

# REPORT ON

## THE LESOTHO PLANNED PARENTHOOD ASSOCIATION

### COMMUNITY BASED DISTRIBUTION PROJECT

### EVALUATION



**SETSI SA TSOELOPELE THUTONG. LESOTHO DISTANCE TEACHING CENTRE**

**P.O. Box 781  
Maseru 100 Lesotho**

**Telephone: Maseru 316961  
Telegraph: DISTANCE  
Telex : 9634334LO**



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## ACKNOWLEDGEMENTS

The authors offer their sincerest thanks to the following:

The Director of LDTC, Mr. John Maime and The Executive Secretary of LPPA, Mrs. Limakatso Mokhothu, for their ongoing support in organising materials and human resources for this project.

Ms. Alice Cole, Ms. Fran Kennedy and Ms. Shirley Hill of the AID Mission in Lesotho, for their active participation in the development and organisation of the study, as well as co-ordinating the various groups involved.

Ms. Palesa Khutlang and Ms. Tseliso Mathafeng for conducting interviews, and Mr. Brown Mahase and Mr. Kahlolo Marite, who saved the lives of the field teams with their careful driving.

Ms. Therese McGinn of Columbia University, for helping to develop the project.

Recognition is due to the many people whose comments on the drafts of the questionnaires helped to shape this study.

Thanks are also due to the many people in villages around Lesotho whose co-operation made this study possible.

We also thank Ms. Christine Mwanyika of the Centre for African Family Studies for a careful editing and typing of this report.

Finally we wish to acknowledge the generous assistance of the U.S. Agency for International Development for their financial and technical support of our research efforts.

We must also accept that despite generous assistance from many sources, any mistake are the responsibility of the authors. Likewise the opinions expressed in this report are those of the authors and do not necessarily reflect the opinion or policies of the various supporting organisations.

Mr. Sam Motlomelo	- Lesotho Distance Teaching Centre
Mrs. Thokoloane Maliehe	- Lesotho Planned Parenthood Association
Mrs. Malineo Sakoane	- Lesotho Distance Teaching Centre
Mr. Gary Lewis	- Center for Population and Family Health, Columbia University

## PREFACE

This report is a presentation of the results and findings of an evaluation study carried out to identify problems effecting the Lesotho Planned Parenthood Association's Community Based Distribution Project and lessons that can be learned to improve future community based activities.

After identifying the need for this study, LPPA consulted the Ministry of Health to approve of funding for this study within the broad Family Health Services Project funded by the U.S. Agency for International Development. LPPA felt that external technical assistance was needed to conduct the study as CBD and project evaluation were new concepts locally. With an input from the Center for Population and Family Health, Columbia University and the Lesotho Distance Teaching Center, the study took off in December, 1988.

The focus of the report is on how the CBD project was implemented and operated looking at such issues as recruitment, training and supervision, logistics, community and clinic support and the reasons why the CBD's dropped out and the reasons that affect use and non-use of family planning.

The report's structure covers five broad areas as follows:-  
Implementation of the LPPA CBD Project, study implementation, results of the evaluation, summary of results and summary of recommendations for future CBD activities.

It is LPPA's hope that the report will be useful not only for the improvement of and expansion of CBD Project but also to the other agencies involved in family planning who would like to start community based activities to increase family planning acceptance in Lesotho. LPPA's experience and the lessons learned should be enriching to all.

We extend our thanks to all who participated in the study.

LIMAKATSO MOKHOTHU  
Assistant Executive Director  
Lesotho Planned Parenthood Association

### ABBREVIATIONS

CBD	-	Community Based Distribution
CPFH	-	Center for Population and Family Health (Columbia University)
FP	-	Family Planning
IE&C	-	Information Education and Communication
IUCD	-	Inter Uterine Contraceptive Device
LDTCC	-	Lesotho Distance Teaching Centre
LPPA	-	Lesotho Planned Parenthood Association
M.	-	Maloti (Lesotho Currency)
MOH	-	Ministry of Health
R&E	-	Research and Evaluation
VHW	-	Village Health Worker
USAID	-	United States Agency for International Development

## I. IMPLEMENTATION OF THE LPPA CBD PROJECTS

The Lesotho Planned Parenthood Association (LPPA) had long recognized that clinic based services were not meeting the family planning needs of the population. This led LPPA to develop an experimental community based distribution (CBD) scheme in 1984. The CBD approach is widely used in primary health care and family planning programs where: widely dispersed population make fixed clinic services difficult; when medical personnel are in short supply; and when available resources (funds) are very limited relative to needs. The CBD Program recruited women from the communities selected and gave them limited training in family planning methods. These women returned to their community with a small supply of contraceptives. They were then expected to raise community support for family planning, direct couples to clinics if required, sell contraceptive supplies, and handle problems experienced by clients. The agents were to be supervised and resupplied on a regular basis by the field educators who were already in the area working for LPPA. The agents were also expected to file simple reports and facilitate family planning activities in the area. There was no formal tie to the clinic system, no follow-up training, and no interim evaluation. With no external support and only limited local resources, four experimental areas were selected, and the process of project implementation begun. The objectives for the project were to provide some understanding of the constraints of implementing a CBD Program, and measuring the potential of such programs to meet the unmet need for family planning.

Unfortunately, LPPA had no detailed management strategy nor any program objectives beyond the learning experience of small scale CBD project development.

The four areas included in the CBD Program are rural areas widely disbursed throughout the country. They were randomly selected from a list of areas in need for services and without reasonable alternative sources.

Ha Ramabanta is a predominantly Catholic area in the Maseru District. Population in the villages covered by the CBD program (Thusong near Kena, Motse Mocha, and Ha Ramosebo) is about 1,100. Most of the people are small scale subsistence farmers. Most households are between 75 to 100 kilometres from the nearest clinic facility which can provide family planning.

The Phamong CBD site is in Mohales Hoek District. Some of the villages with CBD agents are along the Senqu river while others are up in the foothills. The six villages (Habori at Nohana, Phamong Moreneng, Lithipeng Ha Seephephe, Nkojana, Shalane-Tlokoeng, and Malifatjana) have a total population of about 700. There were three clinics in the District at the start of the CBD program but none were providing family planning services. The LPPA nurse visited two of these clinics once a month, providing the only family planning service available in the district. In the CBD villages it is an average walk of 5 to 6 hours on foot to the nearest clinic.

Ghoalinyana CBD area is in the Gachas Nek District and has a population of about 1,600 in the one village served by CBD agents (Sekhalabateng). The area is very mountainous and predominantly Catholic. There are no static clinics which offer family planning services in the area. The nearest government clinic is about 100 kilometres away. Other than CBD services the only other source of family planning has been monthly visits by the LPPA nurse.

Ha Khabo CBD area in Leribe District has an estimated population of 960 in three villages (Ha Khabo-Moreng, Pela-Tsoau, and Menkhoaneng). The area is in the foothills. It has had only limited access to family planning services provided by occasional visits by LPPA to an unstaffed clinic.

The process of selecting specific communities was done in the following manner. The field educator who supervised the selected area met with the project co-ordinator. These two people selected about 10 villages in each area to be the site of a CBD operation. The implementation procedures recommended that villages should be a minimum of 26 Km apart and that a selected village should have a minimum of 50 households. No other criteria were provided, giving the field educator considerable choice in site selection. Once the villages were selected the field educator was also expected to identify a likely candidate to be the village CBD agent. The guidelines stated that the selected agents should: have minimum education (Standard 7), they should not be village health workers (VHWs), they should



With the participants selected, the project co-ordinator set up a training site, sent out invitations, and prepared the three day course to train the selected CBD agents and field educators for their new activities. Training for CBD agents started in May 1985 in Khabo and Ghoalinyana and in September in Phamong. In June 1986, the Ramabanta CBD agents were trained. The objectives of the training were to provide participants with the appropriate skills to enable them to distribute orals and other non prescription contraceptive within their communities.

The course contained:

- an introduction to family planning and the programme
- an explanation of LPPA, its structure and role
- a presentation on human reproductive biology
- lectures on menstrual cycles and ovulation
- an introduction on modern contraceptive methods
- a lecture on communications skills (village level)
- a lecture on counselling clients
- presentations on the logistic issues of distribution of contraceptives, storage, re-supply and problem solving
- reporting and financial procedures.

It should be noted that the field educator attended the CBD agent training but did not receive any special training on her role or functions.

Once training was completed participants were expected to return to their village and begin contraceptive distribution.

Unfortunately, in Ramabanta the actual distribution of contraceptives did not start until several months after the training, due to inadequate staff at the LPPA level. This delay can be assumed to have caused a major loss of motivation and

substantially reduced the impact of the knowledge transferred during training.

With CBD operations in the field, project management stressed supervision of CBD agents. Supervision stressed re-supply of contraceptives and updating records. The program has been allowed to languish with limited management inputs and no resources. Despite the lack of resources after several years there are still CBD agents operating as contraceptive supply depots for their communities. Field educators continue to re-supply and supervise and LPPA continues to learn lessons on the problems of CBD program implementation.

