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FPAK CBD PROGRAM EVALUATION

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FPMD - NCPD - USAID
FAMILY PLANNING MANAGEMENT DEVELOPMENT
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT
NATIONAL COUNCIL ON POPULATION AND DEVELOPMENT

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I. EXECUTIVE SUMMARY

In September 1992, The Family Planning Association of Kenya (FPAK) and USAID/Nairobi agreed to conduct an evaluation of Phase II of its community-based distribution (CBD) program. The intent was to help FPAK assess the progress of the program to date and draw some lessons to use in the design of Phase III of the project. The evaluation team, composed of representatives of the FPMD Project, USAID, and the National Council for Population and Development (NCPD), interviewed clients, CBD agents, field workers, CBD supervisors, community volunteers, and community leaders in making its assessment.

Phase II of the CBD project was launched in 1990 in 19 sites. By 1992, FPAK had recruited 734 CBD agents and 51 field workers as supervisors to expand family planning services to reach over 170,000 new clients. Within two years FPAK surpassed this target.

CBD agents provide short-term family planning methods and refer clients to clinics for long term or clinical methods. Their standard family planning-related services include: supply of contraceptives, referrals for examinations and clinical methods, and family planning counselling. Upon selection for the program, CBD agents receive a comprehensive two-week training course. Agents are assigned to locations covering anywhere from 300 to 800 households. They meet each month as a group with their supervisor to discuss problems in the field, receive refresher training, and be resupplied. CBD agents collect and record a significant amount of information regarding the services they provide. CBD agents seem to be involved in more than family planning services; they also participate in and/or lead activities such as health and nutrition education and civil registration.

FPAK's most significant achievements in developing the CBD program can be summarized as follows: the program's operational goals have been met; it is well established in the communities; structures and systems are in place and functioning appropriately. The implementation of CBD activities at the local level has benefitted significantly from a well-managed supply system, and FPAK headquarters relies on a simple and well designed management information system which produces service information on regular basis.

Additionally, in every site visited by the team, FPAK has been successful in engaging the support of the community. Communities showed positive perceptions of the benefits of the CBD program, and the team found significant community involvement in the launching of the program and in the recruitment of agents. Also, the program has strengthened area level family planning programs by complementing clinic services. Moreover, the program has gained legitimacy within the local health system, both at MOH and NGO levels. Perhaps of greatest importance is the fact that enough empirical evidence exists to indicate that the CBD program is expanding family planning availability and acceptance.

The evaluation team found eight primary areas of concern that should be addressed in the planning for Phase III, and made recommendations in those areas.

Summary of Primary Areas of Concern

1. **Method Mix Expansion:** CBD agents focus primarily on short term family planning methods, particularly oral contraceptives. The clinic referral system is prone to weaknesses in follow-up and verification.

2. **Community Commitment and Involvement:** While community leaders voice strong support for the program and are involved in recruiting the agents, there is no willingness to share the costs of the future implementation of the program. However, the sustainability of the program will strongly depend on the extent to which the community is willing to allocate resources for its implementation.

3. **CBD agent's Workload:** The community, and the agents themselves, see a larger role for agents than the role that FPAK originally intended. As a result, the agents are working significantly more hours than was planned.

4. **Honoraria and Other Compensation:** The CBD honorarium has been and will continue to be a difficult issue for FPAK. Agents, with encouragement from community leaders and volunteers, consistently request higher honoraria.

5. **Planning and Coverage:** There is currently no mechanism for monitoring coverage of CBD areas or for assessing progress toward increasing accessibility of family planning services. Although a community diagnosis is prepared during the agent's first three months, there is no evidence that agents or supervisors return to the diagnosis to monitor progress.

6. **CBD Management Information System (MIS):** While the MIS is well designed and implemented, the data entry is somewhat haphazard and error prone. Agents and field workers may not fully appreciate the purpose of collecting the information. There is no systematic feedback mechanism to the field.

7. **Supervision and Training:** The structure of the CBD system is sound, however there is no way to verify the effectiveness of the supervision. Additionally, training is frequently mentioned as an area that could be improved.

8. **Future Expansion and Phase-out:** A key objective of Phase II of the CBD project was to increase community participation in the services provided, thereby laying the foundation for an eventual phase-out of A.I.D. funding. This objective has clearly not been reached. Community participation is mostly symbolic and has not increased since the project's launching.

Summary of Recommendations

1. Promote the use of long-term and permanent methods through the re-orientation of the CBD agents' motivational and client referral role, and establish targets to promote the shifting of pill/condom users to long-term or permanent methods when the circumstances warrant; overall strengthening of the CBD client referral.

2. Expand community participation by promoting grassroots involvement and liaisons with women's groups, youth groups, etc.; clarify the facilitator/supportive roles of the community leaders and FPAK area level volunteers in the actual implementation of CBD activities; and study the feasibility of increasing the community's contribution of resources for training or other activities.

3. Reorganize the workload to focus on priority clients and maximize the use of time; send a consistent message to all segments involved in the CBD effort regarding the voluntary character of CBD agents; clarify the service provision role of the CBD agents emphasizing family planning and defining their promotional/referral role; encourage the use of a depot system for continuing clients to allow CBD agents to concentrate on new client motivation and client referral for service and resupply; increase the selectivity of the households targeting women according to reproductive risk factors.

4. Replace Honoraria with a partial incentive-based system (fee for service); see Annex I. An increase in honoraria is not recommended as this would overtax FPAK resources and would be inconsistent with the project design. Expand income generation activities among the CBD agents.

5. Institutionalize planning at Central and area levels through training; design simple mechanisms for monitoring coverage and assessing progress; develop mechanisms to use information from the community diagnosis and other sources; and encourage the use of information for decision making at all levels by strengthening data manipulation skills and analytical capabilities.

6. Decentralize system operations by expanding the role of area level staff from data collectors to information users; encourage and facilitate the use of data from the CBD MIS at the field worker/CBD agent planning level and CBD program area level; develop a comprehensive approach to increase the quality of the data by the CBD/MIS; design and implement an intensive training program for all personnel involved in the system in the use of instruments for data collection and data consolidation; develop a clear feedback component which assures program improvement at every level; and strengthen the MIS division by upgrading existing hardware, expanding available software, training MIS staff, and allocating realistic resources to support information needs for CBD activities.

7. Review the supervisory system considering the definition of guidelines for field worker/CBD agent interaction, protocols for effective supervision and problem-solving, clarification of the role of CBD supervisor vis a vis field workers, the definition of overall supervision of the CBD program at the area level; reinforce the ties of CBD agents to FPAK by providing guidance at the field level and more intensive interaction with FPAK staff; design and implement a simple system to monitor the impact of supervisory activities on service delivery; and redefine the purpose of the monthly meeting by including training activities as a key part of it.

   Evaluation team findings suggest that training should emphasize: Technical knowledge of contraceptive methods; ability to respond to misinformation and rumors; counselling in appropriate methods and side effects; guidelines for pill management; voluntary surgical contraception (male and female) and long-term methods; referrals and follow-up; planning; record keeping, and data use.

8. Strengthen the collaboration between FPAK/CBD and MOH/Mother Care at the area level in order to increase the effectiveness of family planning efforts in the area and facilitate interaction between CBD agents and MOH Health Center staff at local level in order to secure implementation of referrals.

II. INTRODUCTION AND BACKGROUND

In September 1992, The Family Planning Association of Kenya (FPAK) and USAID/Nairobi, agreed to conduct an evaluation of Phase II of FPAK's community-based distribution (CBD) program. The intent was to assess the progress of the program and assist in the design of the Phase III efforts.

FPAK is a national, private voluntary organization that has promoted the development of family planning services throughout Kenya for 30 years; it is affiliated with the International Planned Parenthood Federation (IPPF). FPAK has played a key role in developing Kenya's national family planning program. It was the first organization to provide family planning services in Kenya, and provided technical support to the Ministry of Health's (MOH) family planning efforts during the late 1960s. FPAK provides contraceptive methods to approximately 10% of all users of family planning and distributes nearly 13% of all contraceptive methods in the country[1]. FPAK has a wide national network that is organized through over 100 volunteer branches countrywide.

FPAK was the first organization to experiment with the idea of "community-based distribution". Its CBD program is the most comprehensive NGO program in Kenya. FPAK began exploring the CBD strategy with the implementation of its lay educators program as a way to expand its coverage of family planning services during the 1970s. Later, from 1983 to 1987, FPAK implemented a pilot project using CBD agents at two sites and in 1988 it formally initiated Phase I of its CBD program at 18 sites with 535 CBD agents. In the Phase II CBD project (between 1991 and 1993), the program expanded to 21 sites with over 760 CBD agents. The overall objectives of this Phase were to increase contraceptive prevalence in the project sites by providing accessible CBD services and to contribute to the goal of reducing the population growth rate from 3.8% to 3.5% by 1995. USAID provided 1.9 million dollars in funding for Phase II of the program. This period constitutes the core of the evaluation.

The Demography of Kenya and Recent Changes

The population of Kenya is one of the fastest growing in the world. According to census data, Kenya's population went from 5.4 million in 1948 to nearly 11 million in 1969. By 1979 the population had slightly surpassed 16 million. It reached a total population of nearly 25 million in 1989. During this period, Kenyan population was growing at an annual rate well over 3%.

During the 1960s, this rapid population growth became an important public concern. In 1967 the government established the national family planning program as part of the Ministry of Health/Maternal and Child Health program. Although the effort was not very successful, the push for controlling growth continued. To increase the impact, it was decided to strengthen family planning initiatives in both public and private sectors and to place equal

[1]Demographic and Health Survey (DHS), 1989; Family Planning Logistics Management (FPLM) Report, 1990.

emphasis on the supply side and on changing reproductive behaviors. The goal was to reduce the growth rate from 3.8 to 3.3% by 1988.

There is evidence that fertility declined moderately during the 1980s. The total fertility rate (TFR) shifted from 7.9 children per women of reproductive age in 1978 to 7.7 in 1984 and to 6.7 in 1989. It is clear that the initiation of the fertility transition in Kenya is strongly linked to the increase in contraceptive use. The results of the contraceptive prevalence survey in 1978 revealed that only 7% of married women of reproductive age were using any kind of contraceptive methods (traditional and modern). This contraceptive prevalence rate (CPR) increased to 17% in 1984 and to 27% in 1989. When only modern methods are considered, the CPR increased from 4% in 1978 to 8.1% in 1984 and to 17.9% in 1989. The perceived need for family planning in Kenya has increased among currently married women. The percentage of married women who do not want to have more children increased from 32% in 1984 to 50% in 1989. Estimated family planning needs for 1989 were around 60% of married women of reproductive age (32% not using contraception and not wanting more children, and 28% who wanted to space their children).

The total number of Kenyan women of reproductive age (15-49) has been estimated at 5.7 million for 1992 and 6.4 million for 1995 (in both cases nearly 26% under 20 and 47% under 24 years of age). Most of this new demand will be in the rural areas where services are scarce and the possibility of clinic-based service expansion difficult, making the CBD strategy an appropriate alternative to providing services to a large portion of this growing demand.

CBD Programs and FPAK Efforts

A feature common to community-based distribution programs is the provision of services to the community by using the community's own resources. In family planning programs, CBD is a strategy that relies on community resources to distribute contraceptive methods at the community level. The main community resource is the people who are willing to provide some specific services as volunteers. CBD workers are selected by the community and they tend to be women. While they generally do not receive salaries, they often receive other incentives, including cash honoraria. They are assigned to serve a geographic area and are supervised by field workers who may be attached to a clinic. Services are provided through house-to-house visits, retail outlets, community gatherings, or by using the agent's home as a depot. Some CBD programs attempt to intensively cover a small and well defined area; others tend to provide a more limited coverage in a larger area. Although the specific services provided by family planning CBD programs may vary, they all concentrate on the distribution of contraceptive methods such as pills and condoms. Additionally, CBD workers provide information and educate and motivate clients regarding all family planning methods including long-term or permanent methods.

As a service delivery strategy, CBD is generally implemented to increase prevalence in hard-to-reach areas, especially in those under severe resource constraints. CBD programs are successful in rural areas that have a small network of service delivery points, a dispersed

population, and poor socio-economic conditions. By relying on people in the communities, a CBD program can provide effective family planning services to the widely dispersed and economically disadvantaged population. This is especially true in those countries where economic constraints and the spatial distribution of the population make it difficult for a clinic-based program to achieve a rapid and efficient growth that reaches isolated communities. CBD is often the most feasible strategy for expanding services where human resources and economic limitations make other approaches hard to implement.

In the mid-1970s, IPPF and FPAK identified the need to promote family planning through education at the grassroots level. At the time, FPAK relied upon field educators to reach the population. These staff were few in number and were based at the divisional level. As a result this role was difficult for them. FPAK's first community-based approach was to work through the existing network of women's groups and to recruit lay educators within these groups to integrate family planning information into community development programs. After a pilot test in two areas, a full scale lay educator program was put in place in two provinces. The emphasis of this program was to create demand for family planning rather than to provide contraceptives.

In 1983, FPAK determined that services were needed at the community level to meet the demand being created by the lay educators. The Pathfinder Fund supported a pilot project to test this new community-based approach to family planning service delivery in two sites employing 41 CBD agents. Between 1983 and 1987, the pilot program served nearly 16,000 new clients, increasing the overall number of new FPAK clients by about 5% per year. This successful pilot was supported through 1987, when USAID support for an expanded CBD project with FPAK began.

To date USAID has funded two phases of the CBD program with FPAK. During the first phase, between 1988 and 1990, CBD activities were expanded from the original two pilot sites to 18 rural sites. This expansion almost doubled the total number of new clients during the period. In Phase II, additional CBD agents were recruited to cover sub-locations around the same original sites, thereby consolidating the program. Table 1 summarizes the relative scopes of each phase of the CBD program:

Table 1
Scope of Phases

	Period	Number of Sites	Number of CBD agents	New client Targets	Funding
Pilot	1983-1987	2	41	15,840	$300,000
Phase I	1988-1990	18	535	49,000	$850,000
Phase II	1990-1993	21	764	169,200	$1.9 million

In addition to direct support from USAID for the FPAK CBD project, FPAK receives funding for further CBD activities through the Centre for Population and Development Activities (CEDPA) and the Population Council. These activities are in two rural sites which report their service information separately. IPPF supports static and mobile clinic services as well as headquarters costs related to project overhead.

The current USAID bilateral project was designed to operate in 19 sites. The two sites supported through CEDPA and the Population Council bring the total to 21 sites (as shown in the table above) in seven provinces or eight FPAK areas. There is a total of 764 CBD agents, including those in two special sites. Typically a CBD agent covers a small area, comprising from 300 to 800 households, called a sub-location. In some cases two agents are assigned to very large sub-locations.

The overall objectives of the Phase II CBD project are to contribute to the reduction of the population growth rate from 3.8% to 3.5% by 1995 and to increase contraceptive prevalence in the project sites through accessible CBD services. The specific objectives are to serve 169,200 new clients and 182,250 continuing clients, to make 93,600 referrals for clinical methods, and to refine the management information system that was developed during the first phase of the project.

Summary of the 1989 Evaluation Report and its Use by FPAK

In 1989, a team of three specialists (Keyonzo, Kekovole, and Lewis) evaluated Phase I of the FPAK CBD project and concluded that the project had basically achieved its objectives. In general, they found that the CBD program had effectively involved the community in the implementation of the program and was providing continuous family planning services and education. The evaluators recommended the expansion of the program, and provided FPAK with specific recommendations to overcome the weaknesses identified in the evaluation. Table 2 summarizes the recommendations made in the 1989 FPAK CBD Evaluation and FPAK's responses.

Table 2
1989 Evaluation Report Recommendations

Recommendations	FPAK Responses
1. Review the personnel system to facilitate expansion of the program.	Reviewed CBD personnel system in 1991-92 as part of overall redesign of FPAK structure.
2. Financial management policy should continue to be the joint responsibility of Headquarters and the National Executive Committee.	Policy remains the joint responsibility of Headquarters and NEC.
3. Develop written operational guidelines to facilitate monitoring and program reviews.	Developed checklists to facilitate supervision at all program levels; updated Training manual in 1992.
4. Continue encouraging community participation for recruitment of CBD agents.	FPAK has continued collaborating with local and sub-chiefs.
5. Reassess the workloads of CBD agents.	This issue has not been effectively addressed.
6. Use community needs assessments to help agents reassess their operations.	Community diagnosis being planned at each site in 1993. Will be emphasized in refresher courses.
7. Evaluate training procedures, especially for agents and field workers.	Training activities have increased significantly; these efforts have not been evaluated.
8. Strengthen the linkage between the CBD program and clinic services.	Workshops have been implemented to sensitize clinic staff to the value of the CBD program; frequent transfer of clinic personnel is a problem.
9. Standardize the contraceptive logistics system and prepare operations manuals to help avoid logistics problems.	This recommendation was considered for the expansion; no logistics problems have occurred.
10. Research further the issue of compensation of CBD agents.	FPAK has developed some research initiatives regarding payment by clients.
11. Develop non-monetary incentives for CBD agents.	Income generation projects have been implemented with varying success from site to site.
12. Some effort should be made to ascertain the family planning needs of the youth.	FPAK has increased activities at schools, for parents, and for adolescents.
13. Promote and facilitate feedback from community leaders on the performance of the CBD program.	Formalized approaches for feedback have been developed. Informal feedback occurs in public meetings.
14. Review reporting system for accuracy, completeness and timeliness.	The computerized MIS provides feedback on performance to project staff.
15. Establish standardized procedures in manuals or guidelines.	CBD procedures and guidelines are widely documented.
16. Encourage community assistance for materials, finances, and monitoring of program performance.	Meetings with community leaders are carried out for this purpose.

