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FAMILY LIFE ASSOCIATION OF SWAZILAND

CBD PILOT PROJECT EVALUATION REPORT

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I. BACKGROUND

The Family Life Association of Swaziland (FLAS) is an associate member of the International Planned Parenthood Federation. FLAS provides clinic, industry and community-based family planning services through a network of three clinics, and through industry and community-based distributors. The Association is the second largest provider of family planning services in the country, contributing approximately 30% to all services available.

FLAS has received substantial assistance from many international donors for its quickly expanding programme. The Association's projects increased from 6 to 15 between 1980 and 1897.

Further expansion of FLAS activities was recently made possible through a substantial Family Health Services Project financed through a buy-in arrangement between USAID/Swaziland and the Pathfinder Fund. With this five year financial and technical assistance project, FLAS will focus on institutional development and expansion of IEC and service delivery programmes. In addition, a Research and Evaluation Unit has been established within FLAS. This newly created unit will focus on the collection of service statistics, monitoring programme implementation, testing new service delivery approaches and implementing research studies. Through a resident advisor, technical assistance in research and evaluation will be provided to staff in the Research and Evaluation Unit.

FLAS CBD Pilot Project

Motivated by the need to compliment government efforts of providing family planning services to the underserved rural population, FLAS initiated in 1986, a two year community-based distribution pilot project aimed at increasing contraceptive accessibility and availability in rural areas. Through this first CBD project, FLAS also intended to demonstrate the feasibility and effectiveness of a new model for delivering family planning services. The CBD model used twenty trained community-based workers to provide family health information and distribute non-prescriptive contraceptives (foam, jelly and condoms) in three rural areas, Sipofaneni, Mafucula and Hhelehhele.

CBD Project Immediate Objectives

Numerical targets for the pilot project include the recruitment of more than 3000 new family planning users by the year 1990 and maintenance of a 70 percent continuation rate during the same period. Distribution objectives were set as follows:

- October 1986 - September 1987 - Distribute: 60,000 condoms and 25,000 foaming tablets

- October 1987 - September 1988 - Distribute: 50,000 condoms and 20,000 foaming tablets

- October 1988 - September 1989 - Distribute: 75,000 condoms and 25,000 foaming tablets

CBD areas had by 1989 increased to five including two refugee camps. The number of CBD agents had also grown to 31 from the original twenty.

Management of The CBD Programme

At the FLAS headquarters level, the CBD project was until very recently based in the IEC department with Senior Family Life Educator, having overall responsibility for the project, reporting to the Deputy Executive Director/Programme Manager. The CBD project has recently been moved to the Service Delivery Department and new supervisory arrangements are being processed. Until these arrangements are in place, the CBD coordinator from the IEC Department continues to monitor project activities on a 25 percent-time basis.

The CBD coordinator conducts monthly visits to CBD sites to review and collect service records and deal with implementation problems. At the local level an informal arrangement was made with local community leaders mostly chiefs, to oversee CBD agents' performance. In addition to this arrangement, one CBD agent elected by the others is expected to have some supervisory role mostly related to resupplying of contraceptives and convening of meetings.

Evaluation Component in the CBD Project

As indicated above, FLAS planned this pilot project in order to demonstrate the effectiveness of an alternative service delivery approach in increasing contraceptive availability and use in rural areas. Once proven effective, the model was to be recommended for replication on a larger scale in similar rural settings. An evaluation component was therefore built into the FLAS pilot project and in accordance to this plan, FLAS conducted an internal assessment of its CBD activities in 1987. Findings and general conclusions of this evaluation were that the project's immediate objectives were met and the project had community support. Clients' experiences with contraception through the CBD programme and their needs for other methods were highlighted in the evaluation report.

However, a major question related to the future of the pilot project was not adequately addressed by the internal evaluation. Ministry of Health officials indicated a need for additional information in order to decide on the pilot programme's future. Within this context, the Population Council was approached by the Ministry of Health to conduct the first external evaluation of the CBD project along the following suggested guidelines:

In structuring the evaluation report, the terms of reference as set out by the Ministry of Health are covered first. These are followed by the methodology for data collection then the discussion of the findings. Finally, the last part of the report sets out the recommendations and a possible agenda for the future.