Table 1

Number of CBD Agents in Place by Area and Year

Number of CBD Agents (man months worked during period\*)

<u>AREA</u>	<u>1985</u>	<u>1986</u>	<u>1987</u>	<u>1988</u>
Khabo	3 (21)	3 (36)	1 (18)	1 (12)
Qhoalinyana	6 (42)	3 (36)	2 (30)	1 (18)
Phamong	6 (18)	4 (60)	4 (48)	3 (42)
Ramabanta	-	5 (10)	4 (54)	4 (48)

\* Combined 12 months for active agents and partial year for drop-outs.

Source: LPPA Annual Service Statistics

Table 2

Contraceptive Supplies Distributed by CBD Agents\* by Year

	<u>ORALS</u> (Cycles)	<u>CONDOMS</u> (Pieces)	<u>FOAM TABLETS</u> (Tubes)
1985*	3,333	9,600	325
1986	618	1,043	70
1987	1,035	1,955	83
1988	918	736	74

\* Includes contraceptive supplies distributed in home and community visits by all family planning workers. After 1985 contraceptives totals reflect only those supplied by CBD agents.

Source: LPPA Annual Service Statistics Report

## II. STUDY IMPLEMENTATION

### Introduction

Increased interest on the part of the Government of Lesotho in a possible expansion of the limited CBD efforts undertaken by Lesotho Planned Parenthood Association (LPPA) resulted in LPPA seeking assistance in evaluating these efforts. The Association believes that the current project was not successful and that the experience needed to be studied and documented. To fulfil the needs of LPPA, USAID/Lesotho agreed to provide the funding to cover local implementation of a study to be done by the Lesotho Distance Teaching Center (LDTC), with technical assistance provided by the Centre for Population and Family Health, Columbia University (CPFH).

Once agreement was reached on the issues and approach, the evaluation could progress. Columbia University developed a project agreement with LDTC. Columbia developed the preliminary data collection protocols and LDTC and LPPA reviewed, modified, translated and tested them. LDTC recruited field staff and directed data collection. LDTC also edited and tabulated the results, based on an analysis plan developed earlier. Columbia took a lead role in preparation of the report. The draft report was then extensively reviewed and rewritten in Lesotho.

### Study Procedure

Several sources of qualitative information were used in the CBD Evaluation Study. The study populations consisted of 30 CBD agents; four field educators from the districts where the CBD agents were recruited; two community leaders from each of the communities served by the CBD agents; three to five clinic staff members who work in the clinics providing family planning to the CBD areas; and one service recipient (client) from each CBD agent interviewed. The evaluation team agreed that respondent sampling was not necessary because the study population was too small and widely spread to be able to try to draw a representative sample. All groups of respondents were interviewed using a unique questionnaire designed for each specific group. Copies of the protocols have been put together as an appendix to the report, and are available from the sponsoring institutions.

### Purpose

The objectives of this study were:

1. To collect a body of information that will be the basis for designing an expanded CBD program.
2. To identify those factors in CBD project implementation which promote, hinder, or have no impact on the goals of the program.
3. To evaluate the implementation of the CBD project in light of LPPA's specific agenda.

### Pretesting Procedure

Having received the protocols on November 21, 1988 the Research and Evaluation (R&E) Section of LDTC together with the LPPA went through the questionnaires to ensure a common understanding of

every question. Later the R&E Section translated the completed questionnaires and reviewed the results with LPPA.

The pretesting schedule was set up concurrently with the recruitment of two interviewers. In December 1988 LPPA personnel and the interviewers were trained in the methods of interviewing and administering the questionnaires. Their capabilities were regularly tested with role plays and periodic reviews.

The questionnaires could not be pretested in the CBD areas because, all contactable CBD agents were to be included in the study population. LPPA identified people in Maseru who had been involved with various aspects of the CBD programme, and who understood the issues well enough to serve as respondents for the questionnaire. For example, retired LPPA staff, LPPA volunteers, and some current LPPA staff were interviewed.

#### Fieldwork

The team that went out for fieldwork included three LDTC staff, one LPPA staff member and two specially recruited interviewers. Since most of the respondents were women, the field teams were all women.

Fieldwork started on December 5, 1988 with a northern group and a southern group. In each group one of the R&E staff had the dual role of interviewing and supervising.

Each interviewed CBD agent was asked to identify several community leaders whom they dealt with as CBD agents. The team selected two leaders randomly from the list provided. The CBD agent also nominated one of her service recipients. In some areas the chiefs had been notified of our visit by field educators and the teams were well received despite the hectic Christmas period. Field work was scheduled for three weeks, but was completed in two weeks because fewer CBD agents were located than expected, so travel and interview times were less.

Problems always arise during the fieldwork of any research project. The problems encountered in the study of LPPA CBD operations are documented below for the use by others doing similar research.

There were several communications breakdowns so that several CBD agents were not informed of the visit by the research team. Some of the CBD agents were away from their home for an extended period of time on trips to the Republic of South Africa. The agent's position as a CBD agent often indicated participation in a range of economic activities that would make her unavailable for periods of time. The communication breakdown resulted in the need for more recalls and extended waits. Some contacts were never made. As a result more time was spent on getting a completed interview, but fewer interviews were completed.

Transport for field teams was a problem. The vehicles got stuck several times, usually at considerable distance from a village. Getting the vehicles unstuck involved walking to the nearest village and organizing a span of cattle or several strong men to pull the car out of its pit. In other places detours had to be made to get petrol. One time the team had to flag down vehicles on the road and buy fuel. In some areas the CBD agents were not even accessible by vehicle and the interview teams were forced to walk. In Qhoalinyana the team used boats to cross two large rivers to get to a CBD agent who had left her CBD assignment to seek employment elsewhere.

### Respondents

Interviews, using standard procedures, were completed with twenty CBD agents; nineteen community leaders; four field educators; eleven clinic staff and eighteen service recipients. Since only 20 CBD agents could be traced, the number of respondents in other categories was also lower than originally planned. In addition one team contacted only two community leaders per sub-district and not two per CBD-area as expected.

### Data Processing and Analysis

On the first week of January, 1989, the R&E Section started data coding, and partial analysis. Once this was completed the Columbia University advisor helped with a final clean up of the data and began report preparation. The results of this joint effort are presented, analysed and discussed in this report.

## Characteristics of Respondents

### CBD Agents:

Number: 20

#### Age:

Mean: 41.2

Mode: 32

Range: 22 - 56 years

#### Marital Status:

When recruited 100% currently married

Now 100% currently married

#### Number of living children:

Mean: 4.15

Mode: 4

### Ever Use of Contraception

Ever Use: 14

Never Use: 6

#### Current Use:

Current: 7

Not using Now and Never: 13

### Field Educators:

Number: 4

Mean number of years as field educators: 9 years

Mean current assignment: 8 years

Marital Status: All currently married

Mean number of children: 5.75

### Service Recipients:

Number: 18

#### Age:

Mean: 28.4 years

Mode: 25 years

Range: 20 - 43 years

#### Marital Status:

Currently married - 17

Not currently married - 1

Mean number of living children: 3.72

### III. RESULTS OF THE EVALUATION

The findings from the field work are presented in the following section. The various categories of respondents (and questionnaires) have been combined so that the results focus on general issues.

#### 1. CBD RECRUITMENT:

All CBD programs consider as one of their first operational issues - what should be the characteristics of their agents and how should these agents be selected. The decisions made on CBD agent recruitment are ones the program will live with for several years. How much education is too much or too little for an effective CBD agent. Will a member of the community elite bring prestige to family planning but little service, while a regular woman may offer little status but continued effort and easy access. The tradeoffs to be made are an important management decision which can be facilitated by good data on community perceptions.

#### Recruitment Procedures:

There were some disagreements between groups of respondents on how CBD agents were actually recruited. Selection by the community was the most common approach mentioned by study participants, but it is clear from the range of answers that different communities handled the process differently.

About one third of the interviewed CBD agents felt that they

had been selected by the field educators. The field educators reported that the CBD agents were selected by the community, by the chief, or they volunteered.

When asked why they were selected, the CBD agents gave a variety of responses which provide an interesting insight into the process: she had already worked with the clinic or as a village health worker; she was already using contraception; she had children which indicated that family planning is not opposed to children; she was interested in development activities; she was selected because younger women will get objections from their husbands.

It is clear that there were no standard procedures for CBD recruitment. The issue for future CBD program efforts is whether standards should be set and strictly adhered to. The evaluation does not provide sufficient information to make a definite decision, however, observations are worth noting. If community selection of CBD agents is used, a set of guidelines which the community can use should be provided. However, the management and moral problems caused by efforts to strictly enforce the guidelines could be counter productive. The guidelines should be available but left to the community to interpret. The information collected does not suggest that recruitment of inappropriate candidates is a major explanation of the failure of the CBD Project. CBD agents appear to have been reasonably capable of doing their job, when they chose to do it.

The recruitment procedure most frequently used in the LPPA CBD Project - selection by the community to be served - was also the procedure most often recommended by all categories of respondents. Community leaders unanimously said community election. Clinic staff also preferred community elections, although a few stated a preference for clinic staff selection from among current village health workers. This preference for linking family planning services to existing health services was reflected through almost all the responses of clinic personnel.