Evaluation Objectives and Methodology

FPAK and USAID planned this evaluation as part of the overall monitoring of the CBD project in preparation for the design of a follow-on phase (Phase III) of bilateral funding. As such, the evaluation reviews the status of the project, comments on future implementation directions, and outlines structure and modifications for the next phase.

Preparation: FPAK, USAID, and NCPD held several planning meetings prior to the evaluation in order to select the evaluation team and the sites to be visited and to discuss the protocols that would be used. The team selected five sites which represented the full spectrum of CBD areas, i.e. old/new, strong/weak, high/low prevalence districts, etc. As part of its preparation, the team reviewed the previous evaluation, the project document, and quarterly, semi-annual, and annual reports.

Field Activities: The team spent 10 days visiting five CBD sites during which time team members interviewed volunteers, community leaders, and staff at all levels, using a set of questionnaires (See Annex II). In addition to the interview, CBD agents at four sites were given a short exercise which was designed to identify training weaknesses. Clients were also interviewed.

Data Review: In addition to the interviews conducted in the field, the team examined the data being gathered by the CBD agents and followed it up through the MIS at both site and headquarters levels.

The specific areas of focus during the evaluation were as follows:

1. To review and document program achievements

The CBD program's achievements were measured against the program's objectives and the recommendations made in the 1989 evaluation. Specifically, the team looked at service expansion, increase in number of acceptors, and the implementation of CBD services. Recruitment of CBD agents, their training and monitoring, and the supervision of activities were considered of major importance. The handling of supplies and materials is equally critical.

2. To examine the CBD implementation strategy

The key areas examined were:

- Field staff responsibilities and performance
- Clinical back-up to CBD agents (referrals)
- Service delivery guidelines
- Incentives for CBD agents
- Community participation

The team analyzed the structure of the CBD program within FPAK, how CBD activities were functioning within the FPAK area, and the sustainability of the CBD program within FPAK. The team was asked to identify indications of program maturity and the possibility of future phase out of USAID financial assistance. Recommendations for a smooth transition, in the light of the lowering of funding levels, are made in this report.

3. To review the operations of the management information system

MIS operations were reviewed specifically in three areas. The service statistics system's ability to generate accurate and timely accounts of CBD activities was examined with particular emphasis on how (and whether) the information generated is used for decision making. The database was examined specifically for its ability to produce continuous estimates for analysis of outputs.

4. To examine the external support for project activities

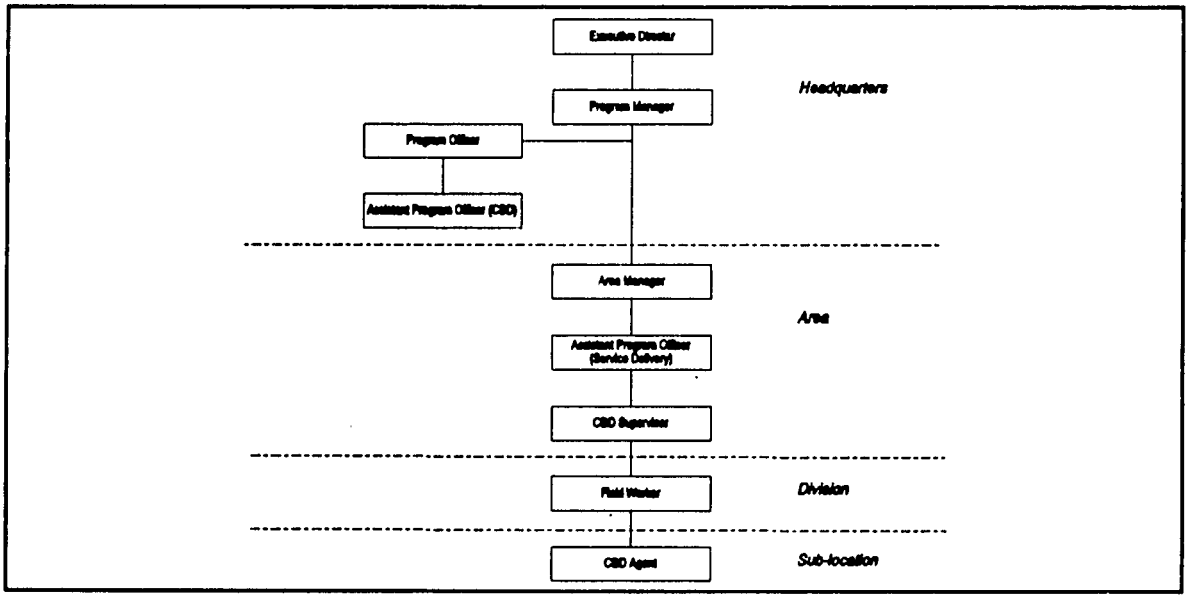
Both USAID and the National Council for Population and Development (NCPD) support to the design and implementation of project activities were examined in general, however the team did not address this issue in specific terms.

III. DESCRIPTION OF THE CBD PROGRAM, PROVIDERS, AND CLIENTS

Program Management and Service Delivery

The CBD program is managed on several different levels, from the headquarters office to the divisional CBD supervisor level. The following organizational chart shows the management configurations at each level.

CBD Organization Chart



FPAK headquarters in Nairobi is responsible for carrying out program design and long-term planning for the national level and for managing relations with donors and the public sector; it also provides management information support, financial support, coordination of commodity logistics, and some of the training. At headquarters, a small unit of three technical staff members have coordination and supervisory responsibilities over the national program. These staff members are the program manager, who supervises the area managers, and the CBD Program Officer and Assistant Program Officer, who coordinate program activities but do not supervise them. They are supported by staff who manage supplies and logistics, and by MIS and evaluation activities.

At the area level, CBD supervisors manage: the distribution of commodities to the CBD agents; collection, review, and forwarding of monthly service statistics; local volunteer relations; and supervision of the field workers.

Field workers supervise the CBD agents, collect and organize their monthly reports, and forward them to the headquarters for data entry. They also conduct on-the-job training. Individual targets for the CBD agents are set at the area level and are monitored by the field workers.

The following sections review the role of the CBD agents, field workers, clinics, FPAK volunteers, and community leaders. The last section contains a profile of a small sample of CBD clients. All of the information is drawn from interviews conducted during the team's site visits.

The CBD agent

In general CBD agents are fairly well accepted by their communities[2]. Most CBD agents are in their early to mid-thirties, and the vast majority are married women who use contraceptive methods themselves. In general, education levels range from Standard 5 to Form 4. Some agents hold other jobs, most often in farming and local commerce. Agents are usually well known and respected in the community, which makes them more readily accepted in people's homes to discuss family planning. Almost all CBD workers felt very strongly that, although a CBD agent could be either a man or a woman, being married was essential.

The CBD agents view their role as including the following major components:

- to bring family planning services closer to the clients
- to provide family planning and family life education for community members
- to act as community counselors and educators
- to act as general health care advisors and providers

[2]Although some stated they have certain difficulties, particularly in religious area where women are less prone to use contraception, no CBD agent reported having had serious problems in performing her/his service delivery function.

- to dispel false rumors concerning family planning
- to distribute family planning supplies

CBD agents agreed on the key qualities and interpersonal skills needed to be effective. Qualities include being a local leader or being well known and respected in the community, and being at ease discussing issues in a frank manner with community members. CBD workers focused on the importance of social skills and marital status for their job. Some stated they felt agents should be literate and should speak several languages. Age did not seem to be an important factor to the agents.

Recruitment and Incentives: FPAK and community leaders work together to interview and select candidates for CBD agent positions; FPAK interviews the candidates recommended by the community leaders and makes the final selection. As many as 20 candidates may apply for a single position, as the job appears to be highly desirable. The recruitment process was found to be uniformly carried out in all of the sites visited.

CBD agents enjoy some enhanced social standing as a result of their work, along with a modest allowance of 450 Kenyan Shillings (Kshs.) per month, which supplements household income. Although the agents are paid little, members of the community seem unaware of this and often refer to them as nurses or doctors. Other incentives FPAK has offered to agents include raingear (coats, gumboots, umbrellas), and bicycles for high performers. Blood pressure machines have been issued to about one-th... of the agents. These not only serve as an incentive to provide better follow-up to pill clients, but further the impression that agents are community "nurses".

Agents have attempted to earn additional money by participating in income-generating projects, for which seed money has been provided by A.I.D. via FPAK. Although the evaluation team did not investigate these projects in detail (they will be the subject of a separate evaluation), it appears that most of the projects are not fully underway, and it is doubtful any will earn significant income. CBD agents have not been prepared with the necessary business and marketing skills to get these ventures off the ground[3].

Training: Upon selection for the program, CBD agents attend a comprehensive training course of two weeks. Thereafter they receive an annual refresher course of three to four days. CBD agents were divided as to whether or not the training was sufficient. The training covers population issues, the need for family planning, human anatomy and reproduction, contraceptive methods, side effects, sexually-transmitted diseases, counselling, and record keeping. Training courses not only equip agents to do their work, but offer another incentive to agents to stay with the program, since the opportunity to increase their skills serves as a personal reward for service.

Many workers felt that the refresher course was too short. Most workers felt there were additional things they needed to learn to be effective CBD workers. Additional training

[3] USAID support for these activities will not continue into Phase III.

needs perceived by agents included: first aid, Norplant, voluntary surgical contraception, and family life education. Several workers felt they should be trained to provide injectables. Recent trainings have used the National CBD Training Curriculum which was developed with NCPD, Population Communication Services, and representatives from the major CBD programs in Kenya. (Prior to that, FPAK followed its own curriculum.)

Almost all workers received written materials to take home with them upon completion of the training. In general, people felt that all the materials were very helpful. Though workers seemed satisfied to have received some information, there was clearly a desire for additional information. Specific requests include: booklets, teaching guides, posters, information regarding voluntary surgical contraception, injectables, and Norplant.

After the CBD agent completes the training, she/he is introduced to the community as a CBD agent by the field worker. This is done both in group meetings and house-to-house. During the next three months, CBD agents conduct a house-to-house survey, called a community diagnosis, which profiles the age, parity and health status of women and couples in the sub-location. This diagnosis is done with assistance from the field worker. The agent then starts providing family planning services.

CBD workers are assigned a catchment area by the assistant chief and/or FPAK. In general, workers appear to be responsible for between 300 and 800 households and serve between 100 and 400 clients. Agents were often not sure how many people lived in the area they covered. Though some agents felt their workload was appropriate, the majority felt they were expected to serve too many clients.

CBD Service Delivery: CBD agents provide pills, condoms, vaginal foaming tablets, spermicidal creams and jellies, and referrals for clinical methods. Their standard family planning-related services include: supply and resupply of contraceptives, referrals for examinations and clinical methods, and family planning counseling. Agents must know the major contraindications to oral contraceptive use and many state they rely on their checklists to determine which clients should avoid this method. In general, they appear to be well aware of these issues.

CBD agents seem to be involved in more than family planning services; they also participate in and/or lead activities such as health and nutrition education, civil registration, and even education on cooking and gardening. As one agent stated, "When you get to a home, you find other problems aside from family planning that need attention. You cannot just focus on family planning." Additionally, agents receive frequent requests for family planning services they are not trained or qualified to provide such as IUD insertion, injectables, tubal ligation, diaphragms, Norplant insertion, children's primary health care, and provision of some essential drugs.

When asked what they would do if a woman wanted to use contraception without her husband's knowledge, the CBD agents contend that women using contraception without their husbands' knowledge is fairly common. In general, agents try to do what they can to assist

women to use family planning without their husbands' knowledge. However, it does not appear that CBD agents generally try to reason with, or counsel, the men.

The CBD agent normally carries out her work through house-to-house visiting, during which she discusses general health issues and family problems leading into the topic of family planning. Some established clients visit the CBD agent at her/his home to obtain supplies. The agent is a volunteer worker and is expected to work about two to three hours per day. However, the actual amount of time spent by CBD agents doing their work is noteworthy. The majority of workers claim they work between 30 and 80 hours a week. Many work six days a week, and those who choose not to work in the field on weekends or evenings receive clients at their homes. The agent provides information to community members both individually and in group meetings. She/he counsels clients on the contraceptive methods and supplies pills, condoms, and vaginal foaming tablets to clients who opt for those methods, and refers clients who select clinical methods to the nearest clinic. CBD agents often receive requests for non-family planning services, including nutrition, ante-natal care, first aid, and immunizations; these cases are also referred to nearby clinics.

Referrals:

FPAK static and mobile clinics are the normal points for referral, if the CBD agent needs to send a CBD client for a checkup or to switch to a longer-term or permanent contraceptive method. Most CBD agents refer their clients to FPAK or MOH clinics, and many state that their clients prefer FPAK clinics. However, given the limited number of FPAK facilities and their location, a significant number of women have to be referred to the MOH health center for family planning services.

It was reported that the majority of clients referred to clinics for family planning purposes come back to their CBD agents following their visit to the clinic, and the CBD agent can record the service as an "effective referral" in the "client register". However, records regarding effective referral in the FPAK/CBD information system tend to be very inaccurate and thus, it is difficult to verify this assertion.

Supervision: Most CBD workers receive a supervisory visit once a month and attend group meetings with other agents once a month. Individual supervision visits are used to identify problems in service provision, go over record keeping and reports, and replenish contraceptive stocks. Group meetings are used to make announcements, discuss problems, and give feedback on performance and agents' progress at meeting targets.

A regular supervision schedule was followed in all of the sites visited; however, the quality of supervision was difficult to assess. In three sites, agents said that their supervisors visited them once per month at home and once per month in district or division-level agent meetings. In one site (Coast), group meetings were held twice per month and one-on-one meetings once or twice per month. In the Nairobi area, individual supervision was less frequent because one field worker supervised 30 agents, twice the average in other areas.

Supply Issues: Agents receive contraceptive supplies twice a month—when they attend the monthly group meeting and when their supervisors visit their homes. Agents keep supplies in metal boxes they have received for this purpose. Several agents complained that these boxes are too small, but in general CBD agents have minimal problems getting their supplies. If necessary, agents can obtain additional supplies at a nearby FPAK or MOH clinic.

At certain times specific methods such as foaming tablets and condoms run out or periodic stock-outs occur at the FPAK clinic, but this appears to be infrequent. A specific problem mentioned was the change in pill types which confuses certain patients. Microgynon, 28-day pill supply, has replaced the former pill which came in a 21-day cycle. At the time of the interview, most CBD agents had enough contraceptives to continue supplying their clients for two weeks to a month.

Records: CBD agents must collect and record a significant amount of information regarding the service they provide. Agents kept the following records and forms: a client register, monthly tally sheets, diaries, notebooks, motivation forms, referral forms, VSC consent forms, and a contraceptive stock book. The forms are designed to help them to remember client return dates and to track their contraceptive needs and clients referred to clinics. Agent responses varied in terms of whether they found the forms helpful or too confusing. A more troubling finding is that they seemed to have little understanding of the reasons for gathering the data in the context of the program.

The Field worker

Field workers are full-time paid staff who supervise CBD agents. They are in general about 43 years old, married, and almost as likely to be men as women; their education ranges from standard 5 to form 4. Field workers interviewed have an average of 5 children each and the majority are users of modern contraceptives. Most Field workers have been in their current job between 1 and 5 years, and they had worked for FPAK for several years as field educators before switching to a CBD position.

They are responsible for an average of 15 CBD agents each, and most seem comfortable with the number of agents they supervise. Primary field worker activities include: correction of mistakes in record keeping, inspection of contraceptive storage, correction of use of blood pressure machine, and assistance to CBD agents with family life education or visits to schools, women's groups, and individual homes. Many of the field workers interviewed mentioned the usefulness of the checklists which they use during their visits.

Only about half of the field workers think that CBD agents receive adequate training, and many believe that agents require more specialized training in IEC for certain methods such as voluntary surgical contraception, Norplant, sexually-transmitted diseases, and in other technical areas such as first aid and primary health care.

Field workers overwhelmingly agree that CBD agents have increased the use of contraception in their communities. In general they believe this success is due to the fact that contraceptives are free, convenient, and readily available at the community level, expensive transportation to the clinic is not necessary, familiarity with the CBD agent makes dealing with family planning easier for the women, resupply by CBD agents is convenient, services can be offered in a private manner, and CBD agents are able to spend time individually counseling clients about the benefits of family planning. Some field workers believe that the current workload of 300 households is too large for the CBD agents.

