed to have materials that will get them informed, well educated, and empower them so that they will be able to take the right decision themselves without being forced—although I appreciate the role of the religious groups. But one thing that is upsetting the religious groups is that some of them tend to want to enforce their ideologies on people. But the Lord God Almighty created the brain, and if God created the brain, certainly God wants us to use that brain, and we should not deny human beings their opportunity to get informed. So this is where I think that the role of all donor agencies, all religious groups and the community is so vital that we should work together to make people better informed.

Although I have mentioned coalition of nongovernmental organizations that met in Cairo, the other coalition that is ongoing is known as NAPARH. It's the National Association of the Promotion of Adolescent Reproductive Health that was formed by the Youth Serving Organization. Another one that I happened to be the coordinator [of], it's called CSGPHA, the Civil Society Group for the Prevention of HIV/AIDS. I coordinate the program in the south, and I have four states under my jurisdiction. And the idea is that we meet, we do capacity building, we invite—we work with the government—a member of the advisory committee of HIV/AIDS in the state so that we sort of advocate for treatment and availability of drugs for people with HIV/AIDS. We are working together with people living with AIDS, and people affected by AIDS, and bringing together people working

on HIV/AIDS so that HIV/AIDS component will be better treated.

Now, on the professional level, I have relinquished my post as the state secretary of the Professional Association for Midwives, but for many years I was—before I retired I was the first secretary general for the nurse-midwife association in the state, and I worked with various organizations using my area of expertise, which is on reproductive health, to find out how best they can integrate reproductive health into their own area of specialty. One thing is that nobody can do it alone. We all need to work together, and if we all work together as a team, I think we all start to benefit. So, I'm very happy that I will be returning to Tunis, where I got the idea of community-based [programs], so that I will share the story of how I have been able to use the community-based approach in improving the delivery of reproductive health services in the country.

We have a library in the organization where I worked. We started with a smaller one, but, again, funds were raised later on, and we now have a big library that actually seats 150 students. It was donated by my four children, and they named it after their father and myself, so it's called the Tunde and Ebun Library. Why [have a] library? Because we feel that knowledge is golden, and if people have somewhere where they can actually improve their knowledge, it will make a difference. This is why we have a stake in the library. So [these are] the few contributions we have made, and I'm still going strong. I'm sixty-eight now, and I still think I will continue because I have others. Professor Ransome-Kuti died at seventy-something.

Another program we're involved with is Eradication of Harmful

Practices, which now is being funded by Family Health International. We are working on the research on how people perceive female genital mutilation—or female genital cutting, as they would want to refer to it now—and we are collaborating again with three NGOs. The idea is the more NGOs that one can strengthen and build, the better it would be. And the more of them you get involved in this type of program, that would be one way of improving healthcare. So, we are working with Family Health International. And, of course, the World AIDS Foundation gave us the small grant that we use with dual?? protection, which we took on. I just thought I should bring one of these two things in because they've all played prominent role in our life.

Sharpless Yes, that's awfully critical.

Delano Yes.

Sharpless Thank you so much. This is just wonderful.

End of interview 2.