#### Ideal Characteristics for CBD Agents:

The recruitment of appropriate CBD agents is an important first step in any CBD program. But what are the criteria for selection that should be used. Most of the respondents were asked to identify the characteristics they considered most important to a successful CBD agent. The two most important characteristics, mentioned by almost all respondents, were strong social skills and trustworthiness. In talking about social skills respondents stressed "ease of communication", "openness", "accessibility". The word most used in explaining trustworthy was "secretive", indicating a strong desire for client privacy. This concern suggests that there is still considerable sensitivity to family planning. In Lesotho, family communication on the topic of fertility control is still limited, while traditional fertility values put considerable pressure on women to conform. This suggests that major IE&C efforts will be

required to reduce sensitivity to contraceptive issues, before there will be any major shifts in contraceptive and fertility practices. In terms of recruiting future CBD agents the ability of the potential agent to maintain client privacy should be a major selection factor. Another characteristic which was mentioned frequently was that CBD agents should be people of high moral repute. The privacy issue and the attitude among males that family planning promotes promiscuity, may explain why it was considered important that CBD agents have good reputations in their communities. Other characteristics mentioned by respondents included: well trained, maturity, someone without major time commitments, people with family support for participation, married, literate, and interested in development. Interestingly, literacy, while mentioned was a low priority and education level was not mentioned at all. Nothing was said about the gender of the CBD agents, but it may be assumed that since all agents and field educators are female, most study participants consider family planning as a job for women. Age, religion, community residence were either not mentioned or mentioned rarely as a selection factor for picking new CBD agents.

In future recruitment efforts the characteristics which are most important are listed below, in order of importance to all the respondents:

- a) The CBD agents should be able to respect the privacy of the client and maintain the confidentiality of the relationship.

- b) The CBD agent should have strong social skills which makes clients comfortable.
- c) The CBD agent should have a good reputation as an upstanding person in the community.
- d) The CBD agent should be a responsible person who will provide the community with consistent service of appropriate quality.
- e) The CBD agent should be available regularly at her home. She should not have major responsibilities which would conflict with the job (business, many young children, etc.).
- f) CBD agents should be very knowledgeable about family planning.

One problem with the community selection procedures is that it can recruit agents who do not really want to be CBD agents but are pressured to accept. This does not appear to be a problem in Lesotho as almost all CBD agents interviewed indicated they wanted to be agents at the time of recruitment. However, information discussed elsewhere in this report suggests that CBD agents had a poor understanding of what the job entailed, and this misunderstanding may have influenced the attractiveness of the CBD position.

## 2. SETTING UP CBD AGENT SERVICE AREAS:

Management decisions on the catchment or service area which a CBD agent is to cover are usually one of the first decisions to be made when setting up the field operations. This decision will influence the workload, duplication of effort, relationships with clinics, commodity needs, quality of service, travel time, supervision structure, and

relationships between the CBD agent and clients. It appears that LPPA did not make a decision during the implementation phase. It was assumed that agents would serve the community where they were recruited and any other areas would just be extra work that the agent wanted to undertake. However the LPPA CBD Project evolved into a depot project, where agents stayed at home and provided services to anyone who came to their house.

Several questions were asked of CBD agents and field educators in an effort to determine how catchment areas were set up and how to set up optimum service areas for future CBD expansion. The answers were not as informative as hoped. CBD agents reported that they covered between zero and six villages. Five villages was the most common response. One CBD agent did not know how many villages she served. When asked who set up their catchment area, most agents said LPPA or they did not know. When asked how many villages a CBD agent could cover the answers ranged from 1-14. Three agents said since clients came to the house it did not matter what size the catchment area was.

Field educators said that catchment areas were set up to cover locations which did not have access to clinics. They felt that agent could cover 10 (2 answers) 50 (1) and 100 (1) households.

In any expansion of CBD activities the issue of CBD agent catchment areas should be considered. The role of the agent (depot vs. house to house) will determine how large an area can be managed effectively by one agent. Another influencing factor will be the issue of CBD program coverage. If future activities opt for complete cover in selected areas (for supervision and logistic reasons) then catchment areas should be smaller and more clearly defined. If the decision is to put CBD agents in widely dispersed locations to maximize the population provided with even limited family planning services, CBD catchment areas can be much larger and do not need clear borders.

### 3. PREPARATION OF THE COMMUNITY:

The use of CBD agents in Lesotho was a relatively new concept when LPPA first introduced it. One issue that must be considered before any expansion can be undertaken is the level of preparation that went on, or should go on in the community before the CBD agent is put in place. The following discussion covers both what was done in the current LPPA CBD Project and what should be done.

Field educators for the current CBD activity prepared the communities by attending community gathering and travelling with the nurse to talk about the CBD program in the selected communities. The field educators felt that in the future the best ways to prepare the community for CBD was to

provide general information on family planning to create a demand, which could then be met by the CBD agent. They also recommended community presentations (undefined by respondents). Additional comments include getting leader support, getting the right person to be the CBD agent, and using the field educator to make house to house visits. Field educators were also asked what CBD agents actually did to prepare the community. The general response was contact potential clients whenever and wherever possible. Generally the field educators felt that the CBD agents tried to prepare the community, but that some tried harder than others. While this is to be expected it does suggest that training and written guidelines in community preparation would be useful.

Field educators also felt that LPPA could do more to prepare the community by working with leaders. Their suggestions include special seminars for community leaders, specifically recruiting leaders as CBD agents, run training programs for leaders; and make them members of LPPA.

In response to a general question on how to do community preparation, clinic staff suggested (in order of popularity); at community gatherings, announcements at the clinic, house to house campaigns, and through the churches. When clinic staff were asked specifically what they could do to prepare the community they suggested presentations on the CBD program at the clinic, clinic staff should regularly

visit CBD agents, and clinics should refer clients back to the CBD agent in their own community. The nature of the responses suggest that clinic staff do not currently consider themselves part of the community preparation process. Clinic staff also recommended using community leaders to prepare the community for the introduction of CBD agents by training them so they could better explain the CBD program and family planning. The leader could also facilitate special meetings of the community to help the CBD agent in implementing their activity.

CBD clients asked about community preparation for CBD activities expressed a very strong preference for group meetings to promote the CBD agent. Recommendations focused on community gatherings with the chief and LPPA speaking, and community discussions. Home visits and notices at the clinic were also mentioned as ways to inform the community about the family planning services available from the CBD agent. It is interesting that about half the CBD clients indicated that they had already heard leaders talking at community meetings about family planning.

Almost all community leaders and CBD agents interviewed in the study suggested that the best way to inform the community of the functions and availability of the CBD agent was to have the agent speak at community meetings on a regular basis. A few leaders also recommended house to house visits, posters and clinic referrals of clients to the

CBD agents. More than half (11 out of 19) of the interviewed CBD agents reported that they were actually introduced to the community at a community meeting.

The consistency of answers by all categories of respondents, on the use of community gatherings as the best way to establish the CBD function and agent in the community, indicates the importance of traditional community structures in introducing new ideas. The current CBD project clearly used community networks but were irregular and inconsistent in getting community support for the CBD agent. Future CBD expansion efforts should incorporate formalized guidelines and support for community gatherings to "kick off" new CBD agents. Also expansion CBD programs may want to incorporate mechanism to maintain high levels of community involvement beyond the start up phase.

#### 4. CBD AGENT TRAINING:

While the primary function of a CBD agent, distributing contraceptives, is not a complicated activity and should not require extensive training, the ancillary activities which determine the overall success of a CBD agent may require training. These activities may include counselling, communications, community organization, combating rumours, liaison with health and other social services, etc. There are a variety of indicators that suggest training of LPPA CBD agents was inadequate.

Clients generally felt the CBD agents had the knowledge which met their needs for information. However, among the questions the CBD agents could not answer to the service recipients' satisfaction were: "Can an IUCD be put in the wrong place and the baby come out holding the IUCD? And can the pill and injection cause permanent sterility?"

The field educators generally felt CBD agents were inadequately trained. Their criticism of the training was that it was neither long enough nor comprehensive enough. Also follow-up and review training was required but never provided. One CBD agent was not trained at all.

The CBD agents were asked a series of questions about their perceptions of their training requirements. The highest priority was for training to improve communications skills. The next priorities were for more reference materials and training in reproductive biology.

Recommendations were also received for training in basic medical skills (blood pressure, injection, etc.) and more information on contraceptive technology.

Only half the CBD agents received background or reference materials during training. Those that received them felt they were helpful. All CBD agents felt additional information provided on a regular basis would facilitate their education and motivation functions.

CBD agents were equally divided on whether the training they received was long enough. Among those who felt it needed to be longer, 60% felt one week was adequate, while the remainder felt two weeks was required.

The broad base of information collected by the study clearly indicates that the training of CBD agents was inadequate. CBD agents have a significant amount of misinformation on contraceptive methods. One source of job dissatisfaction was that the role of the CBD agent was not what the participants expected, suggesting that the training did not provide sufficient information on the nature and operations of CBD agents. A few CBD agents were replaced because of irregularities in record keeping which might have been resolved with better training. The evaluation suggests that the field educators, who should be constantly retraining as they supervise their agents are only a little better informed than the CBD agents they supervise. It is also clear that training/retraining of CBD agents is not a priority with field educators so that even if they were knowledgeable enough to train, they would not do it. It appears that after initial training any new information a CBD agent gets is from informal contacts with clinic staff.