II. TERMS OF REFERENCE CBD PROJECT EVALUATION (Reproduced verbatim from the Ministry of Health text)

In 1986, the Family Life Association of Swaziland began a two year pilot project using CBD workers to distribute condoms and foaming tablets and make referrals to nearby clinics in four areas. The goals of this project were to:

1) increase accessibility and availability of contraceptives

2) demonstrate the replicability of these services in other areas

The assistance of the Population Council is requested to conduct an evaluation of this project. We request that the evaluation review the following:

1) success in achieving project goals
2) implementation and administration of project activities
3) community acceptance of CBD project activities
4) the relationship between CBD agents and clinical services
5) the cost effectiveness of the CBD project

It is expected that such an evaluation will require both qualitative and quantitative research methods and instruments. In-depth interviews of project personnel, CBD clients and community leaders will be required, as well as review of CBD project service statistics.

The assistance of the Population Council is also requested in using the CBD evaluation as an opportunity for planning future project activities. In particular, the evaluation should help establish the following:

1) The extent to which the project can, in its present form, be replicated in other areas of the country.

2) The extent to which services currently provided in the pilot areas could be expanded to further enhance accessibility of family planning services, including the resupply of oral contraceptives.

We look forward to Population Council's acceptance of these terms and future technical assistance.

In addition to the Ministry of Health's Terms of Reference, USAID Mission officials expressed a need for the evaluation to focus on measuring contraceptive prevalence in the CBD areas and to compare this to prevalence in matched, non-CBD areas.

Upon examination of the tasks and time allocated, it was decided to conduct the evaluation in two stages:-

1. The first stage would involve a programmatic assessment of the CBD project using the Ministry of Health's suggested Terms of Reference as a guide.

2. The second stage would involve contraceptive prevalence estimates as requested by USAID mission. It was suggested by the AID mission that this second task will be carried out by the Population Council in collaboration with FLAS' Research and Evaluation Unit. The latter would design the methodology which would be reviewed by the Population Council staff. Council staff will briefly join FLAS' team during the implementation and reporting phases.

III. METHODOLOGY FOR THE CBD EVALUATION

Presently, there are five areas where FLAS CBD activities are taking place in Swaziland. These places are Hhelehhele, Sipofaneni, Mafucula, Malindza, and Ndzevane. Malindza and Ndzevane were not part of the pilot CBD programme since they are servicing the refugee populations from Mozambique. For that reason they were not considered as part of the evaluation. Mafucula, though part of the pilot CBD project, was excluded because the place has only two CBDs, limited activity and is relatively far from Manzini. As a result of the above conditions only the activities of CBDs in the two areas of Hhelehhle and Sipofaneni were considered for the evaluation exercise.

To effectively evaluate the work of the CBDs, it was considered important to examine the work that the CBDS do and their interaction with other existing health subsystems in the communities that they operate in. These subsystems consisted of clinics that are within vicinity and the Rural Health Motivators

who also operate, many times, within their areas. Since the services that they were offering were expected to benefit the community it is equally important to examine communities' views of the work of the CBDs.

The methodology for gathering information about the CBDs was straight forward. All the CBDs from Sipofaneni and Hhelehhele were to be interviewed using a structured questionnaire.
When the interviews were conducted 5 out of 6 CBDs were successfully interviewed from Sipofaneni.
From HHelehhele 7 out of 9 were interviewed. While the structured questionnaires were the standard for gathering information on a uniform basis, further indepth discussions were conducted with the teams.

The above procedure was also used for the clinic nurses, their assistants and the community leaders. Whenever possible, all the available clinic staff and leaders were interviewed.