Field workers face specific difficulties during the rainy season because of poor road conditions. Additionally, transportation reimbursements often take 3-4 months. If transportation were easier, many say they could supervise more CBD Agents.

The Role of Health Clinics in the CBD program

CBD agents refer their clients to clinics for a number of reasons including: IUD and pill checkups, side effects and complications, injections, Norplant, tubal ligations, changing contraceptive methods, pap smears, antenatal exams, immunizations, etc. Clinic staff agreed that they rarely see clients who have been referred by the CBD agents because they are having a problem with their family planning method. Those who are referred with problems usually are experiencing either high blood pressure, spotting, or other menstrual problems.

Overall, supervisors and staff report a positive relationship between CBD agents and the FPAK clinics with which they are affiliated. One particularly enthusiastic supervisor called the CBD worker "the backbone of the clinic". A number of nurses claimed that clinic attendance had increased due to the existence of the CBD worker in the community. The clinics also contribute to the CBD program through the periodic provision of transportation to field workers, storage of contraceptives for field workers, and assistance to CBD agents in reaching clients through the clinic outreach program.

All clinic staff were aware of the CBD program being implemented in their area and all knew either some or all of the CBD agents. Clinic staff described the primary role of CBD agents as assisting communities by distributing contraceptives, motivating women, and referring clients to the clinic. Some clinic staff also believe that CBD agents should take client blood pressure and weigh and thoroughly screen clients.

Most clinic staff believe that CBD training is adequate, however there is a perceived need for an increase in refresher training. The clinic staff tend to think CBD agents should receive more education, particularly in other health-related areas such as immunization, birth attendance, first aid, and weighing. Many also believe the CBD agents should have their own blood pressure machines.

According to clinic staff, they work hand in hand with CBD agents. There appear to be few conflicts or problems among the clinic staff and CBD agents. Clinic staff believe that CBD

agents complement their work by providing much needed services in family planning at the community level. CBD agents and clinic staff appear to work together as a team.

Clinic staff say that they can increase awareness of the CBD program through the media, the involvement of CBD workers in outreach campaigns, and local barazas. Clinics do not see a great need to increase the community's acceptance of CBD. Most communities already welcome the CBD program. Clinic staff support this by stating that women who come to the clinic speak very favorably of their CBD workers. Other ways of getting more couples involved in family planning include education and special counseling for men. Overall, clinic staff believe that the CBD program is the most effective way of getting people to accept family planning.

Overall, clinics have high demand for family planning and few problems with stock outs. Most CBD workers think the current pill distribution mechanism should be retained, many recommended minor modifications. There are two schools of thought: one that believes that women should receive more than the three packets they are currently receiving if there are no contraindications, and one that believes women should receive no more than the currently permitted three packets.

Clinic personnel speak very highly of the CBD program. They all believe it has been accepted as an alternate source of obtaining contraceptives in their areas, and all believe CBD has had a positive impact on the number of women using contraception. The general feeling is that the CBD system is convenient, brings services closer to the women, has increased awareness and demand for family planning, and has enabled men who were reluctant to go to the clinic for condoms to get them from the local CBD workers.

The Role of the Community

The evaluation team interviewed 13 FPAK volunteers and nearly 30 community leaders. Most of these interactions took place through group meetings. In this section, a summary of the views of FPAK volunteers (area level board members) and community leaders is presented.

The FPAK volunteers. The volunteers confirmed the high standing of the CBD program in the communities and considered the CBD program to be the strongest initiative of FPAK. The volunteers believe that community-based distribution of family planning services has significantly increased the number of women using contraception in the areas. They noted that men have also benefited through the increasing availability and use of condoms and by receiving some education on reproduction.

Most volunteers seemed to be aware of the process for recruiting and selecting CBD agents. However, only a few of them indicated that they had participated in the process. They all recognized the key role of the chiefs in this launching.

There is strong recognition of the good work carried out by the CBD agents. Nonetheless, the volunteers believe that there may be an important level of frustration in the agents. The main reason for this frustration is the issue of honoraria and allowances. They proposed increasing the honoraria to the CBD agents to about Ksh. 1,000 per month. It is clear that there is a lack of acceptance of the fact that the CBD agents are doing voluntary work for which they should not receive a salary.

A striking aspect in the FPAK volunteers' views is that, in spite of recognizing the agents' hard work, the importance of the service and the low level of community participation, when asked if the communities should help in supporting (monetarily) the work of the agents, the majority indicated that, under the current economic situation, the communities cannot afford the payment of any fees.

A minority of volunteers, however, suggested that the community has to find a way to maintain CBD agents. They feel there is a need to research and find out if the clients could pay for services. These few people were concerned with the issue of the sustainability of the program in the future, and in general accepted the idea that something should be done in the future regarding the payment of services.

Some volunteers feel very strongly about being involved in the management of the program because they manage their own businesses and know the community; they claim they should be involved in the supervision of the staff and agents because these people respect them. In general, they all think they should collaborate with FPAK in the overall operation of the program. At the same time, they see themselves as policy-makers and facilitators in the community.

When asked about problems and aspects that could be improved, the volunteers mainly refer to the issue of honoraria and the need for them to be increased. Beyond this, they identified the need to:

Provide more training for the CBD agents (both initial and refresher courses on updates of technology) and more assistance for problem solving.

Improve supervision and the interaction between CBD agents and clinical staff.

Expand services to more sub-locations, increase the number of CBD agents, and define a central place where CBD agents can provide services on occasion.

Define the CBD agent's job as a full-time position, as they thought part-time commitment was not an appropriate way to serve the community.

Increase the role of agent as educator (as in the lay educator program that existed before and was discontinued).

The community leaders. Community leaders are involved in recruiting CBD agents, introducing them in barazas and other community forums, and making public declarations in support of the program. Leader involvement is critical to the program's acceptance and success because it gives a sense of legitimacy to the program and encourages community members to feel at ease with family planning.

Community leaders trust and respect the CBD workers for their valuable assistance to their communities. Among the benefits attributed to the CBD program are: improved maternal and infant health, lower maternal and infant mortality rates, ability of people to space births and to maintain their desired family size, improved economic conditions, and increased ability to feed family members.

Community leaders believe that in certain areas there should be an increase in the number of agents to meet the growing needs of the community. However, leaders do not believe their communities can afford to compensate CBD workers. They explain that communities compensate CBD workers with verbal "thanks" but a financial contribution to the CBD program would be difficult. Many think it is the role of FPAK or the government to fund services. Additionally, they maintain that clients will stop using family planning services if they are required to pay for them.

Though insistent that their communities are unable to compensate workers for family planning services, leaders are convinced of the benefits of the CBD program. CBD agents are well liked and well respected by the community leaders. Leaders agree that the CBD program provides valuable services to clients with limited resources.

Leaders identified several problems/issues they believe need to be addressed within the CBD program. According to Community Leaders, there are too few CBD agents covering catchment areas that are too large. They think CBD agents work too hard for too little "pay" and should receive more support from either FPAK or the government. Due to their long hours of work, CBD agents are often unable to spend enough time with their families, and, given their low honoraria, agents cannot afford to hire help. Community Leaders also perceive a need for more male CBD agents to help educate men and increase their acceptance of family planning. In addition, leaders think FPAK should research ways of increasing the use of longer term contraceptive methods and should carry out a pilot study on charging fees for services. Leaders agree with the CBD agents and their supervisors that they need more specific refresher training in certain areas. Leaders would prefer to see the CBD program expanded to include a wide range of primary health care services.

Community leaders mentioned a variety of ways in which they believe the CBD program can be strengthened. The idea of exploring cost sharing was raised, as was the training of CBD agents in administering injectable contraceptives. Most leaders are very eager to see the program expanded both in terms of regions covered and numbers of workers. However, they are much less willing to financially commit the community in support of these changes.

The Client: As part of the evaluation, the team interviewed clients at every site visited. It should be noted that the clients contacted by the evaluation team do not represent a random sample of women or family planning users from the community. The FPAK area offices instructed CBD agents to bring a client with them on the day of the team's visit. Most of the agents brought with them a friend, neighbor, or other regular family planning client; therefore, comments about the quality or effectiveness of services should be viewed with caution.

Eighty-six CBD clients from various districts were interviewed, of which all but two were women. Between 12 and 20 clients were interviewed at each site. Clients were an average of 28.5 years of age with a range from 17 to 40. Eighty-four percent of the clients were currently married and only 7% were single. Most of the married women's spouses were either farmers or small businessmen. The vast majority of clients' educations were between the standard 5 and form 4 levels, with half being between standards 5 and 8. The average number of children per woman was 3.6. Of these clients, about 55 percent responded that they were currently using family planning to limit their family size and that they wanted no more children. The remaining 45 percent said that they were spacing births. The following chart shows the method breakdowns for each site.

Table 3
Method Mix by Visited Sites
Clients Responding to Survey

	KISII	NYERI	EMBU	MOMBASA	KIBERA	TOTAL	PERCENT
Pills	5	5	10	5	13	38	45
Condom	0	1	0	0	0	0	1
Norplant	0	2	0	0	1	3	4
IUD	0	1	1	1	1	4	5
Injectables	5	1	0	7	3	16	19
Permanent	5	0	0	3	2	10	12
None	3	1	6	1	1	12	14
TOTAL	18	11	17	17	21	84	100

Average Age of Women	30.8	28.8	28.1	26.9	27.7	28.5
Average Parity	4.8	3.4	2.5	3.8	3.5	3.6

Forty-five percent of the women interviewed were using oral contraceptives at the time of the survey. Twenty percent were using a long-term or permanent method of family planning (5% reported using an IUD, 4% Norplant, and 12% voluntary surgical contraception); 19% reported using injectables. In contrast with the method mix of the program (in which almost 40% of the methods of contraception used are condoms) only one woman reported using the

condom as a method. Fourteen percent reported that they were currently using no family planning method. Most of the respondents had previously used other methods but reported to have changed due to side effects, desire for more permanent methods, or advice from medical personnel.

Eighty percent of the respondents stated that they normally received their methods from CBD agents. However, 30% of the clients interviewed reported that the CBD program had been their first source of supply for family planning methods. Forty-one percent of clients interviewed were using a clinic method; however, many still saw themselves as CBD clients.

Most clients who rely on their agents for resupply have no problems with obtaining supplies. When clients need to be resupplied, about half go to their agent's home, while the other half receive a visit from their agents. According to the clients, 80% have been encouraged to go to the clinic for methods not provided by the CBD program.

Overall, clients had a very high level of satisfaction with the services offered and felt very comfortable with their agents. CBD clients are all in favor of having a community member who offers family planning services. When asked what other services they would like their CBD worker to provide — although several women mentioned they wanted more help in primary health care, immunization, and hygiene — many stated they just wanted the workers to continue to focus on family planning issues and basic health care referral.

About 30 percent of the clients who want no more children are using short term methods. The range of percentages varied by site from about 16 percent to over 60 percent. Since the clients were not a random sample, these data must be taken as an indication rather than conclusive evidence. Nevertheless, there does appear to be a gap, large in some sites, where clients who have completed their childbearing could be counselled to switch to long-term or permanent methods. The reason for this gap is difficult to assess. Norplant is not yet widely available. Although, when questioned, 85 of 86 CBD agents failed to identify vasectomy as a desirable method for a couple that did not want more children, tubal ligation is well known almost everywhere and is widely available. The reasons clients gave for using short term methods included fear of the vsc procedure due to rumors, husband's refusal to agree to the procedure, and not having been counselled at all about long-term or permanent methods by the CBD agent.

Clients appreciate having someone in the community to provide contraceptives and offer advice on family planning and community health issues.

- Clients interviewed showed an awareness of the relationship between family planning and quality of life, particularly in the face of difficult economic times and declining household resources.

- All clients stated that they felt free to discuss their family planning-related concerns with their CBD agent.

- Clients especially benefit from the CBD program by not having to pay for transport to the nearest health facility and by not having to queue for services.

- If any shortcoming was mentioned, it was that clients would like CBD agents to provide first aid and sell basic drugs for malaria, diarrhea, etc. Some clients expressed a desire for CBD agents to provide Depo Provera injections.

Willingness to Pay: Clients were asked at the end of each interview whether or not they had paid for their method, and if not, whether they would be willing to pay for the CBD service. Most clients had only paid for clinical services, e.g., the FPAK membership or a fee for tubal ligation. Only one client said that she paid for pills supplied by her agent. Of those who received CBD services, the following responses were registered.

Table 4
Clients Willing to Pay a Fee for Service

CBD Site (area)	% willing to pay[4]	Suggested fee (in Ksh)
Kisii (Nyanza)	83	10 - 20
Tetu (Central)	50	10 - 30
Runyenjes (Eastern)	97	5 - 50
Kaloleni (Coast)	94	5 - 20[5]
Kibera (Nairobi)	100	5 - 20[5]
TOTAL	89	5 - 50

It is apparent that clients know they are saving money on transport to get the supplies, which some valued at about Kshs. 40-50, and that willingness to pay is not closely related to income or level of education. It is, rather, related to the perceived benefits of the service.

IV. PROGRAM STRENGTHS AND ACHIEVEMENTS

FPAK's most significant achievements in developing the CBD program can be summarized as follows: the program's operational goals have been met; it is well established in the communities; structures and systems are in place and functioning appropriately; the implementation of CBD activities at the local level has benefitted significantly from a well

[4]These are the percentages of clients asked whether they would be willing to pay (79 total).

[5]Clients were willing to pay more for injections and IUDs.

managed supply system and from a simple and well designed MIS which produces service information on regular basis. Additionally, FPAK has successfully engaged the support of the community. Communities showed positive perceptions of the benefits of the CBD program, and the team found an important community involvement in the launching of the program and in the recruitment of agents. The program has strengthened area level family planning by complementing clinic services. Moreover, the program has gained legitimacy within the local health system, both at MOH and NGO levels. Finally, and most importantly, there is enough empirical evidence indicating that the CBD program is expanding family planning services. The following section describes these achievements in more detail.

1. The CBD program is well established. It has significant legitimacy at the community and local health system levels. Structures and systems are in place.

Overall, the implementation of Phase II of the CBD project has been successful. FPAK has established a well defined and relatively stable program. In each area visited by the evaluation team, CBD family planning activities account for a significant portion of all the family planning services provided by FPAK.

Operations at the area level are executed on a regular basis. CBD activities constitute a priority for the FPAK area management. Although there is some ambiguity regarding definitions of roles and responsibility, the people in charge of the area CBD program (CBD supervisors) receive appropriate support from area management. The supply system works well from the headquarters to the CBD agent level and the only problems detected by the team were associated with national level logistics issues. Information — even though of irregular quality — is produced on a regular basis and could become an important source of program improvement once data quality is improved and mechanisms for its use are addressed.

In general, the evaluation team found that FPAK CBD area management has appropriate knowledge of what is happening at the local level. Field workers' interaction with CBD agents was frequent and communication with the area CBD supervisor regarding the situation in the field seemed to be constant. Most important, in every FPAK area visited by the evaluation team, CBD agents were treated with respect by FPAK staff. In turn, the agent manifested a strong sense of belonging to the organization.

FPAK CBD activities have received wide acceptance from the clinical family planning system. FPAK clinical staff tend to rely on CBD agents as an extension of their clinical activities; there is no evidence of doubt about the agent's skills and capabilities to manage the distribution of short-term methods and to carry out promotional activities. At the local level, the interaction between agent and MOH health centers' staff seems to be beneficial for both parties, though it can be strengthened significantly.

The CBD program also counts on the support of FPAK volunteers in the areas of implementation. Without exception, the volunteers interviewed by the evaluation team

consider the CBD program to be the most important component of the service strategy of FPAK. They reported that this is the program they supported the most, and they showed eagerness to become more involved in its implementation; specifically in areas such as planning, supervision, marketing and overall management.

Overall, CBD family planning activities have been accepted as an important resource by clinicians, communities, and clients. The team feels that the FPAK CBD program can be considered one of the best in Kenya because of its stability, professionalism, good relations with the community, and ability to deliver services to a significant number of clients. This may be the most powerful indicator of the achievement of the program.

The overall level of success of the CBD program provides a strong basis for FPAK to explore strategies for strengthening the sustainability of the program. Indeed, we believe that more than further expansion, the Third Phase of the project must focus on building sustainability. This search for sustainability should focus on the main strength of Phase II, that is, the strong community acceptance of the services, the legitimacy of the program among the clinical community, and the support of the FPAK area volunteers.