If the CBD Program is to be expanded it will require a stronger training component. A major function of the CBD agent, in addition to distributing contraceptives, is to be a source of correct information to combat misinformation.

They now have little training and no material to do this. Also any training program should allow for training of replacements or new agents and periodic retraining of agents on an on-going basis. The retraining would allow updates on technology and administrative procedures. Retraining, may also be a moral issue, since retraining was frequently mentioned as an incentive for CBD agents.

5. SCOPE OF WORK FOR CBD AGENTS:

The LPPA had no formal or written scope of work for CBD agents. From the training curriculum (see page 5) the general activities expected of the agents are fairly clear, and generally coincide with CBD agents' perceptions of their functions. In expanding the CBD program, careful consideration should be given to the scope of work for the agents. The content of the scope will depend on several factors: type of training given, payment scheme, contraceptives available from the program, integration of CBD with clinic services, supervision strategy, logistics system, reporting requirements, and management systems.

Table 3 provides a summary of the results of a series of questions on the major functions of the CBD agent. It is clear from the table that contraceptive distribution is the single most important function. Education of possible clients, often linked with motivational efforts, is also a major function. These functions would be expected in any

listing of CBD responsibilities. The most pressing are the secondary function of the CBD serving clients and clinics, community education and record keeping. This suggests that an increase in these responsibilities is a real possibility for a broader CBD program. The most important perceived responsibilities, in addition to contraceptive distribution, are various types of IE&C activities and more co-operation with health agents and clinics.

TABLE 3

MAJOR FUNCTIONS OF CBD AGENTS IN ORDER OF PRIORITY

<u>Community Leaders</u>	<u>Clinic Staff</u>
Distributing Contraceptives } Education on FP } Counselling Clients } House to House Visits } Referring Clients to Clinics }	Educating on FP } Distribution of Contraceptives } Counselling Clients } Referring Clients to Clinics } Record Keeping }
Record Keeping } Set up Community Training }	Doing simple clinical exams.
<u>Field Educators</u>	<u>CBD Agents</u>
Distribution of Contraceptives } Education on FP } Advice Users on Problems } Community Education (non FP) }	Distribution of Contraceptives } Education on FP } Refer Clients to Clinics } Record Keeping }

A number of questions were asked of how CBD agents should go about implementing their "scope of work". Both community leaders and clinic staff felt that the project should be expanded so that an agent had to cover at least one village. Some leaders felt that agents should provide services by

going to the client's home. A few clinic staff felt that CBD agents should try to work more with couples rather than just the women.

CBD agents were asked how they performed their duties. The majority indicated they provided services by staying home and serving clients who came to their houses (depot approach). The agents also said they used village gathering to communicate with potential clients. Most agents also reported occasional use of home visits to do their work.

CBD agents were asked what they did when they met with a woman who was interested in family planning. All said they talked about the use of family planning to space pregnancies, and about using family planning to limit family size. Almost all report having taken clients to the clinic for services. Most agents also reported talking to men about family planning on occasion.

One operational issue which the evaluation study was interested in, was how CBD agents handled a situation where the woman wanted to use family planning but did not want the husband to know. Virtually all agents indicated they would provide services to those women. A few elaborated on the methods they would promote (injection) or how to keep it a secret, but all would provide services.

6. SUPERVISION:

The supervision of CBD agents is generally considered to be an important factor in explaining the success or failure of any CBD project. The direct supervision of LPPA CBD agents was handled by the field educators. The field educators is the supervisor, re-supply source and problem solver for the CBD agents.

One aspect of supervision is the ability to refer problems upward in the system. The LPPA CBD Program trained CBD agents to pass any problems along to the field educator or the nearest clinic. Almost all CBD agents said they were told what to do if they had any problems. Half the CBD agents indicated that at some point they had a problem which had to be referred to the field educators or clinic. Of those who had a problem, 80% felt the problem was handled to their satisfaction.

The supervision system set up by LPPA called for close supervision by field educators with support from clinic staff in areas where they were available. However two out of the twenty CBD agents interviewed had never been visited by any LPPA personnel. Among those visited almost all found the visits helpful. While direct questioning indicated that supervision was at least adequate, other responses to non supervision questions suggest that it was not adequate. Field educators are only marginally more knowledgeable about

family planning than CBD agents. Supervision visits appear to have been primarily focused on resupply (and therefore "useful" to the CBD agents). The high dropout rate of CBD agents and the reasons given for dropping out suggest that field educators did little to clarify roles, responsibilities and problems for CBD agents. The relative high level of misinformation held by CBD agents also suggests that the field educators did little probing of how the assignments were carried out and did almost nothing to change inappropriate work behaviour.

Field educators visited and resupplied CBD agents about once a month. Some agents waited longer but according to the field educators never more than two months. Among the CBD agents, two reported never having been visited.

One supervision issue which can be considered is whether the perceived amount of supervision influences the activity status of the CBD agents. The results of this comparison are presented in Table 4.

Table 4

CBD Agents Activity Status by the Perceived Frequency of Supervision:

Current Status	Too Often	Too Rare	Just right	Not Visited
Active	6	4	1	-
Inactive	3	4	1	1
TOTAL	9	8	2	1

Caution must be used when working with such a small number of cases. But among those who perceived themselves to be visited more often, more were still active. This suggests the level of supervision may in part explain some degree of loyalty to the programme.

The evaluation suggests that although CBD agent supervision was active, it had little impact on the quantity or quality of services provided. There are many logical explanations for this but the most likely is that the field educators were not trained in CBD supervision and they had no guidelines or other instructions in appropriate procedures. Supervision may have been just an added function for the field educators which they did not take seriously.

7. MOTIVATING CBD AGENTS:

All family planning programs are looking for ways of motivating their CBD agents. Motivation efforts are always

important but especially so in project where agents are volunteers or receive only nominal incentives (uniforms, commissions on sales, etc.). The evaluation looked at the issue of motivation in an effort to make recommendations for future efforts. Non monetary form of motivation were stressed because studies from several countries agree that the ultimate motivating factor is a regular salaried position. In the case of the LPPA CBD Project, motivation was to be supplied by commissions on sales, regular supervision and community respect. As will be seen later, commissions on sales are not much motivation if sales levels are very low, and supervision and respect are intangibles that have to be effectively managed if they are to be motivational factors.

Clinic staff, community leaders, and field educators were asked their opinion of the best mechanisms for motivating CBD agents to be effective distribution agents in their communities. The most frequent response from all three types of respondent was training. It was suggested that training and regular retraining is perceived as a reward for those who participated. The information collected in the evaluation does not explain why training is perceived to be a major motivational mechanism, but it has been observed in other development activities that external training has resulted in increased social prestige. For the participants to be selected by their community, trained by high level personnel, and to acquire skills which are useful to the

community, should raise anyone's status in a rural village. Also important as a mechanism to motivate CBD agents, was a regular salary. Salary and other incentives will be discussed in more detail in a later section. However it is important to note that three groups of respondents gave first priority to non-monetary incentives as the way to increase motivation.

Community leaders stressed the need for regular supervision as an important component of motivating CBD agents. Clinic personnel recommended the provision of free medical services as an inducement to CBD agents. Other motivating mechanisms mentioned include: transport allowances, more active recognition by LPPA, having clinics promote clients for CBD agents, getting husbands to support CBD activities, provide T-shirts and other paraphernalia to CBD agents which advertises their function and role in a national effort, and promote the concept of CBD (on radio).

It should be noted that many of the mechanisms for increasing CBD agent motivation involve changes in program operations rather than changes in benefits to individual agents. A large number of recommendations involved raising the image of the CBD project to a professional, national development program. This is contained in various recommendations which cover expanded promotion, development of stronger links to the existing medical infrastructure and stronger project affiliations (uniforms, training, etc.)

## 8. CASH INCENTIVES FOR CBD AGENTS

The LPPA CBD project used only volunteers as CBD agents. However, to encourage the agents, LPPA set a policy of allowing them to keep 10% of the cash earned from the sale of commodities. This policy was apparently not communicated effectively to the CBD agents, nor was it respected by the field educators. Responses to the question for CBD agents on how much they could keep are informative:

<u>Response:</u>	<u>Number</u>
10% of sales (correct response)	10
Free contraceptives	1
Do not know	2
M 1.00 for every 6 new clients recruited	1
M. 2.00 for every M.4.00 in sales (periodically???)	1
M. 1.00 for each M. 4.0 in sales (25%)	1
Volunteer, received no remuneration	2

When asked whether this was enough, a third of the CBD agents said it was enough while about two thirds indicated it was too little money. It should be kept in mind that some CBD agents had very few sales so the amount of money they would receive would be small regardless of how their commission was calculated.

Another issue to be considered is what is an appropriate incentive for CBD agents. Some issues have already been discussed in the section on motivating CBD agents. However a separate discussion of the responses to direct questions on incentive or rewards is also useful. The most common response from both agents and field educators to the best

form of incentive was a "regular salary". One field educator suggested M. 50.00 per month. It was the second most important incentive (after training) recommended by clinic staff and community leaders. It is clear that the development of a staff of trained and salaried CBD agents would be perceived as a major advance by people operating at the field level. The information in this evaluation will not let us judge whether salaries would actually improve performance, or even if they would be cost effective. This issue will require careful study of both impact and sustainability before any expansion takes place. However it is logical to assume that, given the lack of economic opportunities in rural areas, a salaried position for women would be eagerly sought and all efforts made to hold on to it.