The original design for gathering information from the community had envisaged the CBD record books as providing a sampling frame for clients. However, an examination of the books showed that this would not be a practical approach. Alternative methods of constructing the frame were discounted due to the limited time and available budget. As a result a rapid survey methodology combining both a quantitative and qualitative approach was adopted.
Therefore the CBD clients that were available were invited to some convenient spots where they were interviewed using structured questionnaires. After the interviews, focus group like discussions were conducted. These proved to be very useful for gathering a lot of useful anecdotal information. At Sipofaneni, where it had been difficult to get clients, a stop by a business center led to interviewing 7 clients. A team of 6 women users and non users was found by the riverside washing clothes. With some proper introduction some of the interviewers spent close to 40 minutes with them discussing issues relating to the CBD programme.

For qualitative information, summaries were made in the course of the day since the team members spent most of the day together. For the more quantitative data, summaries and collation was done using a computer. Limitations of the qualitative research methodology would be expected in such circumstances where precise sample calculations cannot be done.

Therefore, the data on community findings is presented with little emphasis on the quantitative measures such as percentages. However, the researchers are confident of the findings and results since this was supplemented, to a large extent, by indepth interviews and discussions.

IV. FINDINGS AND DISCUSSION

Hhelehhele in Hhoho and Sipofaneni in Manzini region are respectively rural and semi-urban. From Hhelehhele, 7 CBD agents were interviewed while 6 were interviewed from the semi-urban region of Sipofaneni. From the total 13 CBS agents, the majority (76.9%) are females and the rest are males. Further profiles of the CBD agents show that half are less than 26 years old and possess, on average, seven years of education.

Close to 70 % of the CBDs are married with almost a quarter reporting that they are single persons. Only one is divorced and working as an agent. On average, the CBD have 3 children and desire five.

Selection

The CBDs operate in the communities that they live in. It is therefore important to determine some selection criteria. Almost 54% of the CBDs mentioned that they were "recommended for the job by community leaders". Virtually, in all instances that meant the local chief. Almost 40% mentioned that they were recommended for the position by a nurse from the clinic and all these come from Hhelehhele. Only one person was selected through some other criteria and this person is also from Hhelehhele.

In probing the CBDs and the local community, the selection criteria were not clearly defined. In Sipofaneni, the nursing sister at the clinic did not think the selection of the CBDs was properly done. It was their recommendation that the area of selection needs proper attention and this was in contrast to feelings of the clinic nurse at Hhelehhele who was more satisfied with the CBDs. It is clear that the Hhelehhele nurses had an input into the selection of the workers and this has a direct bearing on their work relationships and their ability to perform on the job.

Training

Once the CBDs are selected, they are invited for a two weeks' course on family planning. The course, designed to make CBDs function in their communities, covers the following broad topics:

- Teenage Pregnancies
- Sexually Transmitted Diseases
- Community Participation
- Human Reproduction
- Modern Family Planning Methods
- Counselling FP clients
- Motivational Techniques

The evaluation attempted to get information on the adequacy of the training. Most of the CBDs were trained when the program started in 1986 and a few others were trained later in 1987. Asked if the CBDs thought the duration of the course was enough, 6 thought it was and 7 though otherwise. Even those that thought the course was sufficiently long, qualified their statement by saying that it was so because it was later supplemented with a refresher course. On the aspect of adequacy, 68.2% thought the training was adequate for their work. However, everyone except one thought they needed additional training. Already 9 of the CBD group have had additional training by way of a refresher course. From the clinicians at the clinics, one of the recommendations they made was that the CBDs need more training with an extended duration to enable them to better grasp the family planning issues involved. The plan for an extended duration in training will have to take into account the varying educational levels among the CBDs.

Supervision

The supervision of CBDs is important for their performance. Two types supervisory systems have developed. From the head office, the Family Life Educator, from the IEC unit devotes 25% of her time towards supervising the CBDs. This is done mostly on monthly basis, when she goes to resupply the CBDs, collect record books and help solve some of the problems the CBDs may have. For Hhelehhele the visits are less frequent than one per month and tend to converge to about once in two months.