2. There is evidence that the CBD program is expanding family planning availability, accessibility, and use.

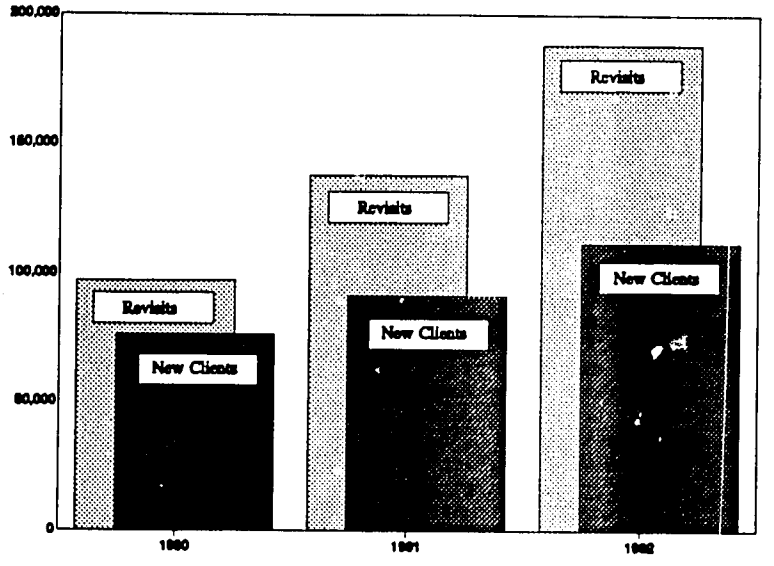
In 1991 FPAK initiated Phase II of its CBD program, expanding it to 21 sites in eight FPAK areas and increasing the number of CBD agents to 764. The objective was that the CBD program would serve about 170,000 new clients between 1991 and 1993.

There is sufficient evidence supporting the idea that the CBD program has significantly expanded family planning practice in the areas of implementation. Graph 1 presents information on services provided by the CBD program from 1990 to 1992. In the first two years of Phase II (1991 and 1992) the program provided family planning services to approximately 200,000 new clients. This implies that in two years FPAK exceeded by 18% the goal proposed for the three year period under Phase II.

Table 5
CBD Service Statistics
1990-1992

	1990		1991		1992	
	Number	Percent	Number	Percent	Number	Percent
New Clients	76,182	44.0	91,019	39.8	111,468	37.2
Revisits	97,129	56.0	137,877	60.2	188,213	62.8
Total FP Visits	173,311	100.0	228,896	100.0	299,681	100.0
Referrals	32,274	18.6	43,866	19.2	52,431	17.5

Graph 1
New Clients and Revisits
1990-1992



Over the period 1990-1992, FPAK service statistics reveal significant growth in the reported number of family planning client visits. Total CBD client visits (new clients plus resupply visits) grew 32% from 1990 to 1991 and 31% from 1991 to 1992. There is every reason to believe that growth will be similar in 1993, as CBD agents are trained and re-trained, and they continue to meet their targets.

Table 5 also shows figures on referrals. These figures indicate that nearly 18% of all visits (new and revisits) end in a referral to other services during each year in the period that was reviewed. Most of these referrals, however, are associated with check-ups for oral contraceptive distribution. Our review of the client Registers indicated that only 8% of the referrals were associated with other reasons (clinical methods or side-effects). At any rate, it is difficult to verify how many of these events are "effective" referrals — that is, resulting in client acceptance of a clinical method, or a change in method due to side-effects. Referrals constitute a very weak area of the program and significant improvements are urged.

Graph 2
CBD program Method Mix
1990-1992

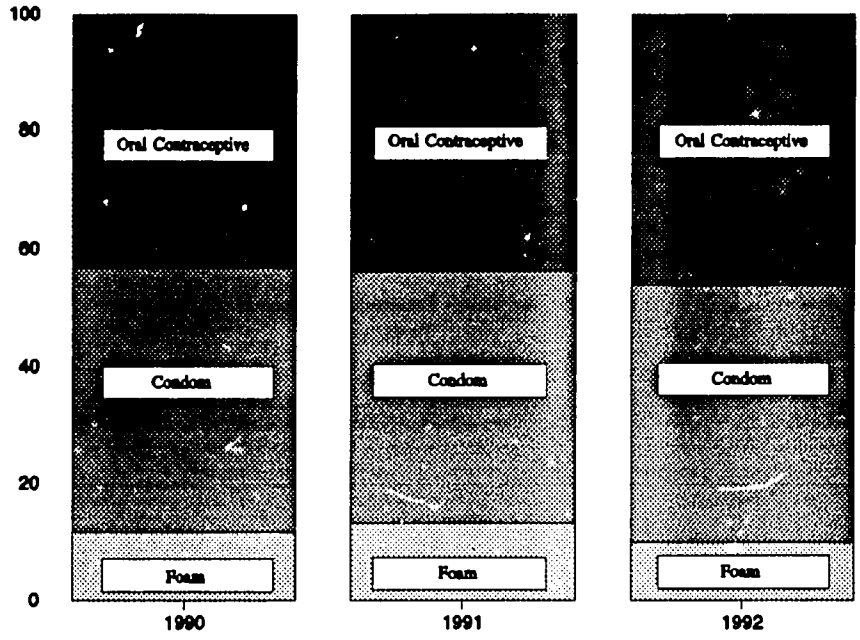


Table 6
CBD program Method Mix
1990-1992

	1990		1991		1992	
	Number of Clients	%	Number of Clients	%	Number of Clients	%
Oral Contraceptive	73,716	42.8	99,294	43.5	133,711	45.7
Condom	77,353	44.9	97,369	42.6	127,419	43.5
Cream/Jelly	722	0.4	1,221	0.5	2,398	0.8
Vaginal Foam Tablets	20,306	11.8	30,440	13.3	29,364	10.0
Total	172,097	100.0	228,324	100.0	292,892	100.0

Method mix over time is shown in Table 6 and Graph 3 for those clients supplied by CBD agents. Oral contraceptives and condoms make up nearly 90% of all methods used by the program. Foam tablets represent between 10 and 13% of the methods distributed. This mix has experienced only minor changes over time; oral contraceptives increased from 43% in 1990 to nearly 46% in 1992.

Although the CBD program reported increases in clients, the reliance on short-term methods suggests a less dramatic increase in couple years of protection (CYP) than could be attained if the program started bringing clients closer to the idea of long term/permanent (LT/P) methods by interacting more intensively with clinics and health posts. While CBD program statistics would not improve from such a shift, overall protection provided by the family planning program would increase.

CYP figures by method are shown in Graph 3 for the period 1990 to 1992. For these years, oral contraceptives constituted the main source of the CYPs produced by the program (50% for both 1990 and 1991 and 52% for 1992); the second major source of CYP is the distribution of condoms (40%, 38% and 38% respectively.) The other methods common to a CBD program comprised together less than 10% of the total CYPs produced by the program every year.

Graph 3
CBD Service in CYP
1990-1992

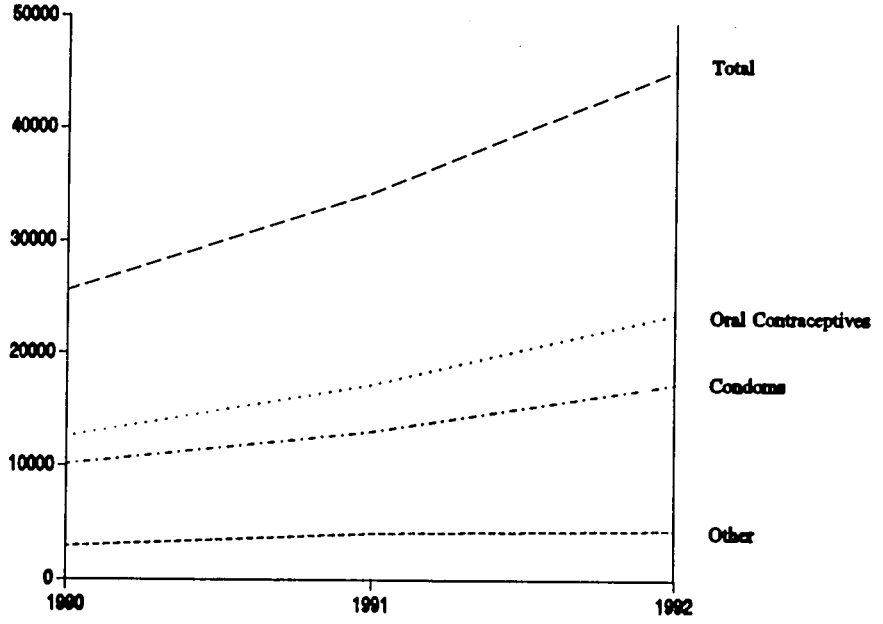


Table 7
CBD Service in CYP
1990-1992

		1990	1991	1992
Oral Contraceptives	Quantity	187,834	257,952	352,751
	CYP	12,523	17,197	23,517
Condoms	Quantity	1,520,834	1,949,542	2,585,671
	CYP	10,139	12,997	17,238
Creams/Jelly	Quantity	4,650	1,825	6,680
	CYP	310	122	445
Vaginal Foam Tablets	Quantity	393,707	596,345	586,201
	CYP	2,625	3,976	3,908
Other	Quantity	1,466	1,169	1,820
	CYP	10	8	12
	Total CYP	**25,607**	**34,300**	**45,120**
	% Increase	--	**34%**	**32%**

As expected, given the stability of the method mix, CYP grew at the same pace as the visits — at a rate of 34% between 1990 and 1991, and nearly 32% between 1991 and 1992. Oral contraceptive-specific CYP grew by 88% from 1990 to 1992, while condom-specific CYP grew by 70%.

The increases in both clients and in CYP reflect a significant achievement of the FPAK/CBD program. Nearly 60% of all CYP produced by any type of FPAK family planning services are produced by the CBD program. Based on 1991 expenditures and CYP data, the CBD program provided family planning services at a direct cost of nearly $12 per CYP.

Although population-based data was not available to the team, this expansion in services can be assumed to have a positive effect on contraceptive prevalence in the geographical area of the intervention. MIS records and the FPAK Annual Report tend to support this assumption. Unfortunately, the lack of data on population size in the CBD areas made it difficult for the team to determine the exact extent of this impact.

3. FPAK has been successful in gaining community support in the establishment and expansion of the CBD program.

By interviewing different segments of the communities where the CBD program is being implemented, the evaluation team was able to establish that the program has significant

legitimacy and wide acceptance at the community level, both among the leaders of the communities and among the people that the program aims to serve.

A reason for this acceptance and legitimacy among community leaders is their involvement in the launching of the program in every site. They participated in the initial planning and they were key in the recruitment of candidates for CBD agent positions and in the final selection of the agents. After the launch, community leaders continue to support the actions of the agents. Leaders invite agents to participate in other community initiatives and urge them to give family planning talks in various types of gatherings. Accordingly, the evaluation team found that the approval of the program by the community leaders was unanimous; they conclusively defined the CBD program as an important asset to their communities and they all seek expansion of the CBD services.

The support for the program among the beneficiaries of the services arises from two basic elements. The availability of services (family planning methods) free in their own local areas is of primary importance. As indicated earlier, about one third of CBD program clients had never used any family planning methods before starting with the program. In general, people complain about the cost (in money, time, and inconvenience) of the clinic-based family planning services, which usually becomes an important factor in method discontinuation. The community-based distribution service has, as one of its main features, the strengthening of continuity through frequent client follow-up. One of most significant sources of clients' satisfaction is the provision of caring services by someone they know and trust.

Beyond their immediate satisfaction with the services, clients and community leaders were very open in sharing their positive perceptions of the benefits of the CBD program. Three of these benefits must be highlighted: First, clients and community leaders emphasized the effect of the CBD program on the general improved socio-economic status of family; they felt that achieving a smaller family size has enabled them to raise their children under better conditions. Second, contraceptive practice was widely recognized as important for the mother's health and the reduction of maternal mortality. Third, clients value the improved quality of services compared to the long waiting time experienced at clinics, particularly at MOH health centers and posts.

In summary, this evaluation team found significant and positive community recognition for the CBD program. The community sees it as an important service, as something that should be continued and expanded to cover most communities.

4. The CBD program has strengthened the overall area level Family Planning program by complementing clinic services.

In general, the addition of CBD activities in the areas of implementation has resulted in an increase in users without reducing the number of clients of clinic based services. In this respect, it can be said that the CBD program has strengthened the family planning program at the area level. In some clinics visited by the team the nurses claimed that clinic attendance had increased as a result of CBD activity in the area. There is no doubt that the

interaction between the CBD personnel and FPAK clinical staff is one of mutual respect and support.

In the few cases where the evaluation team found some tension between the CBD operation and the MOH, the difficulties occurred at the hospital/district level, where there was little recognition of the CBD agent as a service provider. At the local level, the team found a good level of respect and great potential for further association and collaboration. Examples of this collaboration were noted by the team in a few places, most notably in Mombasa. There, the CBD agent helped the MOH staff to carry out educational activities at the health center. The CBD agent also coordinated with MOH staff to establish the best time to send clients for check-ups or for new methods. There is no reason we cannot expect this experience to occur throughout the FPAK CBD program.

There is insufficient data to measure contraceptive prevalence levels at area levels. However, one can hypothesize that there is a significant impact since CBD services tend to be used by a significant portion (30%) of real "new users" (those who have never used a family planning method before), as well as women who had discontinued using family planning but who were willing to resume because of the convenience of the CBD service.

5. Key support systems have been designed and implemented to facilitate the operation of CBD activities.

The implementation of CBD activities at the local level has benefitted significantly from a well managed supply system and a simple and well designed MIS which produces service information on a regular basis.

When it expanded the CBD pilot project, FPAK modified the logistics system in a way that allowed the continuous resupply of the different areas under the project, and from the area level to the agent level. The key point in the success of the supply system is its simplicity; forms and schedules are easy to follow and meet, and the communication between areas and headquarters is fairly flexible.

As a result, the team did not find cases of stock-outs. At the time of the visits, most agents reported that they have sufficient supplies to keep supplying their clients for about three or four weeks, and all of them have a resupply shipment scheduled before then. The records kept by the agents to monitor supplies by method are simple and helpful. The only complaint was the size of the box in which supplies are kept; some of the agents thought it was too small and did not enable them to keep more supplies in storage. However, the design was reported appropriate to ensure the quality of the contraceptive method.

Supplies on hand is an important achievement of the CBD program, as logistics is a problem that often seriously affects the operation of community-based family planning activities. The only cases of stock-out that were reported involved general failure of the national logistics system that affected every point of the national distribution system, independent of whether they were clinic-based or community-based, public or private.

Additionally, a simple and well designed MIS is in place and the staff collects service information on a regular basis. It is easy to define the need for information and the importance that this information may have for planning and streamlining operations. However, we seldom find that information systems produce data on a regular basis, making it available to the respective levels. This is actually happening in FPAK's CBD program. The MIS division of FPAK has been able to design a simple model, with simple forms that can be easily used at the local level; the result is that the headquarters is collecting regular information regarding the services provided by the CBD program in each area of implementation. This is an important achievement.

V. MAIN ISSUES TO BE CONSIDERED IN FUTURE PLANNING

Considering all these achievements and strengths, the overall assessment is a very positive one. Contrasting these achievements with the initial goals of the Phase II of the CBD project, one must congratulate FPAK for its great performance. Parallel to these strengths, however, there are significant weaknesses that should be considered in the design of Phase III. These weakness are sometimes directly associated with some particular achievement.

1. Appropriateness of services and the role of long term/permanent methods

The program relies heavily on the distribution of oral contraceptives and there is no evidence that clients are being encouraged to shift to longer-term or permanent methods after using pills for significant periods.

The CBD program focuses mainly on distribution of short-term methods by the CBD agents. Our review considered nine "client Registers" (in Nyeri, Embu and Mombasa) for which a sample of 543 entries was checked. Fifty-four percent of the women in the sample were registered as oral contraceptive users in the last entry of their records, 32% were receiving condoms and 14% were using other methods. Of the women using other methods, 24 of the 77 women have had tubal ligations. It is interesting to observe that the average parity of these 24 women is 4.8 children and the average age well over 35.

The difference in method mix between the service statistics and the "client Registers" seems to be significant. However, this is not a salient issue; more critical is the distribution of pill user by age and parity. Graph 4 and Table 8 present information regarding this issue.