#### 9. CONTRACEPTIVE COSTS AND AGENT INCENTIVES

In any service delivery system that passes some cost onto the client, it is good to have some notion of the ability of the clients to pay. Community leaders and clinic staff were asked about an affordable price for contraceptives for couples in their community. Clinic staff proposed charges for one cycle of pills of an average M.53 (1 Maloti = US\$.44 at time of evaluation) the most frequent response was M.33 (M1.0 for three cycles). Among community

leaders who had an answer, the optimum price for a cycle of pills was on average M.50 the most common response was M.60 per cycle.

The optimum recommended price for a single condom was about M.05 according to clinic staff and M.15 according to community leaders. The data do not provide any insight to explain the range of responses.

For Neo-Sampon clinic staff recommended an average price of M.65 per tube with the majority recommending about M.50 per tube. Community leaders were not familiar enough with Neo-sampon to estimate a cost.

The information on contraceptive costs were collected a little differently from CBD agents. They were asked how much they charged and then asked to evaluate the customers' ability to pay. For pills, the agents indicated they charged an average of M.67 per cycle, with a range of between M.33 to M. 1.00 per cycle. For condoms, they charged an average of M.05 per condom. The average cost per tube of Neo-Sampon was M.57 with most agents charging M.60. Among agents that had access to foam the average charge was M.64 with M.60 being the most common charge. Almost all the CBD agents indicated the prices they charged were appropriate for their community, neither too expensive nor too cheap.

The cost of contraceptives paid by clients varied considerably like the charges made by the CBD agents. See Figure 1. The average cost paid per cycle of pills was M.51. Neo-samphoon cost an average of M.70 per tube.

Some of the variation in costs/charges is a function of an official change in prices. In August 1987 an agreement to standardize contraceptive prices was implemented by LPPA and the MoH. The old prices were M.60 per cycle, M.60 per tube of foaming tablets, and M.02 per condom. These were replaced by charges of 3 cycles for M.100, M.100 for two tubes of Neo-samphoon, and M.05 per condom. CBD agents who left the program before August 1987 would be expected to report the old prices.

FIGURE 1  
 REPORTED PILL COSTS (CLIENTS)  
 AND CHARGES (CBD AGENTS)

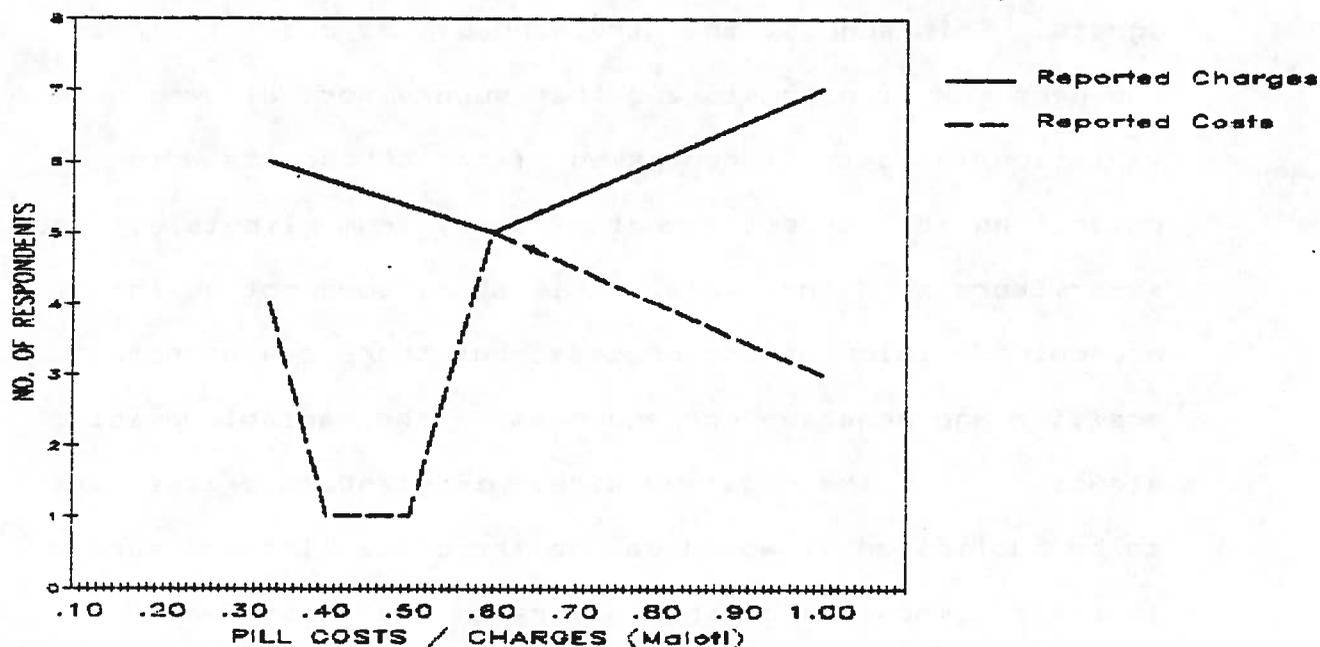
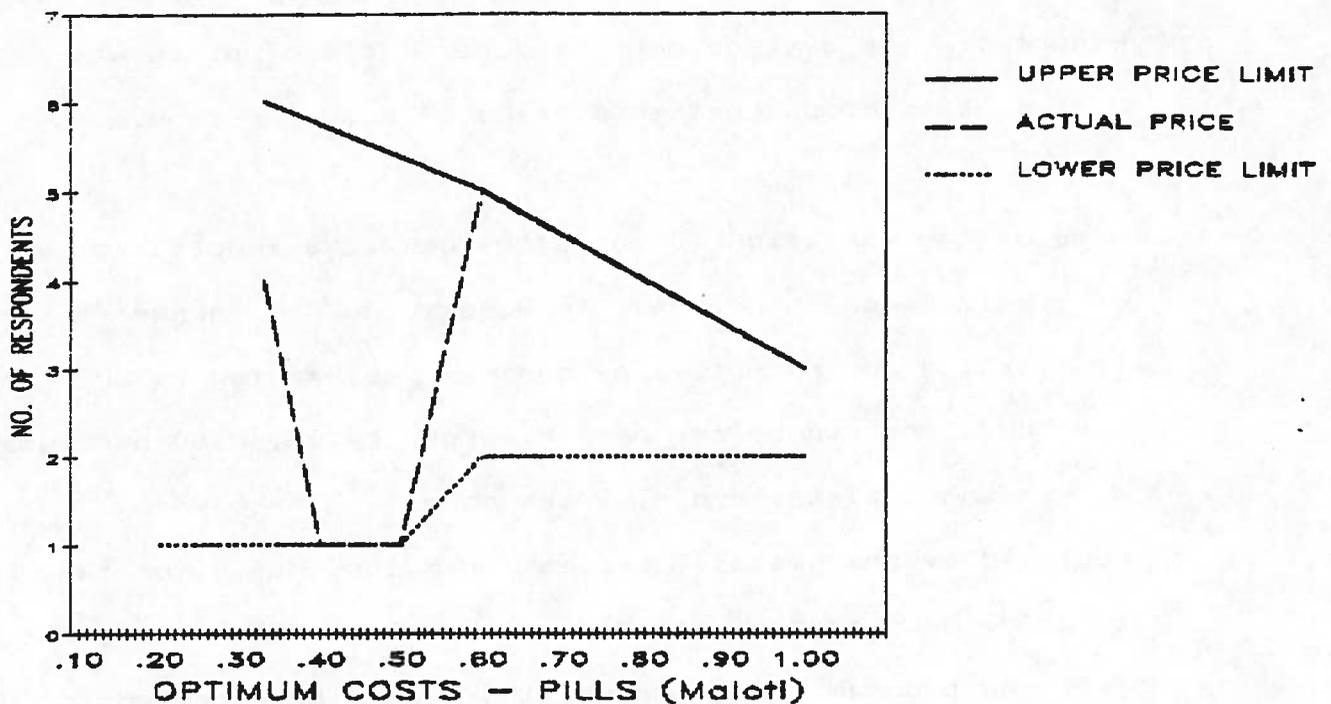


FIGURE 2  
**RANGE OF OPTIMUM  
 REPORTED PILL COSTS (ONE CYCLE)**



The review of the costing information points out two major issues. The first issue is that despite fixed prices for the commodities, there is some price variation among CBD agents. This suggests that training of CBD did not stress the need for fixed costs and that supervisors allowed some variation in costs. When asked if the CBD agents were collecting the correct amount of money from clients all four supervisors said they were. This study does not go into the economic decision making process, but there can be both positive and negative consequences of the variable pricing structure. On the negative side:- if standard prices were to be publicized it would damage the credibility of agents in their community; clients unsure of real costs may hesitate to use contraceptives until they can be sure what it will cost them; it can make record keeping more

difficult; and it can create problems in calculating the CBD agent's share of the sales. On the positive side the variable pricing structure can be used by CBD agents to help screen out would be clients who are likely to waste the commodities they buy; it allows for the variation in community economic status; it allows for changes in community demand for contraceptives (low cost where demand is being created and higher costs where demand is established). Variable cost may also result in higher income for the agent, which could result in a motivated and active agent. The information collected will not allow us to judge if the defacto variable pricing used in the LPPA CBD program was good or bad, but the issue of the costing structure of contraceptives should be seriously examined before there is any large scale expansion.