Considered in the context of CBD qualifications, training and skills, this type of supervision from the central office has been found inadequate. Added to this, the supervisor was not trained for her new role. In the two CBD areas an innovative complementary local supervisory system has been developed. Ideally, the CBD agents of a locality elect a member from their group who coordinates their activity.

At Hhelehhele, this system was observed to work very well. On the other hand, at Sipofaneni, the CBD agents did not recognize the local supervisor as such. It should be pointed out that at Hhelehhele, the local supervisor is male, over 40 years of age and was elected by the CBDs. The local supervisor at Sipofaneni is female in her early twenties and it is not clear how she acquired the post. Indeed this may partly account for the different performance levels of the two groups of CBDs.

The CBDs were themselves equally split on whether the head office supervision was adequate or not. Seven CBDs thought it was adequate while 6 thought it was insufficient. Clients at both CBD sites thought the supervision for CBDs was inadequate and needed strengthening. This is both at the local and central levels.

Record-keeping System

Attempts to determine how CBD agents performed in their various functions by reviewing their record books were unfruitful. Books for the earlier years of the project- 1986 to 1988 were mostly unavailable. The records for 1989 and part of 1990 were better kept but for Sipofaneni they were incomplete.

An attempt will has to be made to keep the records in a consistent manner for all the CBDs. Another issue which will need verification relates to definition of terms such as new acceptor and revisit. With some CBDs these categories were outlined in the record books but there was clearly some confusion as to how clients are to be treated when they switched between CBDs and methods.

Supplies and Logistics

The CBDs receive their supplies from their Head Office supervisor when she pays her monthly visit to the field. The system seems to be currently working very well. Should the CBDs run out of supplies, they are able to get replenishment from among themselves or from the clinics. Neither the CBDs nor their clients mentioned the issues of supplies as a problem in their work.

CBD Activities and Performance

The activities and performance of the CBDs is a function of the sub-systems discussed above, that is, selection, training, supervision and logistics. The CBD activity is one of the many activities that has to compete for the time of the CBD among other home demands. Almost invariably the CBD sets up her work schedule as she/he sees fit. In a weeks' period 38% of the CBDs says they devote a day to community work and an equal percentage say they devote 2 to 3 days to CBD work. A more realistic picture would be that most of the CBDs devote about a day in the week for CBD activities.

It was not clearly defined what "CBD activity" was and thus could be misinterpreted to mean even casual minimal contacts with resupply clients. It would also appear that each CBD covers between 10 to 30 homesteads in their activities. A similar number of clients was given as the coverage for CBDs. This implies that the CBDs are established in the homes they cover and see about one resupply client in each of the homesteads.

An attempt to analyze the performance of CBDs using standard family planning indicators and compare them over years was not made. For the records that existed, the tabulations are shown below in Table 1. The data is for half year records for the months of October to April for the years 1986/1987 and 1989/90.

Table 1

Comparative Table of New Clients and Distribution of Condoms and Neo Sampoons for Sipofaneni and Hhelehhele CBD Areas.

		New + Revisit	Condoms Distbtd	Neo Sampoons
Sipofaneni (Madleya	1986/7	770	7613	4090
	1989/90	212	5120	1990
Hhelehhele	1986/7	432	5545	4156
	1989/90	536	7980	3966

From the table above appears that in 1986/7, Sipofaneni was doing better than Hhelehhele. However, in 1989/90 the reverse seems true. Also it appears that Sipofaneni was perfoming less effectively in 1986/7 as compared to 1988/89. Observations about the pattern of distribution of commodities (condoms and foaming tablets) and the number of new clients recruited since 1986 are inconclusive due to incomplete records. Similarly the statistics gathered over the years do not allow for the calculation of continuation rates.

Finally, the effective coverage of the CBDs can be assessed more accurately if there exists some vital statistics about the their catchment areas. This information is not yet available.

The Community Support System

The work of the CBDs is supported by almost all the members of the community especially the leadership. A perception of what the community thought of the CBDs was obtained by having indepth discussions with the local leaders-chiefs. The clinic nurses who are part of the wider rural health infrastructure, were also interviewed.