Graph 4
Method mix by age of users according to client register

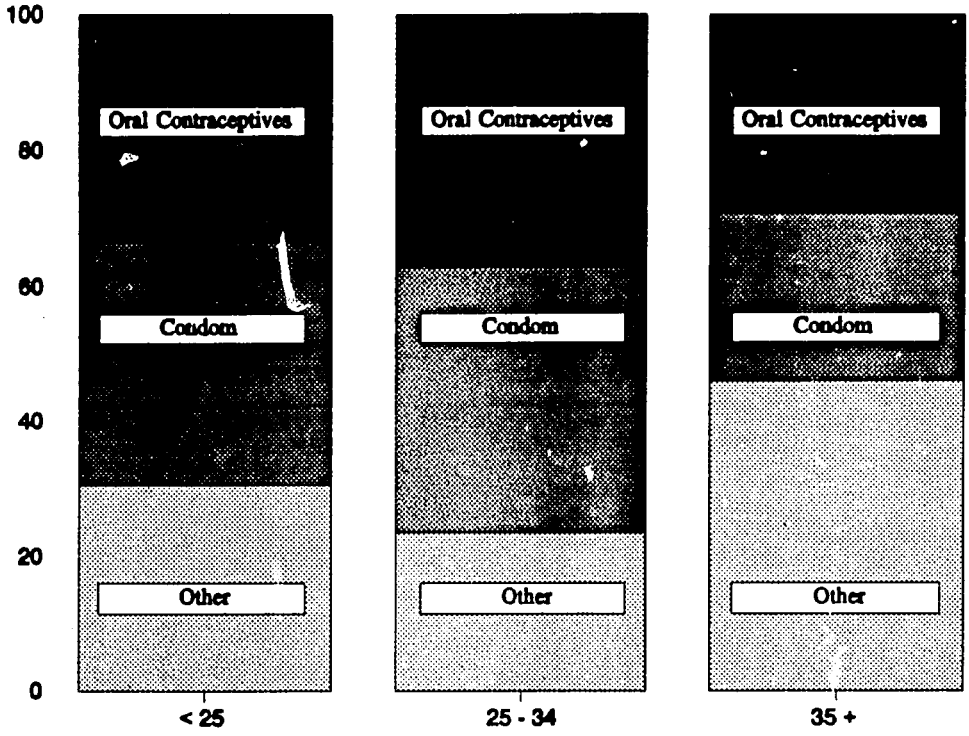


Table 8
Method mix by age of users according to client register

Age	Oral Contraceptives N	%	Condom N	%	Others N	%	Total N	%
<20	11	3.8	15	8.7	6	7.8	32	5.9
20-24	59	20.1	30	17.3	11	14.3	100	18.4
25-29	68	23.2	37	21.4	8	10.4	113	20.8
30-34	63	21.5	45	26.0	14	18.1	122	22.5
35-39	51	17.4	33	19.1	20	26.0	104	19.1
40+	41	14.0	13	7.5	18	23.4	72	13.3
Total	**293**	**54.0**	**173**	**32.0**	**77**	**14.0**	**532**	**100.0**

The average age of pill users, according the Register, is 32 years. Table 6 shows that more than half of all pill users are over 30 years of age and over 30% are over 35. This situation becomes even more serious if we consider the distribution of pill users by both age and parity. Table 4 presents information on these relationships. According to this Table, sixty-seven women using pills are over 35 years of age and have four or more children, this is 22.9% of all oral contraceptive users and 12.3% of the total number of records considered in the exercise.

Table 9
Oral contraceptive use by parity and age according to client register

		Parity (children ever born)				
Age		**0-1**	**2-3**	**4**	**5**	**Total**
<20	N	8	3	--	--	11
	%	2.7	1.0			3.8
20-24	N	28	19	11	1	59
	%	9.6	6.5	4.4	0.3	20.1
25-29	N	22	18	21	7	68
	%	7.5	6.1	7.9	3.1	23.2
30-34	N	12	26	15	10	63
	%	4.1	9.2	5.5	4.1	21.5
35-39	N	3	13	19	16	51
	%	1.0	3.8	5.5	4.8	17.4
40+	N	--	9	15	17	41
	%		3.1	4.4	5.5	14.0
Total	N	73	88	81	51	293
	%	24.9	29.7	27.6	17.8	100.0

Note: All percentages are based on the total N=293

Keeping older and higher parity women on oral contraceptives is, no doubt, a health risk. Moreover, the check-ups for side effects tend to be irregular and relatively unmonitored despite the fact that check-ups are significantly present in the reporting system. Women of high parity (i.e. 4 living children) should consider longer-term or permanent methods, particularly if they have already reached their desired number of children. CBD agents should be encouraging these women to do so.

Analysis of the client registers indicates that relatively few clinic referrals are made for reasons other than pill check-ups. Of the 543 records that were checked, 397 were found to have at least one referral during the last two years; this is a good rate of referral (nearly 75%). However, 85% of all referrals were associated with "pill check ups", and 3% with MCH services; only 12% were found to be related to changes toward long-term/permanent methods. Therefore, it seems likely that CBD clients continue for too long on pills and other distribution methods. This should be reviewed in the design of the next phase: improving training in counseling for appropriate methods, increased referral for LT/P methods, and strengthening the links of the CBD program to the clinical services.

2. Community commitment to CBD activities

As mentioned earlier, the implementation of CBD activities has met with extensive community participation. However, most of this involvement has been limited to the organization and launching of the program in local areas, particularly the recruitment and interviewing of CBD agents. community leaders "mobilize the community" during public meetings. They invite CBD agents to give family planning talks and provide education. community leaders refer clients to CBD agents, and they introduce CBD agents to the community.

Community leaders consider the program important and are ready to help the agents in expanding their work throughout the community. However, they tend to put additional pressure on the CBD agents to get involved in other community activities and in expanding their services beyond their training. Community leaders have significant influence on the CBD agents. Because community leaders are politically influential in the community, and because they are instrumental in the selection of CBD agents, agents are reluctant to contradict or oppose them.

This situation gets even more complicated when the role of the FPAK volunteer is considered. Volunteers feel they have a limited role in the CBD program. However, this is not contradictory with the design of the CBD program; the volunteers are policy makers of FPAK, and mainly interact with the national level managers and the area managers. They are supposed to be advocates of the family planning program in their communities. Nevertheless, they see themselves as the link between the CBD agents and the management and they would like to have more say in the implementation of CBD activities, at both the planning level and in a supervisory role at the field level. Sometimes they get in touch with the CBD agents and provide some technical guidance.

The involvement of community leaders, and to a lesser extent volunteers, in the CBD agents' daily activities has created a dual accountability for the agents: to FPAK management and to community leaders/volunteers. This situation requires clarification because it is directly connected the agents' increasing workload and to their increasing demands for higher honoraria.

In the future, the sustainability of the program will strongly depend on the extent to which the community is willing to allocate resources for its implementation. The evaluation team found, however, that both the community leaders and the area FPAK volunteers opposed the idea of using community resources.

For example, the work done by CBD agents is recognized and appreciated by the community leaders and volunteers and they even suggested the need for an increase in the number of CBD agents and an expansion of the CBD program to new areas. When considering funding and resource issues, however, they felt that there are no community resources to cover compensation for CBD workers. They suggested that the Government and FPAK should be providing compensation by increasing the agents' honoraria. They also think that the future of the program should be the responsibility of either the government or FPAK.

The vast majority of community leaders felt that asking clients to pay a fee for service would result in dropouts. CBD agents do not seem to think that clients will be willing to pay for the service, particularly if the government offers free services. A significant number of clients, on the other hand, were very receptive to the idea of paying for services.

3. CBD Agent's Workload

In all sites visited, the team found that agent workload exceeded expectations, and that the geographical areas to which they were assigned could only be partially covered.

The number of households in a sub-location is too great for one agent to cover through home visits. When asked the size of the area they covered, agents estimated from 300 to 800 households. When asked how many households they could effectively serve, agents responded from 100-300 households. There is excessive pressure on CBD agents to work full-time. They already provide services eight hours a day, including distributing contraceptives, counselling clients, following up, referring clients, and giving family planning talks in public meetings. Sometimes the agents escort the clients to the clinic for surgical procedures. As a result, actual hours exceed planned hours.

Estimates of numbers of couples served also varied widely. It is difficult to compare responses among CBD areas because some agents can only state the number of visits made per month, not the total number of their clients. The total number of individuals served can only be determined by reviewing every agent's client register or by using CYP as a crude estimator of potential numbers of clients. In some areas, such as the Coast, the distances that agents travel prevent them from visiting more than a few households in a day.

Agents are viewed as community health workers in many areas, which creates pressure to spend more time with each household and to work longer hours. When queried, agents said their work includes giving advice on primary health care, immunizations, and nutrition; civil registration; first aid; and other tasks. To some extent, this is inevitable and even desirable. In areas where low-income families face high infant mortality and a range of other health problems, it would be unacceptable for CBD agents to deliver contraceptives without attending to maternal and child health concerns.

As noted earlier, the number of continuing clients grows every year the program is in operation, resulting in an increasing need for resupply visits.

The actual number of households in a sub-location needs to be verified (through the district offices), as does the number of households agents currently serve (from client registers). The currently assigned areas are too large to cover through house-to-house canvassing. The guideline of 300 households cited by many agents may be more realistic, but it is currently unclear how these are to be targeted within the larger sub-location.

4. Honoraria and Other Compensation

The CBD honorarium has been and will continue to be a difficult issue for FPAK, as agents consistently ask for more resources. Some agents see themselves as poorly paid employees rather than volunteers. Others believe that someday they will become full-time salaried employees. In either case, this poses a management problem, since agent expectations do not match project design. Agents want not only to be better paid, but also to be better equipped with raingear, transport, more IEC materials, and blood pressure machines. Many agents also asked for assistance for their families, since they spend so much time away from home.

The team does not recommend raising the agents' honoraria, because it would not be affordable under the current budget and would only lead to an upward spiraling of unmet demands. It is also inconsistent with the project design (which sees CBD as a temporary approach) to take on full-time salaried employees. Some lower-cost options might include trophies, time-in-service awards, new educational booklets, and better raingear. FPAK has already used these as incentives in the past, and could continue to do so.

Parallel to the review of the CBD agent's role and the rationalization of their workload, it is important to consider some other alternatives that can directly improve the situation regarding honoraria. Apart from offering small or token rewards, the team sees as a possible option for dealing with CBD compensation replacing honoraria with a partial incentive-based system (fee for service). A number of pros and cons relating to service fees should be considered. These pros and cons are discussed in detail in Annex 1, where a proposal for a service fees approach is discussed.

Payment for services has been discussed before in FPAK, but mainly in the context of clinic-based services. As a way of exploring potential fee options and their effects, the team posed questions to FPAK managers, volunteers, and clients regarding willingness to pay. As noted in Section 3, about 86% of clients interviewed said that they would be willing to pay for services. However, most FPAK volunteers and managers thought it unwise to introduce fees. In their view, clients would be unable to pay. There is therefore no consensus on whether this would be the right course of action for the CBD program. FPAK should explore this issue further.

5. Planning and Coverage

There is currently no mechanism for monitoring coverage of CBD areas or for assessing progress toward increasing accessibility of family planning services. Estimates of the number of households served are extremely vague, and it is impossible to determine what proportion of women of reproductive age in the area are covered by CBD services. It is also very difficult to verify whether high priority clients are being served, e.g., women most likely to have high risk pregnancies. Thus, decisions about priorities, areas of expansion, or phase-out cannot be made based on real information, but only by guessing what proportion of the population currently has access to family planning services.

The implementation of CBD activities at the area level could greatly benefit from an improvement in planning capabilities. It is important for FPAK area management to pay

more attention to CBD activities in the annual planning process. Usually, activities are defined automatically (from the previous plan) without a serious assessment of priorities. The program should be able to evaluate progress and set new targets; this is the only way FPAK can determine the level of impact of its CBD efforts.

Improvement of planning activities can be facilitated through the use of information from the MIS to establish realistic targets and monitor progress. As indicated in the previous section, information collected through the CBD/MIS is not currently used at the area level; designing mechanisms to use information for decision making at the area level could significantly strengthen the CBD program at this level.

Area level planning capability should be considered an important issue in designing Phase III of the CBD project. Considering that it would difficult for FPAK to expand the program by increasing the number of CBD agents, the best hope for expanding coverage in the project areas is by maximizing the use of resources. Planning skills are determinant in achieving this goal.

6. CBD Management Information System

In Section IV it was stated that one of the important achievements of the CBD program is the design and implementation of the MIS for CBD services. Indeed, FPAK has been able to develop and implement a simple MIS that has great potential. However, some key weaknesses of this system have to be considered, particularly for the design of the next phase of the CBD project. Four major weaknesses were identified in the working of the system and are discussed below.

First, although the system is simple and easy to implement, its design is highly centralized, geared mainly toward producing information for the Headquarters. CBD agents gather too much information without a clear purpose; information which they may never see again.

Second, it is hard to determine to what extent the system is designed to support decision-making. In general, there is minimal use of information at the central level and no use of the information from the system at the area or local levels. The system does not have mechanisms (tools) to facilitate the use of information. Reports are only snapshots of the information that is gathered by the system, and feedback to areas is limited to a printout of these snapshots.

Third, even if mechanisms for the use of information were developed, there must be improvement in the quality of the data. In effect, this is perhaps the most significant weakness of the system. A quick review of a sample of entries in the CBD agent forms and the field worker consolidation forms gave us a rate of errors in data of nearly 30%. That is, nearly one-third of the pieces of information recorded in any of these two instruments were subject to some kind of error. There are multiple sources of errors.

- The main source of error is that the area/site level staff are asked to collect information without being provided with a clear understanding of the objectives and

purposes of that information. CBD agents and field workers try to perform the best they can in recording and collating data, however their lack of sound knowledge regarding the purpose of this data collection leaves them without protection against errors. This tends to be even more serious if we consider the relatively low conceptual knowledge of those who have to record the information.

- FPAK staff have to constantly struggle with terms such as new family planning acceptors, new acceptor to CBD program, continuation/dropouts, methods monitoring, conversion factors, effective referrals, etc. without knowing exactly what they mean.

- The insufficient supply of materials tends to create serious problems in recording information. Confronted with a lack of appropriate forms, agents and field workers try to improvise solutions, sometimes making decisions that dramatically affect the quality of the information.

Fourth, entangled with these issues is the lack of appropriate and systematic MIS training. FPAK must pay close attention to strengthening its MIS unit in order for them to have the capability to support the information needs of the CBD program.

7. Supervision and Training

The team found no problems with the structure of supervision in the CBD program. However, it is difficult to measure the impact of supervision visits on the quality of service provision. It seems that monthly meetings are basically dedicated to collecting MIS forms, checking supplies, and discussing other general issues, but they are not used as an opportunity to identify and discuss problems or to retrain agents in areas where improvement may be needed.

Two problems should be addressed by FPAK regarding the supervision of CBD activities. First, field workers need more guidance about how to carry out effective supervision. They need more training in both clinical and organizational aspects in order to be ready to respond to questions that can arise in more dynamic supervisory practice. Supervision should be viewed as an opportunity for ongoing training of CBD agents. There is also a need for more standardized instruments for supervision that can facilitate the monitoring of the quality of services provided through the CBD program.

Since motivation is a key to volunteer community work, supervision will continue to be important for the duration of the project, if only to continually energize agents. The more technical education that can be added to supervision visits and meetings, the better.

The majority of agents interviewed said that the training they had received was not adequate to do their jobs effectively. When asked what additional training they needed, a long list of family planning and non-family planning topics was offered including contraceptive methods, side effects, VSC counselling, giving injections, inserting IUDs, first aid, primary health care, midwifery, and nutrition.

When the evaluation team gave CBD agents a short test drawn from the program training manual, wide variation in knowledge was detected. Average agent scores ranged from 56% correct answers in Kibera to 75% in Embu. Areas of weakness appeared to be in technical knowledge of contraceptive methods and in the ability to respond to misinformation and rumors about family planning. Knowledge about STDs and AIDS also varied widely.

A key issue to consider regarding training is cost. Training costs are roughly 16% of the CBD budget. In order to conduct training in hotels that have meeting facilities and can accommodate the agents overnight, fees of Ksh. 500 per day per agent can be expected.

In summary, CBD agents need additional training on contraceptive technology, counselling on side effects, and use of long term and permanent methods. These requirements for additional training can be met, in part, through monthly supervisory meetings. These meetings could be supplemented by having a guest (local nurse, doctor, someone from Headquarters) lead a one- to two-hour seminar on topics of concern. Additional training could be conducted at the area level in community centers where agents do not need to stay overnight. Lower priced meeting facilities should be sought out whenever possible.

8. Future Expansion and Phase-out

A key objective of the second phase of the CBD project was to increase community participation in providing the services, thereby laying the foundation for an eventual phase-out of A.I.D. funding. This objective has clearly not been reached; community participation is mostly symbolic and has not increased since the project's launching.

It is difficult to visualize how a CBD project of this type could sustain itself, even under the best of circumstances. It is unrealistic to expect the community to provide any monetary support, particularly given worsening economic conditions. The introduction of a small service fee — the most direct form of cost recovery — could only partially defray costs or help to absorb the cost of additional agents or service expansion. The bulk of commodities and costs of managing the program would have to come from external resources. If donor resources were to be suddenly curtailed, the program would simply cease to operate.

An alternative solution at some point in the future would be the replacement of CBD by social marketing, where commodities would still be subsidized but distribution costs would be recovered through product sales by local distributors at various sales points in the community. CBD agents could be retrained as quasi-commercial agents, or perhaps other shopkeepers and traders could be identified.

A primary objective of community-based family planning services is demand creation. Once most households have been educated on family planning and the practice becomes widespread, the service becomes a convenience more than a necessity. Certainly most women would like contraceptives brought to their doorstep, but the number of agents required to serve a growing population of users would be unimaginable, and unmanageable. Since community demand for home services is infinite and resources are limited, options for modifying the nature of the service must be considered.

A central issue for the CBD program is attaining and maintaining sustainability. Ultimately, community-based distribution of contraceptives in Kenya must rely on the indigenous resources of the community in which it is operating. Planning and implementation of the program should, and hiring and training of personnel must, be designed with this goal in mind.