The second cost issue raised by the results of the evaluation is that current costs are considered reasonable (See Figure 2). The range of acceptable costs and the number of respondents who indicated costs were reasonable suggests that cost is not an issue in whether women accept or continue to use contraception. Furthermore, the price flexibility implied by the results suggests that cost recovery family planning activities like CBD and social marketing could be successful in Lesotho.

## 10. ACCEPTANCE OF CBD POSITION AND ROLE

The LPPA CBD Project was one of the first community based social services in Lesotho. In fact the entire family planning program in Lesotho is still in a pioneering stage. Given the lack of experience of LPPA in rural non clinic based service delivery and of the target population with fertility regulation and contraception, LPPA was extremely interested in the acceptability of CBD functions and services.

One issue of concern was the level of acceptance the community showed for the family planning role of the CBD agents. Although there is some evidence of resistance to family planning, direct questioning indicated general community support for the CBD agent.

Community leaders indicated their acceptance of family planning, because people in their community needed family planning first to space out their births and second to limit births in relation to available resources.

Clients indicated (by a factor of five to one) that they liked having contraceptives available in the community. About 20% of the clients indicated that they would not use if there was no CBD agent in the community to provide contraceptives. About 80% would go to clinics or more distant CBD agents for supplies. This is an interesting

indicator. It suggests that once recruited by a CBD agent, most women are motivated enough to continue to use even if the CBD agent stopped providing service.

Of the CBD agents, one-fifth indicated that they met with some resistance from their communities. Note that community acceptance in this context, refers to the function of the CBD agent rather than an acceptance of family planning. Almost all of the communities surveyed by the study accepted the new CBD role, but accepted family planning on a limited basis. Most of the agents who met resistance were able to ultimately achieve some community acceptance by patiently educating the community, getting support from leaders and field educators.

The field educators generally felt the CBD agents were accepted by the community.

One educator indicated that she lost a CBD agent because of harassment by the community. So although not a serious constraint to effective operations, developing community support should be considered in any expanded CBD effort.

The generally high level of community acceptance of the CBD agent (even when not accepting family planning) may be a result of the recruitment process which attempted to include the community in selecting one of their own members to serve.

Another aspect of acceptance of CBD agents in the community is the attitude of the family towards the CBD activities. The information from the study suggests that the family's attitudes towards the family planning role of CBD agent was a factor in the success of the agent. Field educators listed as one of the top three supervision problems the constraints put on the agents by their families. This was also given as a major reason why CBD agents quit. (3 out of 6). CBD agents also give family problems as their reason for quitting (4 out of 9).

The lack of support from the family appears to be a major constraint to effective CBD operations in Lesotho. The objections seem to come equally from husbands and in-laws. The information collected gives only a limited insight into the reasons for objections and this area may require further study. Future CBD activities may want to incorporate some efforts to generate family support for the CBD agent. These could include special programmes for family members, recognition of husbands by the CBD program, and IE&C efforts directed at promoting the social status of the CBD agent.

#### 11. THE CBD PROGRAM AND THE ROLE OF CLINICAL SERVICES:

For a variety of reasons the ties between CBD agents and clinical services in Lesotho were informal. CBD agents were not trained in clinics or by clinic staff. There was no formal program to introduce the CBD agent to the clinic

staff. The clinics were not encouraged to use the agents as motivators or to do any sort of follow-up. However CBD agents were expected to send new clients, clients wanting clinical methods and clients with medical problems, to the clinic. The Evaluation Team was interested in seeing if these informal procedures worked, if more formal procedures were required, and what procedures could facilitate greater co-operation between CBD agents and the health infrastructure. It should be noted that clinical services in Lesotho are offered by a number of organizations. The three most relevant to the pilot CBD areas are the Ministry of Health, the Catholic Church and LPPA. LPPA clinics were of course, responsive to the CBD Project needs. Catholic clinics do not provide family planning services so had no collaboration with the LPPA CBD agents. MoH clinics offered family planning services and in some cases collaboration with local CBD agents and in others refused to recognise the agents having any role in service delivery.

Most CBD clients reported they were encouraged by the CBD agent to go to a clinic (11 out of 17). Almost all had visited the clinic for health services and family planning. All that went got satisfactory service. Clinic personnel talked to 4/5 of the clients who went to the clinic about family planning. No problems using the clinics were reported.

To support CBD agents in the future, clinic staff recommended regularly informing clients of the availability of CBD services in their community. One other suggestion made by clinic personnel was that clinic staff should make regular visits to the CBD agents. This could facilitate the recognition of the CBD agent by the community, allow for training of CBD agents, improve the handling of clients' problems, and generally strengthen the ties between field and clinic based family planning service providers. They also felt that acceptability of contraception would be increased if the clinics could be used to train CBD agents.

To provide better family planning services in their own facilities, clinic staff suggested the need for a constant supply of contraceptives, more staff, and teaching aids. One of the clinical staff reported problems between LPPA and Ministry of Health facilities. Apparently MoH clinics have refused to serve clients from LPPA clinics in the past.

All clinical staff felt positively about CBD service delivery. Their reasons range from reduced cost of provision of services in the field, and inadequate clinical facilities, to the need to decentralize services.

In an effort to measure how much CBD agents rely on clinics, CBD agents were asked what they did with clients that wanted to use methods requiring a clinical visit. All first time pill users were sent to the clinic. All IUCD users were

sent to the clinic. Almost all women wanting to use injection were sent to the clinic. Two agents said they discouraged women using injection by telling them it caused infertility.

Despite the informal nature of the relationship, relations between clinics and CBD agents appears to be good. Family planning clients needing special attention are sent to the clinics regularly. Most CBD agents have some contact with a clinic. Although some seem to have regular contacts, while other have very limited contacts. Clinic staff seem to hold the concept of CBD agents in high regard and seem willing to consider CBD agents as clinic outreach workers. Clinic staff have a bias towards making CBD agents all purpose village health volunteers, but do not exclude family planning-only agents. The only problem appears to be an inability to integrate LPPA and MoH clients so that services can be received from the most convenient facility rather than where the client has received services in the past.

## 12. THE ROLE OF COMMUNITY LEADERS:

One issue which this evaluation was interested in was the actual and potential role of community leaders in developing CBD programs.

CBD clients were asked whether they had ever heard their community leaders talking about family planning. Half had

heard their leaders talk about family planning. One leader was opposed to it while the rest supported it.

Community leaders felt that they could contribute most by speaking out at community meetings. Presentations could cover both the role of the CBD agent and the need for family planning in the community. They also suggested that community leaders should be the first recruited to use family planning.

Field educators suggested that to get more support from community leaders, LPPA should support communications training, participation in planning, and use leaders to serve as CBD agents.

It is clear from the results of the evaluation that community structures play an important role in influencing behaviour. Likewise, it is clear that the perceived leaders of the community are an important part of that structure. It is also clear that the community leaders interviewed in this evaluation were generally favourable to family planning. In developing an expanded CBD project, several aspects of the potential role of community leaders should be examined. What types of leaders are most effective for the purposes of the program; should leaders be involved in attitude changing, educational efforts, service delivery or serve purely to mobilize the community for others; what kind of program inputs are required to get community leader

involvement; is leader support necessary for only the start up or throughout the entire project; and how does the program handle hostile leaders.

13. QUALITY OF SERVICES BY THE CBD AGENTS:

As a measure of CBD service quality, service recipients were asked to judge the quality of services provided by the CBD. All the clients indicated that they got good services. To clarify what was meant by good service the clients were asked to elaborate their answers. The responses were almost equally divided between the CBD agents provided; "good advice and explanations", "needed services" and they were readily available when the client wanted to contact the agent. The client's judgement that CBD services were "good" needs to be viewed in context. In rural areas where any services are difficult to get, the provision of even very limited services would be perceived as a major advance. The client's perspective is that when the choice is between no services and limited services, even the poorest services are "good". The "good" answer does not imply that the CBD services were high quality, only that they were available.

Service recipients also gave high marks to the quality of services provided by the clinics.

14. REASON FOR USE AND NON-USE OF FAMILY PLANNING:

In an effort to understand the reasons for use and non-use of contraception, several questions were asked of all respondents. It was hoped that future CBD efforts could take advantage of the perceived positive aspects of family planning and combat the negative impressions.

Women who got services from the CBD agents reported overwhelmingly that they used family planning to space births (14). Some also used it to prevent additional pregnancies (3) and one used to "keep husband at home".

CBD agents were asked why women in their service area would not use family planning. The major reason given was fear of side-effects (18). This was followed by family disapproval and fear of infertility. Other reasons for non-use include: "contraception promotes promiscuity, husband dislikes it, it is not effective, and there is so much misinformation that few women will use it because they do not understand how it works".