In both the areas where CBDs operated, leadership support for the CBD programme was cited as a major contribution to its success. The Chief at Sipofaneni had invited FLAS to start the CBD programme in his area after he had heard of the FLAS campaign for an area to start the programme. Besides, the socio-economic benefits of family planning the Chief was also aware that this would help curb diseases such as AIDS and STDS. In his opinion, the four year old CBD programme was successful and fruitful. He encouraged his CBDs to cover a wider area than that falling under his jurisdiction. He recommended an education of the Chiefs in order to make them more effective participants in family planning activities. At Hhelehhele, the Chief was not in his area during the evaluation exercise. However, the approximately 80 year old mother of the Chief whom the team visited, was aware and supportive of the programme. This was further reinforced by the CBDs and clients.

The clinics that operate in the areas where CBDs provide services offer the following family planning methods; oral pills, condoms, vaginal methods, injectables, IUDs, and diaphragms. The most common methods are the injectables, orals, condoms and foaming tablets. IUDs are hardly inserted mainly due to lack of staff with technical expertise to insert the devices. RHMs, wherever they provide services, or supply the same non-clinical methods as the CBDs. This clinical set up provides a good environment for a working referral system between the CBDs , the RHMs and the clinic nurses.

Users of CBD services were hard to get. At Sipofaneni some did not want to be identified and others were busy in the fields or with other personal activities. At Hhelehhele, users could not easily be identified because of a death of an elder in the community. All in all, great insights were obtained from the interviews and discussions from 7 users from Hhelehhele and the 8 from Sipofaneni. Other groups of women washing clothes by the riverside and men by the stores provided useful information. The summary of the community perception follows.

Those who were using FP methods for contraception got their supplies from CBDs. A few other users mentioned the clinic as their source for family planning supplies. Women using CBDs as sources of methods are regular and consistent in use over the previous six months. It was interesting that those using the CBDs as sources of FP methods all said they would continue to use the same source even if a clinic service was provided close to their homes. They mentioned advantages of convenience and confidentiality as reasons for preference of CBDs. They could meet with the CBD "any time" and obtain condoms or foaming tablets. Almost half of the women interviewed said they would prefer to use some other method which the CBD is not providing. The methods mentioned are injectables, oral pills and IUDs.

In the discussions with non-users, women identified two main reasons for non-use. Those with the experience of contraceptive use cited "side effects" and strong male opposition as causes for dropping out. This male factor was mentioned by the chief, the CBDs and clinic nurses. CBDs mentioned the difficulties they experienced in the early days of the programme. Most of these difficulties were a result of male opposition to family planning in an environment which is chiefly traditional and dominated by men. It is to the credit of the CBDs that in the areas that they work, the mention of family planning is no longer a taboo and male opposition has decreased considerably.

Without exception, the work of the CBDs is known. The community supports its expansion with some improvements in training, cooperation and coordination. Proper introduction of the CBDs and education in the communities they work seem to promote community support.

V. RECOMMENDATIONS

A. Programme-Related:

1. Because the community-based approach was demonstrated through the FLAS pilot project to be an effective channel for getting family planing services to otherwise underserved rural communities, it is recommended that the model be used in other rural settings where clinic-based services are limited. In replicating this model, programme personnel will need to ensure adequate supervision, appropriate selection of sites and agents and close collaboration with the local medical community. Where these components were adequately in place as the case in the Hhelehhele site, better performance in terms of client recruitment and distribution levels were observed.

   In selecting CBD sites consideration needs to be made to avoid sitting CBD activities too close to other family planning services as this will tend to be duplicative. It also may promote bad competition among service providers instead of useful collaboration. Also there is need to select CBD agents in such a way that they will cover a wide area. The Sipofaneni area where CBD activities were too close to clinic services and where CBD agents were clustered around one small area, is a good example of what needs to be avoided.