VI. RECOMMENDATIONS

This section outlines the evaluation team's recommendations for action on the specific issues analyzed in the previous section.

1. Method Mix Expansion

- Promote a wider method mix among CBD clients, particularly of long-term and permanent methods through the re-orientation of the CBD agents' motivational and client referral role.

  - Establish a well defined connection with clinic-based services:
    - There must be clear agreements between FPAK area management and MOH for effective referral from CHD to MOH health centers
    - There must be clear guidelines for FPAK clinics to support and facilitate effective referrals from CBD agents.

  - Retrain CBD agents in motivational and counselling skills, focussing on reproductive risk factors for pills and dispelling rumors about IUD or VSC.

  - Include referral for other methods as a key component of CBD agents performance evaluation.

- Develop specific methodologies and instruments to define (and revise) area level targets during Phase III of the project in order to promote the shifting of pill/condom users to long term or permanent methods when the circumstances warrant.

  - Create map of assigned areas to show the major concentrations of women and the sectors with larger numbers of clients in order to accurately plan current activities and future expansion.

  - Define initial targets for clinic referral using last year's actual referrals for other methods (between 5 - 7% of total CBD clients). Increase future targets according to performance (or achievements).

- Strengthen the CBD referral system overall.

  - Define procedures for referrals from CBD agents to either FPAK clinics or MOH health centers.

- Define procedures for recording referred cases at the clinic level, particularly FPAK clinics.

- Develop a simple monitoring system for referral to be managed by the area level CBD supervisor.

- Develop focused training activities for CBD agents in the following areas: technical knowledge of all family planning methods, particularly long term or permanent methods, targeting clients who want no more children for long term or permanent methods, and referral management and effective referral reporting. Design a refresher training program for CBD agents and field workers on contraceptive technology (non-clinical and clinical methods, current and new methods).

- Encourage CBD agents to refer clients to clinics for long term or permanent family planning methods when the circumstances warrant.

2. Community Commitment and Involvement

- Strengthen community participation by promoting grassroots involvement and liaisons with women's groups, youth groups and others. Educate community leaders on the need for broad-based community participation in the CBD program for the long-term benefit of the community.

- Clarify the roles of the community leaders and FPAK area level volunteers; they should be viewed as supporters and facilitators, but not supervisors of the CBD agents or field workers. Reinforce the ties of CBD agents to FPAK by providing guidance and more intensive interaction with FPAK staff regarding technical implementation issues.

- Study the feasibility of increasing the community's contribution of resources for training or other activities. Possible areas of contribution include the following:

  - seeking volunteer contributions of time and resources from members of the community who have some professional status;
  - using community facilities for meetings and training activities;
  - using community resources for transportation and communication.

3. CBD Agent Workload

- Streamline the CBD agent workload in order to allow agents to focus on priority clients and maximize the use of time (reduce total working hours to the planned level). This can be achieved through several of the suggestions that follow.

- Encourage the use of a depot-based supply system for continuing clients. Agent productivity might be increased and their home-life made more manageable by setting up a location and schedule for resupplying clients, and making visits to workplaces

and other meeting places. Challenges to this approach are maintaining privacy and counselling time for clients, and following-up on those who do not come for resupply.

- Increase the selectivity of the households served. Agents should use community diagnosis forms to target couples of high parity/poor health, who particularly need individual home visits. During their training courses, agents learn to identify women who are likely to have problems during pregnancy and childbirth (too young, too old, too many children, too close together). This process of identification needs to be put into practice when canvassing households.

- Clarify the service provision role of the CBD agents, emphasizing family planning and referrals for non-family planning services (i.e. primary health care and maternal/child care). Expanding the CBD agents' role as a primary health care service provider is not recommended given limited resources.

4. Honoraria and Compensation

- Replace Honoraria with a partial incentive-based system (fee for service). An increase in honoraria is not recommended as this would overtax FPAK resources and would be inconsistent with the project design. A detailed proposal regarding this recommendation is presented in Annex I.

  A fee for service payable by CBD beneficiaries is desirable and a welcome idea for the future, and is in the spirit of cost-sharing and CBD service sustainability. Evaluation team findings suggest that the level of this charge could be in the range of Kshs 5/= to Ksh.20/= per 3 cycles of pills. Two options for the management of these funds are:

  - CBD agents retain all of what they collect
  - CBD agents retain a portion of what they collect and return a portion to FPAK

- Other low-cost options for providing agents incentives include trophies, time-in-service awards, new educational booklets, and better raingear.

- Evaluate the income-generation activities carried out by CBD agents to determine the viability of these projects and advisability of continuation or expansion.

5. Planning and Coverage

- Use existing information for more systematic planning and monitoring of CBD activities. Agents, field workers, and area managers do not need to collect more information; rather, the information they have needs to be used better.

- Identify specific indicators for measuring coverage of the community and procedures for monitoring progress on a regular basis.

- Use the community diagnosis forms to develop realistic estimates of the number of households to be served, the number actually served, and the number of high risk clients.

- Design simple but effective mechanisms for monitoring coverage of CBD areas and for assessing progress toward increasing accessibility to family planning services. As has been suggested earlier, mapping of service areas can provide a picture of which groups of households have been served.

6. CBD Management Information System

- Decentralize system operations by expanding the role of area level staff (area Manager, CBD supervisor, and field workers) from data collectors to information users. The FPAK/MIS Division should explore some alternative for decentralizing automated data processing at the area level.

- Encourage and facilitate the use of data from the CBD/MIS at the field worker/CBD agent planning level and CBD program area level. This effort should include the development of tools and guidelines to facilitate data use.

- Develop a comprehensive approach to ensure the quality of the data produced by the CBD/MIS. This should include: an assessment of the information that is needed at different levels of the program vis a vis the information that is actually collected; a revision of the concepts and indicators that are defining the data collection; the design and implementation of an error detection and correction component, and the development of protocols for data recording, aggregation, and transfer.

- Design and implement an intensive training program for all personnel involved in the system in the use of instruments (forms) for data collection and data consolidation. A key issue in this training is the need to increase the understanding of the purposes of the system.

- The MIS, in collaboration with the CBD program, should develop a clear feedback component which assures program improvement at every level.

- Strengthen FPAK/MIS division by upgrading existing hardware, expanding available software, training MIS staff, and allocating realistic resources to support information needs for CBD activities.

7. Supervision and Training

- Review the CBD supervisory system, paying particular attention to the following components:

  - Area CBD supervisor — CBD field worker
    Create a list of activities to be considered as routine supervisory events
    Institutionalize the monthly supervisory meeting

Provide written feedback from supervisor to field worker
Provide follow-up of recommendations/solutions

- CBD field worker — CBD agent
  Develop checklist to facilitate and standardize supervision
  Provide planned monthly supervisory meetings
  Record and follow-up supervisory outcomes (recommendations, solutions, problems).
  Provide written feedback from field worker to agent.

- Provide short training event (3-4 days) in supervision for field workers

- Design and implement a simple system to monitor the impact of supervisory activities on service delivery.

- Redefine the purpose of the monthly meeting by including training activities as a key part of it.

- The evaluation team findings suggest that the following areas of training should be stressed:
  - Technical knowledge of contraceptive methods
  - Ability to respond to misinformation and rumors about family planning
  - Counselling in appropriate methods and side effects, and in IEC topics
  - Standards for pill management, voluntary surgical contraception (male and female) and longer term methods
  - Referrals and follow-up
  - Planning, record keeping, and data use

- Provide CBD agents with material for counselling, motivation, and other IEC activities. Ensure all IEC materials are distributed to the area and to the site.

- Emphasize the development of one-day training events at the area and/or local levels (i.e. in community centers) that minimize disturbance of the agents families resulting from the need for overnight stays at training sites.

8. Future Expansion and Phase-out

- Future program planning and hiring of personnel should be conducted with sustainability issues in mind. In particular, FPAK should look toward the eventual phase-out of CBD honoraria, as the payments could not be sustained indefinitely for such a large number of agents with either community or donor resources. As discussed in Annex I, these honoraria could be replaced by fee-for-service.

ANNEX I

INCENTIVE-BASED SYSTEM

or

FEE FOR SERVICE

ANNEX I

FEE FOR SERVICE SYSTEM

Payment for services has been discussed before in FPAK, but mainly in the context of clinic-based services. As a way of exploring potential fee options and their effects, the team posed questions to FPAK managers, volunteers, and clients regarding willingness to pay. About 86% of the clients interviewed said that they would be willing to pay for services. However, most FPAK volunteers and managers thought it unwise to introduce fees; in their view, clients would be unable to pay. Thus, there is far from a consensus on whether this would be the right course of action for the CBD program.

A number of pros and cons relating to service fees should be considered. Realistically, a policy change involving service fees can only be made after careful consideration by FPAK managers and volunteers. The advantages of introducing service fees can be seen as follows:

- CBD pay would be more performance-based. The fee earnings would provide Agents an incentive to increase clients and cover more households.
- If Agents work longer hours, they will be compensated for the additional time away from their families.
- Clients are more likely to value the contraceptives and therefore use the supplies they purchase.
- The burden of CBD honoraria on the project budget could be reduced. More Agents could be recruited and deployed. Donor dependency could be slightly reduced.
- Program performance monitoring and record keeping could be simplified, because numbers of visits and motivational activities would be the means and not the end. Quantities of contraceptives distributed would be the principal output indicator.

The possible disadvantages of fees are as follows:

- Agents might only serve those who can pay, including those clients who currently have access to private services and supply sources.
- CBD Agents' attention might be increasingly focused on delivering contraceptives rather than on informing, educating and counselling families on reproductive health.
- Fees might discourage non-users from accepting a method.

- Fees might create incentive to Agents to continue to supply temporary methods rather than refer clients for clinical methods. (On the other hand, the clients might have an incentive to switch to other methods.)

- The administrative burden of collections could overwhelm program management if revenues had to be returned to the program.

The impact of fees on Agent compensation would vary from one area to another. For example, if fees were set at Ksh. 5 for a cycle of pills and Ksh. 1 each for condoms and foaming tablets, Agents in Eastern Province, on average, could almost triple their honoraria if they distributed the same amount of contraceptives as in 1991. On the other hand, Agents in Nyanza Province would just about break even, and Agents in the Coast Province would fall short of their current honorarium.

A simpler way to estimate the effect of fees on earnings would be to assume that an Agent could earn roughly Ksh. 15 per visit if an average of three cycles of pills (x Ksh. 5) or 15 condoms (x Ksh. 1) were provided for each family planning acceptor visit. This rough calculation produces the same result: that is, Agents in Eastern Province would earn more than their current honorarium; in Nyanza Province they would earn roughly the same; and in Coast Province, Agents would earn less.

Potential Fee Income (@ Ksh 15 per visit)

	Eastern Province	Nyanza Province	Coast Province
Avg. visits per Agent per month	89	33	18
Fee income per Agent (in Ksh.)	1,335	495	270

It is important to note that while the introduction of service fees could provide an opportunity for service expansion, it would not enable the program to attain self-sufficiency. At the fee levels described above, earnings could at best recover the CBD honorarium, which occupies only about 20% of the CBD project budget. Thus, dependency on external resources would only be partially reduced.

The report recommends reducing agents' workload through greater selectivity and prioritization of clients. However, introducing a fee for service might change the agents' incentives in such away as to favor current family planning users over non-users. Certainly better planning, targeting, and fee-charging could be done simultaneously, but the targeting approach implies identifying the neediest clients, whereas the fee-for-service approach implies meeting community demand for contraceptives. Whether or not community needs and demand for services are

identical is difficult to judge. Since the introduction of fees is a significant program change, it might be further explored and tested in areas of higher contraceptive prevalence first.

FPAK managers should consider conducting a survey, similar to the clinic survey completed in recent months, to determine an acceptable fee level for CBD clients. Five shillings was the lowest fee suggested by the clients interviewed for this evaluation; however, sample size was small and somewhat biased. A repeat survey would reinforce the findings.

FPAK should also consider selecting one or two regions in which to introduce fees on a pilot basis before introducing them nationally. Managers could then monitor the effect of fees on Agent performance and acceptance by the communities and clients.

In order to minimize the potential disadvantages of fees, some precautions may have to be followed:

1. To minimize the effect on family planning acceptance, fees should be low enough so as to be affordable to the vast majority of clients.

2. Operationally, it is easier to have one set of fees (by method) for all clients than to have different fees based upon the client's level of income. Differentiated fees creates an opportunity for "bargaining" between Agents and clients, and also for friends of Agents and community leaders to receive a better deal. While some of this might happen privately anyway, it is best as a policy matter to have one set of officially agreed-upon fees. Fees could, however, vary between regions of the country, based upon demand or income levels in those areas.

3. To minimize the administrative burden, Agents could be allowed to keep all of the fees they collect, and honoraria could be reduced commensurately. For example, in Eastern Province, fees could entirely replace the honoraria, whereas in Nyanza Province, FPAK might want to begin by retaining half the honoraria.

4. To gain community acceptance, the introduction of fees should coincide with similar policy changes in the Ministry of Health. The level of fees could be announced in public meetings, so that clients cannot be cheated or caught by surprise.

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ANNEX II

FPAK CBD PROGRAM EVALUATION

QUESTIONNAIRES

ANNEX II

FPAK CBD PROGRAM EVALUATION

PROTOCOL FOR GROUP DISCUSSION WITH COMMUNITY LEADERS

1.	Where did the idea of starting up the CBD program come from?
2.	Describe the CBD program as you understand it.
3.	How was the CBD program launched in your area?
4.	Could you tell us of any problems that you found with the way the launching was done?
5.	How should the launching have been done?
6.	How have the community leaders been involved in the organization of the Program?
7.	Now that the CBD Program has been going on for some time, do you see any needs for enhancing community participation?

8.	Do you know how the CBD Agents recruited in this area?
9.	Are you satisfied with the way the recruitment has been managed?
10.	You are aware that the CBD Agents are predominantly volunteers in their respective communities. Do you think the communities should consider compensating these CBD Agents for their work? If so, could you tell us **how**?
11.	To what extent are resources available in the community with which to compensate CBD Agents?
12.	What do you think are the benefits of this program to your community?
13.	What is your perception of the CBD Agents and their supervisors with respect to providing family planning services in this area?
14.	What problems do you see, if any, that are related to the CBD Program? Please suggest any solution ot these problems in your answer as well.

15.	Do you think that the community based distribution of family planning services have increased the number of women using contraception in this area?	1. Yes, significantly 2. Moderate increase 3. Negligible increase 9. No difference	_____ _____ _____ _____

16. Do you think there is a need to establish CBD activities in other areas?

17. Are there any additional services that you would require in addition to the ones that are offered in the CBD Program?

18. Do you have any other suggestions for the improvement of the CBD Program that have not been discussed?

FPAK CBD EVALUATION

MANAGEMENT PERSONNEL DISCUSSION GUIDE

1. What is your opinion of the current CBD recruitment procedures?

   PROBE (if necessary):

   1. How was it done?
   2. How should it be done?
   3. Was it done according to the guidelines?
   4. What kind of people were recruited?
   5. How could the procedures be changed to recruit better people?

2. a) Were the CBD Agents given sufficient training that would help?

   b) Is there any additional training that would help?

3. What is your opinion of the field supervision of the CBD Agents?

   PROBE:

   1. How is it done?
   2. How should it be done?
   3. Is supervision important to the success of an individual CBD Agent?

4. What kind of communities should be given priority in any expansion of CBD services?

5. How should communities be prepared for the introduction of a CBD programme?

6. What kind of reward or incentive should be given to the CBD Agents to encourage full and active participatin in the programme?

7. Have you observed any problems getting supplies to the CBD Agents for distribution to clients?

   PROBE: What were the problems?

8. a) About how many clients do you think an average CBD Agent can serve?

   b) About how many CBD Agents can a Supervisor effetively work with?

9. How should the services provided by the CBD Agents be linked to the services provided by clients?

10. What is the most effective approach for a CBD Agent to use in recruiting and servicing clients?

11. Do you think CBD Agents should have performance targets?

    PROBE: What kind of targets would be most effective?

12. What type/number of activities do you think a CBD Agent/Lay Educator can effectively handle?

13. Are there other functions/services that are being provided by the CBD Agent? Are these functions/services hindering or complementing the role of the CBD Agent?

14. What are some of the common problems in managing a CBD programme?

15. Do you think FPAK is adequately providing support to the CBD staff?

16. What is the role of the monthly meeting?

17. How do the CBD Agents relate to other similar workers in the area?

18. What is your general opinion of the effectgeness of CBD Agents in providing family planning services?

    PROBE:

    1. Cost versus output

    2. CBD Agents versus a clinic only system?

    3. Influencing long term attitude and behaviour change?

19. What is the future of the CBD programme?

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PROTOCOL FOR MANAGER'S INTERVIEW OR GROUP DISCUSSION

BACKGROUND

Name:	
Functions:	
Responsibility with CBD Program:	
Years with FPAK	
Years in this position	
Age	
Sex	1. Male _____ 2. Female _____

PROGRAM DESCRIPTION

1.	Could you describe the main components of the CBD Program in FPAK?	
2.	Are the services provided by the CBD Agents linked to the services provided by clinics?	1. Yes _____ 2. No _____
3.	If YES, how are they linked?	
4.	What type of service do the CBD Agents provide?	**[Please list all services]** 1 _____ 2 _____ 3 _____ 4 _____
5.	Are there other functions (services) that can be provided by the CBD Agent?	
6.	Do the CBD Agents receive any compensation for their work? If so, what kind?	