Clinic staff had some similar responses. Contraception causes promiscuity and fear of side-effects were the two main reasons given for non-use by clinic staff. Other less important reasons were: fear of infertility, religion, family objections, lack of understanding, and finally that it causes (1) and promotes (1) abortion.

Community leaders were asked why couples in their areas would not use family planning. The major reasons were side-effects ("illness, fatness, wetness, menstrual irregularities, circulatory problems") and it promotes promiscuity.

The clinic staff interviewed also reported a strong need for family planning in their service areas and a wide range of reasons why it was needed. The most common reason given was that families lack resources for child rearing. Also commonly mentioned was the need to help women space their children. Answers of lesser importance included preventing teenage pregnancies and illegal abortions.

It is clear from the reasons given for non-use of contraception that an incredible amount of misinformation on family planning is prevalent in most Basotho communities. This suggests a variety of program responses. Current programs have failed to provide adequate good information to overcome misinformation. Programs have failed to deliver information in a way that reaches the population in need of services. Traditional values which support high fertility have not been adequately addressed in current IE&C efforts. Future program efforts, including CBD programs may want to put major efforts into educating the population about family planning before actual service delivery becomes the main focus of program efforts.

## 15. CONTRACEPTIVE LOGISTICS

Logistics is a major area of management for any family planning program. Ensuring adequate supplies of contraceptives to far flung clinics or CBD agents can be an administrative nightmare. How do you get supplies to the distribution point. How do you avoid oversupply and storage problems. How do you project demand. How do you handle emergencies. These are all issues which LPPA had to consider in settling up the CBD Project. The Evaluation Team was interested in how effectively the logistics system operated.

CBD agents were asked about getting contraceptive supplies in an effort to see whether the logistics system was working. Of the 20 CBD agents interviewed, seven had run out of supplies at some time in the past. Six agents ran out of supplies more than once. Logistics problems also exist for the clinic system. Half the clinic staff interviewed reported that they had run out of contraceptive supplies at some time. Some were out of supplies at the time of interview (2 out of 9).

Clearly logistics problems exist in the current CBD Project. Since CBD agents are usually resupplied monthly, it suggests that buffer stocks held by the agents were not adequate to

meet fluctuating demands, or that the monthly resupply rule was often violated with the result that buffer stocks were depleted.

16. REASONS FOR DROPPING FROM THE CBD PROGRAM:

One of the indicators used by LPPA to evaluate the CBD program was the high CBD agent dropout rate. After three years almost half the trained CBD agent were not active. Almost half the interviewed CBD agents were not active at the time of interview. When asked why they dropped out the answers they gave provided an understanding of the pressures on the CBD Project.

- Husbands and/or family are opposed (4)
- LPPA took away kit (unhappy with record keeping) (2)
- Misunderstanding between field educator and CBD agent (1)
- Moved out of service area (1)
- LPPA turned area over to MoH (1)

To check on the CBD agent responses, the field educators were also asked why CBD agents had dropped out of the program. The pattern of responses between the two sets of respondents is very similar. The reason given by the CBD agent to the field educators include:

- Family does not support efforts
- No sales
- Illness in family
- Moved from service area
- Harassed by community
- Wanted salary
- Quit over supervision dispute

As we can see the agents have problems due to a lack of support at home, poor training and supervision and changes in program operation. Only the respondent who moved from the area had a reason for leaving the program which could not be solved by good management, supervision, or better planning. Efforts by the CBD Project to generate family and community support, develop demand for services, improve supervision and recruit better candidates might have been enough to keep all these women in the program.

One aspect of CBD agent drop-outs is the contraceptive use of the agent themselves. It could be assumed that agents that have used contraception may be more dedicated agents than those who have never used contraception. If this hypothesis were true it would suggest that one of the recruitment priorities should be a past/present use of contraception. Unfortunately the data do not support this hypothesis, as shown in Table 5. The data do not suggest that use of contraception influences CBD agent's duration in the position.

Table 5

CBD Agents Use of Contraception and Current Activity Status

Status	Ever Use	Never Use	Total
Active	7	4	11
Inactive	7	2	9
Total	14	6	20

#### IV. SUMMARY OF EVALUATION OF LPPA CBD PROJECT

##### 1. Recruitment of CBD Agents Procedures

- There were no systematic guidelines available for recruiting CBD agents. The lack of guidelines meant that different criteria were used in different areas. There is no evidence that the agents selected were incapable of doing the work. Although it is probable that more refined selection would have resulted in agents who would not have dropped out.
- Community participation in selection of CBD was considered important.
- The CBD agent characteristics considered to be most important are:-
  - Respectful of client privacy
  - Strong social skills
  - Good reputation in the community
  - Responsible to duties as a CBD agent
  - General availability to provide services
  - Well trained.

##### 2. Setting Up CBD Agent Service Areas

- The limits of the community to be served were never established or communicated to the CBD agents. As a result service areas just developed without preparation of the communities, the clients, and the agents. This is one aspect of the general problem of lack of work procedures. Because service areas and work procedures were never set, each CBD agent had her own work procedures, some good and some not, and all difficult to supervise.

##### 3. Preparation of the Community

- The CBD program had no planned or structured effort to prepare the communities in advance or after the placement of the CBD agent. As a result community preparation, leadership support and knowledge of the program varied from place to place. Since LPPA did not plan to do formal community preparation, they can not be criticised for not doing what they did not plan to do. However it is clear that any future CBD programs should have had a structured and formal strategy for incorporating community preparation.
- The general feeling was that community preparation could be managed through the community leaders.
- The use of community gathering was widely felt to be the most effective way of preparing the community and generally transferring information.

- The information from the evaluation suggests strongly that the use of community structures is essential for effective service delivery.

#### 4. CBD Training

- CBD agents were inadequately trained. They did not have enough information on contraceptive methods, work procedures, reporting, and no training in auxiliary skills like counselling, community organisation, and communications.
- No follow-up training was provided despite evidence of poor performance.
- The field educators who were to supervise the agents provided no training (and little supervision).
- The field educators are only marginally better trained than the agents and have no training in CBD supervision or management.
- No mechanisms were set up to train new agents recruited to replace drop-out agents.
- No reference materials were provided the agents at the time of training.
- Agents apparently received little training on the role of a CBD agent. This contributed to misunderstandings, job dissatisfaction and the subsequent high drop-out rate for agents.

#### 5. Scope of Work for CBD Agents

- LPPA provided no written or formal scope of work for CBD agents. As a result the supervisors had nothing from which to judge performance. The agents knew what they were suppose to do, but not how to do it.
- There is need for agents to incorporate a family planning educational function within their normal duties. This could be done by the agents by organising for others to do the actual education programs.
- The CBD Project very quickly became a depot program with clients coming to the house of the agent. There was a limited amount of house to house visits and more reliance on community gathering to recruit new users.
- The perceived responsibilities of the CBD agents were slightly greater than originally anticipated. Additional responsibilities included community family planning education, liaison with clinics, and liaison with community leaders.

- Participants in the evaluation indicated a strong preference for CBD agents to serve one community only.
- CBD agents generally provide services to all women who want them regardless of husband or family opposition.

6. Supervision

- There is almost no evidence of supervision in a management sense on the part of the field educators. What is called supervision is in fact resupply of contraceptives.
- Field educators had no training, instructions or procedures to guide their supervision of CBD agents.

7. Motivating CBD Agents

- To motivate CBD agents in their current non-salaried position the evaluation found such actions as; regular training, national recognition of the program, and T-shirts and other paraphernalia were strong motivational factors.

8. Cash Incentives for CBD Agents

- The current incentives (commission on sales) are not consistently applied, suggesting an equal lack of understanding on the part of the agents and the field educators.
- Salaries for CBD agents are perceived at the field level as the most significant incentive to performance. There is no data to suggest whether salaries would be cost effective.

9. Contraceptive Costs and Agent Incentives

- Some CBD agents are not charging the rates for contraceptive supplies set by the program.
- Prices charged were generally perceived to be affordable.

10. Acceptance of CBD Position and Role

- Community leaders generally approved of having a CBD agent in the community.
- Clients liked having easy access to services, and most would try to continue to use even if the CBD agent was not available in the community.
- There was some community resistance to CBD but over time it was overcome.

- Acceptance by the agent's family of the CBD role was more problematic than acceptance from the community. Family problems were a major supervision problem and reason for dropping out of the CBD Project.

#### 11. The CBD Project and the Role of Clinical Services

- There was no effort to link CBD and clinics services, although agents were trained to refer clients. Informal ties have developed.
- All respondents felt more formalized links between CBD agents and clinics would benefit both.

#### 12. The Role of Community Leaders

- Community leaders generally support family planning because of the link between fertility control and limited resources.
- The evaluation found considerable evidence that community structures are strong and that any effort to penetrate a community with services will have to take account of those structures.

#### 13. Quality of Services by the CBD

- There was general satisfaction with the services provided by the CBD agents. However this finding should be considered in context. There were no services available locally before the CBD program and there are not many options available to a rural woman who wants to use family planning. In this situation any service would be perceived as satisfactory.