2. An expansion of the CBD activities may need to begin in the existing CBD areas. It is unlikely, for example, that the nine CBD agents currently operating in Hhelehhele can adequately cover this whole area which is characterized by very difficult terrain served by a inadequate and relatively

expensive public transportation system. There is need for further experimentation to determine cost effective ways of expanding service coverage beyond what was observed in the pilot project. Thirty-one CBD agents who on the average covered between 10 and 30 homesteads were able to serve a relatively modest 3,000 clients in four years. One possible approach which can be tried is the depot holder concept which utilizes trained volunteers to stock contraceptives in their homes for collection by their neighbors. In this model, selected and trained CBD agents assume a supervisory role, each overseeing activities of a given number of volunteers. Members of the local communities may have suggestions for other appropriate outlets which could serve as contraceptive depots.

3. Expansion of CBD activities within and beyond existing areas could also be conceived in terms of integrating CBD activities within the ongoing Rural Health Motivator Programme as has already been suggested by medical personnel, community leaders in CBD areas and others. Among the important attractions of this model is the fact that the recurrent costs covering CBD agents stipend would be absorbed by the government hence relieving FLAS of this responsibility. It is also assumed that as more RHMs get trained each year, the number of RHMs will be increasing in rural areas hence broadening the pool from which potential family planning providers can be drawn. There are however some unanswered questions regarding RHM's ability, motivation and required preparation for them to assume additional family planning responsibilities. The Ministry of health is planning to conduct a study which will measure the impact of training and using RHMs as providers of family planning information and services.

Findings of the proposed 18 months study should answer some of the above questions, and in the process enable the Ministry of Health to determine whether or not the proposition to use RHMs as service providers is a feasible one. The question remains, however, regarding the immediate future of the FLAS pilot project. It is therefore recommended that given availability of funds within FLAS permission be granted by the Ministry of Health for FLAS to proceed with the expansion plan within and/or without the existing CBD areas along the lines suggested above and along other innovative and cost effective delivery models. It is further recommended that FLAS evaluates and documents the impact of expanded CBD activities to increase the information base on CBD activities in the country. To facilitate the evaluation, there is need for more rigorous documentation of baseline measures in the project areas, and close attention to record keeping and reporting systems.

4. In order to provide clients in the CBD programme with a method choice, there is need to include the resupply of oral contraceptives in the distribution list of CBD agents. Currently, CBD agents distribute non-prescriptive contraceptives, condoms, foaming tablets and jelly. Clients have reported high failure rate with the foaming tablets. They have also expressed difficulties in using this method correctly. The ten minute waiting time after insertion of the tablet seems to be in disaccord with many people's sexual behavior. In effect then, when clients are unable to use foaming tablets the current programme can only offer them condoms as an alternative or jelly which is not popular. Use of condoms for family planning purposes requires active participation of the male partner. Getting males to participate in the CBD programme is one of the major problems encountered by CBD agents in performing their duties. The programme is therefore limited in terms of method choices available to clients. A carefully planned introduction of pill resupply by CBD agents will help ease the choice problem clients currently face.

In planning the resupply programme attention will need to be paid to ensure that CBD agents are adequately trained and supervised and have a strong referral system to existing clinics. FLAS could initiate this programme in phases starting with areas with highest potential for good supervision and collaboration with the local medical personnel.

B. CBD Agents

1. <u>Selection:</u>

Given that CBD agents have interaction with a cross section of the population in their assigned areas, in terms of age and sex, their selection needs to reflect this factor. In addition, there is need to establish minimum selection criteria and make these well known to those responsible for the selection process. In view of the current CBD agents job requirements which include record-keeping responsibilities and in anticipation to additional oral contraceptive resupplying role, it is desirable that a minimum basic educational background be established as one of selection criteria in addition to good standing in the community, good communication skills and demonstrated interest in community work.

2. Supervision:

Centralized supervision by headquarter staff needs to be supplemented by decentralized local supervision to maintain CBD agents morale and more closely monitor their activities. Mechanisms for ensuring local supervision need to be strengthened where they exist as in Hhelehhele and established where they are non-existent as in Sipofaneni. Short training courses for local supervisors is one way of recognizing and strengthening this role. Supervisory visits from headquarters could then focus on problem solving and provision of on-the-job training and less on routine tasks as is currently the case.