7.	What percentage of the FP services provided by FPAK are actually delivered through the CBD Program?	
8.	Do the CBD Agents have performance targets?	1. Yes _____ 2. No _____
9.	If NO, do you think they should have targets?	1. Yes _____ 2. No _____
10.	What kind of target have they? or should they have?	
11.	What strategy do the CBD Agents use in reaching and engaging new clients?	
12.	Could you describe the average person the Program recruits as a CBD Agent?	
13.	Please describe FPAK guidelines for recruiting CBD Agents.	
14.	Are these guidelines followed?	1. Yes, always followed _____ 2. Mostly followed _____ 3. Seldom followed _____ 4. Never followed _____
15.	In your opinion, are these guidelines helpful in ensuring that good people are recruited?	1. Yes, very much so _____ 2. Provides some assurance _____ 3. Provides no assurance _____
16.	If they provide only some assurance, or no assurance at all, how can the process be improved?	
17.	Are these CBD recruits appropriately trained before they start their work in the community? Please describe:	

18.	Do CBD recruits continue to receive training?	
19.	If you think so, what kind of training?	
20.	Approximately how many clients do you think an average CBD Agent can serve?	
21.	What kind of reward or incentive should be given to the CBD Agents to encourage full and active participation in the program?	
22.	In general, what is your opinion of the effectiveness of CBD Agents in providing FP services? Please describe:	

SUPERVISION

23.	Please describe how the supervision of the CBD Agents is planned and programmed?
24.	Does the CBD staff have regular meetings? If so, how regularly are these meetings held?
25.	What is the purpose of these meetings?
26.	How often is field supervision done?
27.	On average, how many CBD Agents are supervised by one person?
28.	Approximately how many CBD Agents can a Supervisor work with effectively?

29.	To what extent does the supervision of CBD Agents assure an appropriate quality of service?
30.	Do you think supervision makes a difference in the success of an individual as a CBD Agent? Please elaborate:
31.	In general, what do you think of the role of supervision in expanding and increasing the quality of the services delivered by the CBD Program?
32.	In your opinion, what are the main problems of field supervision?

MANAGEMENT ISSUES

33.	What are some of the common problems in managing a CBD Program?
34.	How do you ensure that CPAK adequately provides support to the CBD staff?
35.	Have you observed any problems getting supplies to the CBD Agents for distribution to clients? If so, what were the problems?
36.	Have the supply problems affected the performance of the CBD Agents?

37.	In general, what is the future of the CBD Program?		
38.	Is FPAK planning to expand the CBD Program?	1. Yes 2. No	_____ _____ (Skip to Q. 40)
39.	What kind of communities should be given priority in this expansion of CBD services?		
40.	Please give any additional comments regarding the role, the working, or the future of the FPAK CBD Program.		

FPAK CBD PROGRAM EVALUATION

QUESTIONNAIRE FOR CBD CLINIC STAFF

1. BACKGROUND INFORMATION

1.	Name:	
2.	What is your age?	_____ years
3.	Sex	male _____ female _____
4.	Marital status	married _____ single _____ widowed _____ divorced/separated _____ Other (specify):_____
5.	What standard of education have you completed?	No formal education _____ Std. 1-4 _____ Std. 5-8 _____ Form 1-2 _____ Form 3-4 _____ Higher _____
6.	How many live children have you ever had?	Number _____
7.	Have you ever used contraception?	Yes _____ No _____ (Skip to Q. 10)
8.	Are you currently using contraceptive?	Yes _____ No _____ (Skip to Q. 10)
9.	What method are you using?	
10.	Are you aware of the FPAK CBD program that is being implemented in your area?	1. Yes _____ 2. No _____ 3. Not Sure _____
11.	Do you know all the CBD Agents in your service area?	1. Yes _____ 2. No _____
12.	Can you describe the CBD Program as you understand it.	

13.	What should be the major functions of the CBD Agents?	
14.	What role, if any, do you have in the CBD Program?	
15.	What is the best way of identifying a person in the community to be a CBD Agent?	
16.	Do you know how CBD Agents are recruited?	1. Yes _____ 2. No _____
17.	What do you think should be done for these CBD Agents to motivate them to more actively distribute contraceptives?	
18.	What is the role of health clinic and health clinic staff in the CBD Program?	
19.	In your opinion, do the roles between CBD activities and clinic activities complement each other in family planning, or do the activities conflict with each other?	
20.	Why?	
21.	Do CBD Agents refer clients to you regularly?	1. Yes _____ 2. No _____
22.	What are the main reasons for referral?	

23.	Do you see many referrals from CBD Agents of clients who have had problems with their method?	1. Often ____ 2. Sometimes ____ 3. Rarely ____ (Skip to Q.26)
24.	What kinds of problems do you see?	
25.	What can clinics do to increase awareness of the CBD Agents' services?	
26.	What can clinics do to increase the community's acceptance of the CBD Program?	
27.	How would you describe the training of the CBD Agents to provide family planning commodities?	1. Good ____ 2. Adequate ____ 3. Poor ____
28.	What kinds of comments, if any, do the women who come to your clinic make about the CBD Agents?	
29.	**What is the best strategy for getting couples in your area to use family planning?**	
30.	Does your clinic have much demand for family planning?	1. Yes ____ 2. No ____
31.	Do you have family planning supplies available now?	1. Yes ____ 2. No ____
32.	Do you alwalys have supplies?	1. Yes ____ 2. No ____
33.	Should the current systems of providing pills to the client by the clinic and the CBD Program continue the way it is? Should it be modified or done away with?	1. Continued ____ (Skip to Q. 34) 2. Modified ____ 3. Done away with ____

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34.	Why should the system be modified or done away with?	
35.	In your opinion, is the CBD Program accepted as an alternative source of obtaining contraceptives in your area?	1. Yes _____ 2. No _____
36.	In your opinion, have CBD activities in this area increased the use of contractives or have they not made a difference in the number of women using family planning?	
37.	Why?	
38.	Are there any other comments/issues regarding the CBD program that have not been covered?	

QUESTIONNAIRE FOR CBD AGENT SUPERVISOR

1. BACKGROUND INFORMATION

1.	Name:	
2.	What is your age?	_____ years
3.	Sex	male _____ female _____
4.	Marital status	married _____ single _____ widowed _____ divorced/separated _____ Other (specify):_____
5.	What standard of education have you completed?	No formal education _____ Std. 1-4 _____ Std. 5-8 _____ Form 1-2 _____ Form 3-4 _____ Higher _____
6.	How many live children (births) have you ever had?	Number _____
7.	Have you ever used contraception?	Yes _____ No _____ (Skip to Q. 10)
8.	Are you currently using contraceptive?	Yes _____ No _____ (Skip to Q. 10)
9.	What method are you using?	

2. RECRUITMENT AND TRAINING

10.	How long have you been a CBD Agent Supervisor?	
11.	What was your job before being a CBD Agent Supervisor?	
12.	How did you become a CBD Agent Supervisor?	
13.	Can you describe the CBD Program as you understand it?	
14.	Are you involved in the recruitment of CBD Agents?	Yes _____ (Skip to Q. 17) No _____
15.	Do you know how CBD Agents are recruited?	Yes _____ No _____ (Skip to Q. 18)
16.	Could you describe how the CBD Agents are recruited?	
17.	Do you think the best people are recruited?	Yes _____ (Skip to Q. 19) No _____ Not sure _____

18.	What problems, if any, do you see with those recruited?	
19.	What is the best way of identifying a person in the community to be a CBD Agent?	
20.	Do you think your CBD Agents have had enough training to perform their current activities?	Yes _____ (Skip to Q. 22) No _____
21.	What additional training do you think would be useful?	
22.	How do you help the CBD Agents to get started in their areas?	
23.	What do you think are the major functions of CBD Agents?	

3. IMPLEMENTATION

24.	What are the tasks of a CBD Agent (list all that you think matter)?
25.	About how many households is a CBD Agent expected to serve effectively?
26.	In your opinion, have CBD activities in this area increased the use of contraceptives or have they not made a difference in the number of women using family planning?
27.	Why?
28.	How many CBD Agents are you supervising?
29.	What activities do you supervise? (List all that you think matter.)
30.	How often do you visit the CBD Agents?

31.	Describe in detail what you do on a routine supervision visit to the CBD Agent?
32.	What are the major problems you have in supervising CBD Agents in your area?
33.	How many CBD Agents do you think you could effectively supervise?
34.	How often do the CBD Agents need to be supplied?
35.	What kind of problem, if any, have you ever had in re-supplying CBD workers?
36.	What do the CBD Agents do when they have a problem (e.g. run out of supplies or client reports complications)?

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37.	How does a CBD Agent let the Community know that they would provide contraceptives?		
38.	Could you describe the kind of records a CBD Agent must keep in doing his/her job?		
39.	What is the purpose for keeping these records?		
40.	Are there any problems in the CBD Agents understanding and completing these records?	Yes No	_____ _____ (Skip to Q. 42)
41.	What are these problems?		
42.	Are you satisfied with the current motivation of the CBD Agents?	Yes No	_____ (Skip to Q. 44) _____
43.	If necessary, what do you think should be done to increase the motivation of the CBD Agents?		

45.	What is the role of health clinic and health clinic staff in the CBD Program?
46.	What type of contact do the CBD Agents have with the health clinics in their area?
47.	In your opinion, do the roles between CBD activities and clinic activities complement each other in family planning in this area, or do the activities conflict with each other?
48.	Why?
49.	What do you think are the best ways to make contraceptive supplies available to the Community level?
50.	What role do the community leaders play in helping CBD Agents perform their jobs?

51.	How could FPAK get more support for family planning from the community?
52.	Do you have any other comments or observations on the issues of community based family planning services which we have not already addressed?

FPAK CBD PROGRAM EVALUATION

QUESTIONNAIRE FOR CBD AGENT

1. BACKGROUND INFORMATION

1.	Name:	
2.	Location:	
3.	District/area:	
4.	What is your age?	_____ years
5.	Sex:	1. Male _____ 2. Female _____
6.	Marital Status	1. Married _____ 2. Single _____ 3. Widowed _____ 4. Divorced/separated _____ 5. Other (specify):_____
7.	What is your husband's occupation?	
8.	What standard of education have you completed?	1. No formal education _____ 2. Std. 1-4 _____ 3. Std. 5-8 _____ 4. Form 1-2 _____ 5. Form 3-4 _____ 6. Higher _____
9.	How many live children (births) have you ever had?	
10.	Have you ever used contraception?	1. Yes _____ 2. No _____ (Skip to Q. 12)
11.	Are you currently using contraception?	1. Yes _____ 2. No _____

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2. RECRUITMENT AND TRAINING

12.	When were you selected as a CBD Agent?	
13.	How did you get selected?	
14.	What do you think is the major role of a CBD Agent?	
15.	Before becoming a CBD Agent, did you have another job?	1. Yes _____ 2. No _____ (skip to Q. 17)
16.	What job was this?	
17.	In your opinion, what kind of people make the best CBD Agent? Why?	
18.	You were trained as a CBD Agent. Was that training enough to help you to perform your job well?	1. Yes _____ 2. No _____
19.	Could you describe the main topics covered in this training?	

20.	What additional training do you think you need?	
21.	Were you given any educational materials to read or take home with you when you were trained?	1. Yes _____ 2. No _____
22.	How helpful have these materials been?	1. Very helpful _____ 2. Somewhat helpful _____ 3. Not very helpful _____ 4. Useless _____ 9. Don't know _____
23.	Have you been supplied with educational materials after your training?	1. Yes _____ 2. No _____ (Skip to Q. 25)
24.	How helpful have these materials been?	1. Very helpful _____ 2. Somewhat helpful _____ 3. Not very helpful _____ 4. Useless _____ 9. Don't know _____
25.	What kind of educational materials would be helpful in your work?	[check all that apply] 1. Booklets _____ 2. Pamphlets/Leaflets _____ 3. Charts _____ 4. Manuals _____ 5. Other (specify) _____

3. SERVICE DELIVERY

26.	Can you describe how you were introduced to your community as a CBD Agent after your training?	
27.	What area do you cover as a CBD Agent? **[include village and/or locality]**	
28.	What other sources of distribution of contraceptives exist in your areas?	
29.	How many people live in the area that you cover?	1. Number _____ (Skip to Q. 31) 2. Don't know _____
30.	If you don't know, could you give an approximate number of people living in the area you cover?	
31.	Is the area you are covering too small, just right, or too big?	1. Too small _____ 2. Just right _____ 3. Too big _____ 9. Don't know _____
32.	Who decided what area you should cover?	
33.	How many people do you serve?	
34.	Do you know what is your target (number of people you should serve)?	
35.	Please describe the service you normally provide as a CBD Agent.	

36.	What type of contraceptive method do you distribute?	
37.	Describe how you do your work.	1. Community supply post _____ 2. Community supply post _____ 3. House to house canvassing _____ 4. House/Home based _____ 5. All of the above _____ 6. Other (specify):
38.	How much time in a week do you spend doing CBD work?	Amount of time:
39.	What type of clients do you find most interested in using your services?	1. Young who want to space/delay birth____ 2. Those who want to limit births _____ 3. Those whose husbands are away _____ 4. Other (Specify):
40.	Are there any other family planning related activities that you are being asked to do? Please describe:	
41.	What kind of services do your clients ask for that you don't provide?	
42.	Do you ever refer clients to health clinics?	1. Yes _____ 2. No _____ (Skip to Q. 45)
43.	For what reason(s) do you refer clients to health clinics?	

44.	What clinic(s) do you refer your clients to?	
45.	Does the client who has been referred to a clinic come back to you after receiving the service from the clinic?	1. Yes _____ 2. No _____
46.	To what extent has your community accepted you as a source of family planning supplies?	1. Complete acceptance _____ 2. Some difficulties _____ 3. Serious problems _____ 4. Do not accept me at all _____
47.	What do you think FPAK should do to help you as a CBD Agent to make your work easier?	
48.	What kind of activities do you carry out in the community to increase the use of contraception?	
49.	Please describe how you motivate new clients to start using contraceptive methods?	

50.	To what type of women do you recommend not to use pills?

5. SUPERVISION

51.	How regularly are you visited by your supervisor?	1. Daily _____ 2. Weekly _____ 3. Every 2 weeks _____ 4. Monthly _____ 5. Quarterly _____ 6. Never _____ 7. Other (Specify) _____
52.	Are these visits as too often, just right, or not enough?	1. Too often _____ 2. Just right _____ 3. Not enough _____
53.	Could you describe what does the supervisor does during these visits?	
54.	How helpful are these visits to you?	1. Very helpful _____ 2. Somewhat helpful _____ 3. Not very helpful _____ 4. Useless _____ 9. Don't know _____

55.	In case of need, how can you contact your supervisor?	1. 2. 3. 4.	Wait for next meeting _____ Go to his/her workplace _____ Go to his/her home _____ Other

55.	What kind of problems do you have that you need to report to the supervisors?

56.	When you report these problems, do you get a helpful response from the supervisors?	1. 2. 3. 4.	Always _____ Sometimes _____ Seldom _____ Never _____

56.	I understand that you meet each month with the supervisor and other CBD Agents. Please describe what these meetings are about.

57.	Do you think the meetings should be continued in the same way? Should they be modified? Should they be discontinued?

5. SUPPLIES

58. How do you obtain your supplies?	
59. How often do you get your supplies?	
60. Where do you store these supplies?	
61. What kind of problems, if any, do you have obtaining supplies?	
62. For how many days can you continue distributing contraceptive supplies at a normal rate with the supplies you have on hand today?	
63. In the last six months, how many times have you run out of any of the contraceptive methods you normally distribute?	

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64. What kind of records do you keep regarding distribution?

65. How do these records help you in performing your CBD role?

66. Do you have any problems keeping these records?

67. What would you do if a woman wanted to use family planning without her husband's knowledge?

68. Do you have any other comments or observations on the issues of community based family planning services which we have not already addressed?