#### 14. Reason for Use and Non-use of Family Planning

- The major reason for using family planning is to space births.
- Non-use is frequently the result of fear of side effects. Many of the perceived side effects are not real. Better counselling and IE&C should be able to reduce the negative influence of fear of side effects.
- The majority of reasons for non-use are the direct result of misinformation. This suggests that CBD agents do not have enough information and no skills in combating misinformation. It also suggests that larger national efforts in increasing knowledge and awareness of contraception have not been effective.

#### 15. Contraceptive Logistics

- The CBD program had an operational logistics system that usually worked. Unfortunately logistics systems have to work all the time to be effective. It also appears that

the efforts to keep CBD agents resupplied were done at the expense of supervision training and other program activities.

16. Reasons for Dropping from the CBD Project

- The major cause of agents discontinuing to provide services was a lack of support or even objection from the agent's family.
- Supervision problems were also an important reason for quitting the CBD Project.
- All the problems which caused agents to drop out of the Project could be handled by better supervision management, recruitment or planning.

## V. RECOMMENDATIONS FOR EXPANSION AND FUTURE DEVELOPMENT OF CBD PROGRAMS

The recommendations made in the following section were prepared by the authors. The recommendations are based on the results of the Evaluation, linked with observation and the experience of other CBD Projects. The purpose of providing recommendations is to facilitate the translation of evaluation findings into operational issues and encourage discussion of the issues. The reader is reminded that these recommendations were prepared in the absence of any plan for future modification or expansion of CBD activities in Lesotho. Once such a plan is available and project design and resources are known, many of the recommendations may become redundant or irrelevant.

### 1. CBD Recruitment

- Community selection of CBD agents should be used.
- The CBD implementing organization should have the right of review or refusal of any candidate.
- The CBD implementing organization should prepare clear written guidelines for use by the community in selecting a CBD agent.
- The community should be allowed some flexibility in applying the recruitment guidelines.
- Community leaders rather than program officials should organize the recruitment of agents.
- Characteristics to be considered in selection should include:
  - Maturity (25-55 years old with preference towards older women)
  - Responsible
  - Ever married
  - Should have children
  - Prefer ever users of contraception
  - Availability to provide services
  - Family supports CBD role
  - Agent can respect privacy of clients
  - Good social skills
  - Good reputation in the community.

### 2. Setting Up CBD Agent Service Areas

- Setting up service areas will depend on how the CBD program is designed - high density vs. widely dispersed agents, home visit vs. depot style service delivery. The general recommendation is to use a high density home visit CBD program. If this approach is taken, clear written guidelines will have to be prepared to help set up recognized service areas for each CBD agent. It is

unclear from currently available information exactly how big (number of clients) a CBD service area should be. Further study in this area is required.

- In the first phase of any new CBD activity agents should be placed in communities that have at least some access to a clinic facility which provides family planning. The general recommendation is that CBD services will be most effective in areas where clinic back-up services are at least perceived to be available.
- Policies and written guidelines will have to be prepared on the selection of areas for inclusion in the CBD program, and the division of these areas into individual service areas for CBD agents.

### 3. Preparation of the Community

- A manual on how to prepare a community for the introduction of a CBD agent should be prepared. The manual may need several versions for use by the program staff, community leaders and by the CBD agents.
- Community preparation should try to first involve community leaders and then use them to gain access to the rest of the community.
- Get higher leaders and people with credibility like the health service nurse to give prestige to the CBD activity.

### 4. CBD Training

- For CBD agents more training, better training and regular retraining are required. Training should stress contraceptive methods, counselling, communication, and community organizing.
- Agents should be provided a reference kit that allows them to review procedures and family planning information in their homes.
- Clinic staff should be asked to serve as trainers to facilitate co-operation between the agents and clinics.
- A standard training curriculum should be developed.

### 5. Scope of Work for CBD Agents

- CBD agents should have a written job description which covers their responsibilities, activities, and priorities.
- The educational functions of the CBD agent should be expanded in any new CBD efforts. The increased importance of the CBD agent's educational role should be

reflected in the training, materials provided, supervision and reporting.

- Consistent with an earlier recommendation to more closely link clinic and CBD services, a major activity for CBD agents should be liaison between clients and the clinic.

#### 6. Supervision

- The failure of supervision procedures in the current CBD program suggest the need for a totally new supervision structure.
- There should be written guidelines and checklists for supervisors.
- Supervisors should be trained in supervision.
- Supervisors should also be supervised.
- Careful consideration should be given to how supervisors are deployed to reduce travel time and costs and develop better working relationships with the CBD agents and the communities.

#### 7. Motivating CBD Agents

- A regular program of retraining should be used as a reward for service. Possibly specialized training can be used as a reward for exceptional performance.
- The CBD program should be widely promoted as a national development activity. This will raise the status of the project and the CBD agents in their communities.
- In designing new CBD efforts, support should be included for activities which build a strong sense of team spirit among CBD workers.
- Programs should be developed which promote family support for the CBD agents role in the community.

#### 8. Cash Incentives for CBD Agents

- Obviously salaried CBD agents would be the most effective way of providing contraception at the community level. However in light of resource constraints and issues of sustainability it is doubtful that salaries are an option for any CBD programs in the near future. However small honorariums should be considered.
- Commissions on sales should also be considered as a way of rewarding good performance and augmenting the honorarium. However a better management system will be required if the commission system is to be used.

- Other forms of non cash incentives should be incorporated in any new CBD efforts. These could include prizes for performance, increased official recognition of performance, etc.

#### 9. Contraceptive Costs and Agent Incentives

- The evaluation does not provide any insights on contraceptive costing strategies, but it is clear that there is an opportunity for the CBD program to consider cost recovery and partial self sufficiency in designing new programs. Further consideration and study on these issues are recommended.
- An expanded CBD program may want to consider procedures for waiving contraceptive fees for those who can not afford them. If this decision is incorporated in the CBD program, procedures should be written to guide field staff on how to identify candidates for free contraception. Also mechanisms will have to be built into the management information system to balance income and contraceptive distribution.
- A higher commission may be important if no other salary or honorarium is paid.
- A policy on the use of the sales income should be prepared.

#### 10. The CBD Program and the Role of Clinical Services

- The CBD program in the earlier phases of the project should be closely linked to clinic services. CBD agents should operate as family planning extension workers for the clinic, working in areas which have limited access to a clinic.
- Clinic staff should participate in CBD training to facilitate co-operation.
- A system should be set up to facilitate and encourage clinic staff to refer clients to local CBD agents for resupply.
- To avoid problems and maximize the impact of the CBD program, Ministry of Health clinics should be involved in the program from the start.
- The CBD program would be greatly facilitated if clinic staff could make occasional visits to CBD agents in their community. This activity can not require so much time from clinic staff as to hinder clinic operations, but an occasional field visit when possible could give the CBD agent credibility in the community and help resolve problems.

- To prevent logistics problems, clinics could serve as contraceptive depots for CBD agents. Clinics regardless of affiliation should be able to borrow supplies from other clinics. The record keeping system should allow borrowing with minimal administrative problems.
- All efforts should be made to integrate reporting from all service providers. However the reporting system must be flexible enough to allow each level to prepare the type of reports needed for their particular situation.

#### 11. The Role of Community Leaders

- The CBD program should recognize the immediate access leaders have to their communities. These leaders should be involved in the introduction of family planning services as early as possible.
- Special materials should be prepared for community leaders. The materials should cover such issues as population and resources, and family planning and its relationship to economic development, maternal health, child health, and family life.

#### 12. Reason for Use and Non-use of Family Planning

- Misinformation on all aspects of family planning from methods to purpose, is common. The provision of services, in the absence of a good family planning educational effort, is likely to fail to meet the needs of the people of Lesotho.
- If CBD agents are to be grassroots services providers they must be given the communication skills to combat misinformation.

#### 13. Contraceptive Logistics

- In an expanded CBD program, CBD agents should be given more than a one months supply of contraceptives. This would reduce the amount of resupply travel currently being done and reduce the occasional periods when supply lines are broken.
- A logistics management system should be a major component of the implementation of a new CBD effort.
- CBD agents should be provided storage boxes to allow them to keep a larger amount of supplies in a more protected environment.
- Clinics, both LPPA and MoH, should be able to resupply CBD agents. The use of clinics as supply depots may be an emergency or back-up measure or it could be part of the regular logistics system. If clinics are not

available to CBD agents, the program should consider using a central CBD agents as a supply depot for other agents in the area.

- A new CBD effort should develop a logistics and service reporting system that is relatively simple to operate and avoids most of the overcounting errors common in the current system.

#### 14. Reasons for Dropping from the CBD Program

- Since family problems were the major reason given for dropping out of the CBD program, new efforts should incorporate programs for the family. Examples include: performance prizes for couples, materials and training for husbands and recognition of family support by community leaders.
- The administrative and management causes for leaving the CBD program could be overcome by better training, good supervision, and more written performance guidelines. Keeping trained CBD agents should be a management priority, especially in a volunteer program.
- The entire supervision system for CBD agents will have to be redesigned for any new CBD efforts. Supervisors will need supervision and communications skills. The supervisor could be a paid position, with the CBD program as a major activity.

## APPENDIX

Annex is available at Lesotho Distance Teaching Centre (LDTC) on demand.