3. Training:

Recognizing the importance of refresher/continuing education in adult learning , it may be worthwhile to experiment with shorter but more frequent training sessions instead of one long training session. This approach may facilitate better absorption and digestion of the course content, may be convenient for mothers who will stay shorter periods from home, and trainees will bring back field experiences to enrich the training sessions. If it is too impractical/difficult to organize training in this manner because of resource constraints, at least one refresher course is recommended per year.

4. Motivation/Remuneration

Virtually all CBD agents expressed dissatisfaction with their current monthly E20 stipend. However, what is a small stipend to CBD agents is quite a heavy financial responsibility to FLAS. This financial burden is likely to grow if recommended expansion of CBD activities is to be implemented.

Ways of maintaining high motivation among CBD agents given this discrepancy need to be explored and tested. One possibility is to allow FLAS to introduce contraceptive sales in new CBD areas. Sale proceeds could be used to supplement or replace E20 stipend. It is advisable to initiate this activity on a study basis to ensure that such concerns as the impact of the cost element on potential service use and cost control measures will be appropriately addressed and documented.

5. Community Involvement

The Pilot CBD programme made excellent efforts to inform local leadership and involve them in CBD activities. The process which resulted in community knowledge and support of the CBD programme needs to be continued. Area Chiefs have played a significant role in getting CBD activities accepted in local communities. In recognition of their support and in order to further enhance their collaboration, it is recommended that opportunities be found to expose these local leaders to some successful CBD programmes in neighboring countries especially in those countries where language barriers do not exist.

The pilot project was successful in mobilizing the support of the local medical community in Hhelehhele but this aspect could be much improved in Sipofaneni. In Hhelehhele, the area medical personnel are so involved with CBD agents' activities that they have assumed supervisory role for CBD agents. They were involved unofficially in the CBD agents' training, and formally introduced to CBD agents after training, and on a more or less regular basis they meet with them at the clinic. To further strengthen this involvement, clinic staff could also participate in the selection of CBD agents. Their professional inputs should strengthen the selection process. These channels of collaboration need to be introduced in new CBD areas and strengthened in existing areas as appropriate.

VI. EMERGING RESEARCH NEEDS

The following emerge as possible areas of investigation through operations research:

1. Planned experiments to determine cost-effective ways of increasing service coverage in CBD areas, for example experimenting with the depot holder concept.
2. Operations research studies to introduce and measure the impact of contraceptive sales as an approach to programme sustainability.
3. Studies to determine optimum coverage areas for CBD agents.
4. Studies to increase male support for and involvement in family planning programmes.

The Research and Evaluation Unit at FLAS may wish to review and revise this list in order to produce a prioritized Operations Research agenda and an implementation plan (If this has not been done already). FLAS can utilize resources within the Research and Evaluation Unit, to implement the plan. In case additional resources are required, donor agencies including the Population Council can be approached.

VII. CONCLUSIONS

The pilot CBD project successfully demonstrated that the community based approach of delivering family planning services can increase contraceptive availability and accessibility in underserved rural areas. Success in terms of service use was very much influenced by the level and quality of supervision, appropriate selection of agents and areas and adequate training. In the proposed and recommended expanded programme, these factors will need to be considered carefully planned and implemented. Another area of consideration in the expanded programme is the need to expand choice of methods given to clients and how to increase service coverage. A research agenda which will address issues related to better delivery and sustainability of CBD services needs to be developed and implemented.

Due to time constraints, one major element contained in the Terms of Reference, the cost effectiveness of the CBD project, was not addressed. A review of FLAS documents indicated that the cost of CYP in the CBD programme was 35% lower than in FLAS' clinic-based services. However, only some of the cost inputs were reviewed and calculated to get the CBD cost estimates. Given availability of relevant data, this aspect could be included in the second phase of the evaluation.