FPAK CBD PROGRAM EVALUATION

QUESTIONNAIRE FOR CLIENTS

1. BACKGROUND INFORMATION

1.	Name:	
2.	Location:	
3.	District/area:	
4.	What is your age?	_____ years
5.	Sex:	1. Male _____ 2. Female _____
6.	Marital Status	1. Married _____ 2. Single _____ 3. Widowed _____ 4. Divorced/separated _____ 5. Other (specify):_____
7.	What is your husband's occupation?	
8.	What standard of education have you completed?	1. No formal education _____ 2. Std. 1-4 _____ 3. Std. 5-8 _____ 4. Form 1-2 _____ 5. Form 3-4 _____ 6. Higher _____
9.	How many live children (birth) have you ever had?	
10.	Have you ever used contraception?	1. Yes _____ 2. No _____
11.	Why did you decide to start using contraception?	1. Want no more children _____ 2. Want to delay next birth _____ 3. Do not know _____ 4. Other reasons (specify)

12.	Are you currently using contraception?	1. Yes 2. No	_____ _____
13.	What method are you actually using?		
14.	Why did you choose the current family planning method?		
15.	Do you normally obtain this method from a CBD Agent?	1. Yes 2. No	_____ _____
16.	Do you know the name of your CBD Agent?		
17.	Have you ever had a problem in getting resupply by the CBD Agent?	1. Yes 2. No	_____ _____
18.	Do the CBD Agents answer your questions about family planning and contraception to your satisfaction?	1. Yes 2. No	_____ _____
19.	Is there anything you wanted to know about family planning which he/she could not answer?	1. Yes 2. No 3. Not sure	_____ _____ _____
20.	What was this?		
21.	Have you had any problem with this method?	1. Yes 2. No	_____ _____ (Skip to Q. 22)
22.	What were they?		
23.	Did you talk to the CBD Agent about your problems with the method?	1. Yes 2. No	_____ _____

24.	What did the CBD Agent do about your problem?		
25.	Did you get contraceptive methods before you first started them from the CBD Agent?	1. Yes 2. No	_____ _____ (Skip to Q. 26)
26.	What was the source of the method?		
27.	Why did you change to the CBD Agent?		
28.	Last time you were re-supplied, how did you get contraceptives from the CBD Agent?	1. Went to agent's house 2. Agent came to my house 3. Send someone to agent's house 4. Other (Specify)	_____ _____ _____
29.	Does the CBD Agent have supplies available?	1. Yes 2. No	_____ _____
30.	Does the CBD Agent always deliver supplies to you on time?	1. Yes 2. No	_____ _____
31.	Has the CBD Agent encouraged you to go to the clinic for methods not provided by the CBD program?	1. Yes 2. No	_____ _____
32.	How satisfied are you with the services provided by the CBD Agent?	1. Very satisfied 2. Fairly satisfied 3. Somewhat satisfied 4. Very dissatisfied	_____ _____ _____ _____
33.	Apart from family planning services, what other services would you like a CBD Agent to provide to you?		

34.	Do you like having someone in your community who can supply contraceptives?	1. 2.	Yes No	_____ _____
35.	Why?			
36.	How comfortable do you feel with the CBD Agent?			
37.	Have you ever heard the leaders in your community talk about family planning or contraception?	1. 2.	Yes No	_____ _____

ANNEX III

PERSONS CONTACTED

ANNEX III

I. CENTRAL AREA (NYERI)

FPAK MANAGEMENT

NAME	POSITION
Ms. Rosemary Kamunya	Acting Area Manager, Central Area
Ms. Margaret M. Manyara	CBD Field Supervisor
Ms. Mercy Muthoni Muhota	Nurse/Midwife, Nyeri Clinic
Ms. Doreas Muthomi Githinji	Nurse/Midwife, Nyeri Clinic
Mr. David Sua Kimbui	Nurse/Midwife, Nyeri Clinic
Ms. Elizabeth N. Kirichu	Nurse/Midwife, Nyeri Clinic
Ms. Grace W. Muturi	VSC Counsellor, Nyeri Clinic
Ms. Zipporah Muthoni	VSC Counsellor, Nyeri Clinic
Ms. Anne W. Kuria	CBD Fieldworker
Ms. Beatrice W. Ndungu	CBD Fieldworker

FPAK VOLUNTEERS

NAME	POSITION
Mr. Simon Muteru	Area Chairman (Ex-Senior Chief)
Ms. Anne Mwangi	Branch Committee Member

COMMUNITY LEADERS

NAME	POSITION
Mr. Charles Kamongu	Asst. Chief, Muruguru
Ms. Juliet Ndungu	Karuna-ini
Ms. Marietta Gitahi	Ihururu Women's Group
Mr. Joseph Kamau	Asst. Chief, Githiru
Mr. Joel Hindi	Asst. Chief, Ithekahuno
Mr. Angellus Warutuno	Asst. Chief, Kihatha
Mr. Amos Kmyaki	Asst. Chief, Mungaria/Aguthi
Mr. Michael Wandira	Asst. Chief, Gaaki
Mr. Peter Itotia	Church Leader, Marua
Mr. Raphael Munyori	Chief, Thegenge
Mr. John Warui	Chief, Muhoya
Mr. Gerald Wamberia	Chairman, Githiru Primary School
Mr. John Nuhu	Asst. Chief, Marua

CLIENTS	CBD AGENTS
Ms. Florence Gichuki	Ms. Jane Mugecha
Ms. Eunice Munyoro	Ms. Cecilia Machira
Ms. Rahab Wanjohi	Ms. Anna Manjiru
Ms. Anne Wamboi	Ms. Beth Munyi
Ms. Nancy Ndungu	Ms. Eunice Gichuki
Ms. Mary Wanjiru	Ms. Lucy Wangombe
Ms. Agnes Nduta	Ms. Lydia Gakui
Ms. Lucy Mugugu	Ms. Tabitha Wagura
Ms. Charity Mandia	Ms. Alice Wangechi
Mr. Peter Itotia (also interviewed as a Community Leader)	Ms. Leah Ndungu
Ms. Esther Ndungu	Ms. Esther Githaiga
Ms. Margaret Nyambura	Ms. Elizabeth Ndirangu
	Ms. Purity Mahugu
	Ms. Teresa Ndirangu

II. NYANZA AREA (KISII)

FPAK MANAGEMENT/CLINIC

NAME	POSITION
Ms. Grace Awiti	Acting Area Manager, Nyanza
Mr. Abishai Oyoo	Program Assistant
Ms. Janet Ogutu	CBD Supervisor
Ms. Priscah Oonge	VSC Counsellor, Kisii Clinic
Ms. Anne Otieno	VSC Counsellor, Kisii Clinic
Ms. Herina Doli	Nurse Midwife, Kisii Clinic
Ms. Jane Tombe	Nurse Midwife, Kisii Clinic
Mr. Peter Bosire	Community Nurse, Kisii Clinic
Mr. John Ongachi	CBD Fieldworker
Ms. Pacifica Ondieki	CBD Fieldworker
Ms. Teresa Mohari	CBD Fieldworker
Ms. Catherine Mogaka	CBD Fieldworker

FPAK VOLUNTEERS

NAME	POSITION
Mr. Joseph Oyoo	FPAK Area Chairman
Mr. Jackson Osoro	FPAK Branch Chairman
Mr. Peter Omosa Simba	FPAK Branch Chairman

COMMUNITY LEADERS

NAME	POSITION
Mr. James Omwenga	Asst. Chief, Mwamosioma
Mr. Thomas Onsongo	Chief, Mwakibagendi
Mr. Zachariah Ondieki	Asst. Chief, Mogusi
Mr. Zachariah Ongoto	Asst. Chief, Kisii
Ms. Teresia Mogendi	Women's Leader, Bonyagatanyi
Mr. James Sanganyi	Chief, Nyakeri
Mr. Abraham Onsongo	Chief, Rigema
Mr. Joseph Ton'gi	Farmer, Rigema
Mr. Nelson Manduku	Chief, Bochana
Mr. Manson Monyenye	Asst. Chief, Girango
Mr. Joseph Monyancha	Chief, Rigema
Mr. Henry Ogeto	Development Asst.

CBD AGENTS	CLIENTS
Ms. Alexina Kembo	Ms. Jane Osinde
Ms. Jennifer Ongeni	Mr. Joseph Onjiri
Ms. Joyce Omwenga	Ms. Anne Ochengo
Ms. Prisca Otiso	Ms. Jemima Bosibori
Mr. Francis Ngugi	Ms. Sarah Onsomu
Mr. David Osinde	Ms. Nelly Orina
Ms. Sipora Onsuma	Ms. Rosa Nyangata
Mr. Patrick Angwenyi	Mr. Joseph Tongi
Ms. Joyce Omwenga	Ms. Teresa Monyenye
Mr. Nelson Okioma	Ms. Rispa Bosire
Ms. Rosalia Mokaya	Ms. Alice Moraa
Mr. Pete Omurwa	Ms. Margaret Kembo

CBD AGENTS	CLIENTS
Ms. Margaret Kerandi	Ms. Teresa Onsongo
Mr. Elijah Omwenga	Ms. Marcela Nyaburai
Mr. Elmer Omweri	Ms. Bathsheba Sanay
Ms. Salome Ogori	
Ms. Elizabeth Amenya	
Ms. Trufosa Chuma	

III. EASTERN AREA (EMBU)

FPAK MANAGEMENT/CLINIC

NAME	POSITION
Mr. Njagi Muchiri	Area Manager, Eastern
Ms. Mukwanyaga Kithae	CBD Supervisor
Mr. Jonathan Ndumpa	CBD Supervisor
Mr. Josephat Nyaga	CBD Fieldworker
Mr. John Njeru	CBD Fieldworker
Ms. Anne Mburia	Clinic Nurse, Embu Clinic
Ms. Mary Njue	Clinic Aid
Ms. Consolata Kathie	Clinic Nurse
Ms. Rachel Kagundu	VSC Counsellor

FPAK VOLUNTEERS

NAME	POSITION
Mr. Ben Muriria	Chairman, Embu District
Ms. Jane Njoroge	Secretary/Treasurer
Mr. Evans Ndwiga	Committee Member

COMMUNITY LEADERS

NAME	POSITION

AREA MOH CLINIC STAFF

NAME	POSITION
Ms. Angelina Nyaga	Nurse Midwife, Kibugu Clinic
Ms. Grace Njoka	ECN, Runyenjes Clinic
Ms. Angelica Njiroke	Nurse Midwife, Kanja Clinic
Ms. Lucy Mwaniki	Nurse Midwife, Nembure Clinic

IV. COAST AREA (MOMBASA)

FPAK MANAGEMENT/CLINIC STAFF

NAME	POSITION
Mr. Salim Mbete	Area Manager
Ms. Grace Mbote	CBD Supervisor, Kilifi
Mr. Briston Mwalimo	CBD Supervisor, Taita Taveta
Mr. M. Mwachepha	CBD Fieldworker, Kwale
Mr. Phitus Makinja	CBD Fieldworker, Kaloleni
Ms. Jane Waiyaki	CBD Fieldworker, Kaloleni
Ms. Rose Marumba	CBD Fieldworker, Kaloleni

FPAK VOLUNTEERS

NAME	POSITION

COMMUNITY LEADERS

NAME	POSITION

CLIENTS	CBD AGENTS
Ms. Mary Jana	Mr. Ernest Khea
Ms. Sidi Charo	Ms. Mary Kazungu
Ms. Susan Gambo	Ms. Margaret Ngala
Ms. Alice Mgeni	Ms. Florence Masha
Ms. Sophia Tsuwi	Ms. Grace Mzungu
Ms. Sidi Nyale	Ms. Margaret Mwangemi
Ms. Patience Stevens	Ms. Martha Kalama

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CLIENTS	CBD AGENTS
Ms. Juma Kenga	Ms. Mercy Mure
Ms. Medza Watsuma	Ms. Sarah D. Zia
Ms. Miriam Karisa	Ms. Christine Mwagongo
Ms. Kazo Jonathan	Ms. Selina J.K. Mitsanze
Ms. Gertrude Tsuma	Ms. Selina Ruwa Khambi
Ms. Khadija Hamisi	Ms. Constance Ziro
Ms. Petronila Sirya	Ms. Alice Mshelle
Ms. Mary Lwambi	Ms. Victoria Gonda
Ms. Mariam Magandi	Ms. Alice Tsuma
Ms. Rael Ndumba	Ms. Grace Simba
Ms. Josephine Barr	Ms. Margaret Mwadziwe
	Mr. John Chembe

V. NAIROBI AREA/KIBERA

FPAK MANAGEMENT

NAME	POSITION
Ms. Margaret Ngaira	CBD Supervisor
Ms. Janet Ingasu	CBD Fieldworker
Ms. Rose Ngahu	APO Service Delivery, Eastleigh
Ms. Wairimu Peters	Former CBD Supervisor

FPAK VOLUNTEERS

NAME	POSITION

COMMUNITY LEADERS

NAME	POSITION
Mr. Ali Jauden	
Mr. James Murage	
Mr. Nguyo Mbante	
Ms. Teresia Kodo	

CLIENTS

Ms. Margaret Anyango
Ms. Naomi Mwangi
Ms. Rose Syengo
Ms. Medina Said
Ms. Margaret Kehot
Ms. Victoria Mukiki
Ms. Margaret Njeri
Ms. Rhoda Kavuda
Ms. Jennifer Anami
Ms. Grace Waithira
Ms. Mariam Abdullah
Ms. Jane Andove
Ms. Zaituna Omari
Ms. Elizabeth Akinyi
Ms. Marieta Mumbua
Ms. Ziporah Mulekano
Ms. Grace Wanjiku
Ms. Priscilla Kanini
Ms. Rosemary Kalara
Ms. Pamela Akinyi

CBD AGENTS

Ms. Lucy Gaitoni
Ms. Lucy Ngendo
Mr. Anthony Wambua
Ms. Rael Onyanja
Ms. Josephine Mwangi
Ms. Anne Wanjiru
Ms. Monica Njoroge
Ms. Amina Aminalla
Ms. Annah Nyakabi
Ms. Asha Said
Ms. Khaltuma Ismael
Ms. Peninah Bosbore
Ms. Gaudencia Achieng
Ms. Paris Muthoni
Ms. Joyce Mugure
Ms. Husna Said
Mr. Gabriel Mwinzi
Ms. Sarah Wayua

ANNEX IV

EXERCISE FOR CBD AGENTS

ANNEX IV

Exercise for CBD Agents

In four of the sites visited, the evaluation team asked CBD agents to complete an exercise designed to test their recollection of topics and skills taught during their training course. Questions were taken directly from sections of FPAK's CBD training manual. The test was administered in Swahili and English, depending on the skills of the agents.

The questions covered the following topics:

- The importance of population and family planning
- Identification of high risk pregnancies
- Dispelling rumors about contraceptive methods
- Steps involved in counselling clients
- Contraceptive methods and how to use them
- STDs/AIDS

Average agent scores ranged from 56% to 75%, with agents in Kibera (Nairobi) scoring lowest and agents in Embu scoring highest. Not surprisingly, the educational level of agents in the Embu district were also highest.

On individual questions, scores ranged from 29% to 100%. Agents scored lowest overall on Question 6, which asked which methods an agent should discuss and recommend to a 30 year old woman with four children who wanted no more children. A minority mentioned permanent methods, and none mentioned vasectomy for the husband. Agents also gave weak or incomplete responses to Question 4, dealing with rumors about contraceptives. they also had difficulty explaining NORPLANT, what to do about missed pills, and identifying symptoms of STDs. Recommendations are included in the report for strengthening these technical areas in CBD training courses.

Exercise For CBDs

1. Name two problems caused by rapid population growth:

2. What 4 groups of women are likely to have problems during pregnancy and childbirth?

3. What are 4 reasons couples should use modern family planning to plan their families?

4. If your client tells you she will not use injectables or pills because they will make her barren what would you say?

5. What are the 6 counselling steps?

6. If a 30 year old client with 4 children came for counselling and told you she wanted no more children, what methods would you discuss with her? And which method do you think would be best for her?

7. What is NORPLANT? And how does it work?

8. If a client forgets to take her pill one day, what should she do?

9. What are 3 symptoms for STDs?

10. What are 3 ways people can avoid getting HIV/AIDS?

	Out of 10										%
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Avg.
Nyeri	7.3	6.0	8.1	5.0	5.1	4.6	6.2	5.0	6.9	7.7	61.9
Embu	10.0	7.7	7.1	5.4	9.0	4.7	5.0	7.7	9.2	8.7	74.5
Mombasa	6.6	8.4	5.7	5.8	4.9	3.9	6.1	7.6	4.6	7.5	61.1
Kibera	6.5	6.8	3.8	5.0	5.8	2.9	6.0	5.0	7.0	7.7	56.3
%	65-100	60-84	38-81	50-58	49-90		50-62	50-77	46-92	70-87	

FAMILY
PLANNING
MANAGEMENT
DEVELOPMENT

FPMD
Management Sciences for Health
400 Centre Street
Newton, MA 02158, U.S.A.

August 12, 1993

Nate Wooley
POL/CDIE/DI
Room 209 SA-18
A.I.D.
Washington, D.C. 20423-1802

Dear Mr. Wooley:

Enclosed please find one copy of the following document:

FPAK CBD Program Evaluation, February, 1993.

Regards,

Jacki Forbes

Jacki Forbes
FPMD Program Assistant

Phone: 617-527-9202 Fax: 617-965-2208 Telex: 4990154 MSHUI