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**QUALITY OF FAMILY PLANNING
COMMUNITY-BASED DISTRIBUTION
SERVICES IN MALAWI**



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EXECUTIVE SUMMARY

The National Family Welfare Council and JSI-STAFH implemented an analysis of the quality of family planning CBD services in Malawi. During February through April 1995 case studies of seven CBD projects were conducted. (One half of the total number in the country.) They were selected to provide an ethnic and geographic representation of the country.

Goal and Objectives

The goal was to provide comprehensive information on the selection, functioning and quality of CBD services in order to understand the strengths and weaknesses of the programs. The findings were to be used for the improvement and expansion of services and, as a baseline for future assessments of the CBD program.

The objectives were to assess the quality of services, program needs, and management of the projects; and to identify referral needs and mechanisms linking the CBD and clinic based services, community involvement, and the selection process of CBD agents.

Methodology

Case studies were conducted by a team of seven researchers. Focus group discussions were conducted of villagers and village leaders. In-depth interviews were conducted of CBD agents, clients, and CBD managers and family planning providers. Observations were made to assess the quality of the consultations and, records and supplies were examined of CBD agents and referral clinics.

SPSS was used to analyze the quantitative data.

Major Findings and Conclusions

The CBD projects were basically effective and contributed positively to the contraceptive prevalence rate in Malawi. The CBD agents exercised a major influence on villagers' acceptance of contraceptive use, and on the whole, were well received by their communities.

There were variations in the effectiveness and quality of the different CBD projects mainly due to differences in commitment of the CBD managers, support from the District Health Officer or NGO project managers, the quality of supervision, and sensitivity to specific cultural and geographical characteristics of the CBD catchment areas.

Although the CBD agents received little material incentives for their work, there was very low turnover. However, consistency of their work tended to decline after time. Regular field supervision of the CBD agents with corrective feedback by the CBD manager and project supervisor contributed to the continual and effective functioning of the CBD projects.

Sustainability continues to be a serious problem as, while the community members were willing to provide moral support, they were not willing to provide material support and had little means to do so. Projects mainly dependent on the government had difficulties because of the limited governmental resources. Those managers who were skilled in proposal writing and practiced efficient planning were able to procure non-governmental grants on a continuous basis and thus ensured the continuity of their projects.

While there was clear evidence that the CBD projects were making a positive contribution to family planning, the study identified several problems which must be addressed to ensure a steady improvement in the quality and effectiveness of the services. They are as follows.

Technical Competence and Safety

CBD agents had many misconceptions about the contraceptive methods. They did not understand enough about side effects to effectively help clients, and they did not sufficiently understand the screening check list to assure that information collected is accurate.

Quality of the CBD-Client Consultation

The amount of information currently required to be given by the CBD agent during the consultation may be too much. This could result in a first time consultation which is too long to ensure client retention of important family planning information .

Consultations were not always conducted in privacy nor was confidentiality ensured. Interpersonal communications were polite. However, there was not always sufficient active interaction between the client and CBD agent to ensure that the client understood the information or had all her/his concerns addressed. Scanty and sometimes erroneous information was given and little use of visual aids was made. .

Choice of Method

There was a bias toward oral contraceptives in terms of availability and information given. More information was given on pills than any other methods and they were more consistently available than the other contraceptives as well.

In general the contraceptive supply systems worked in each CBD project, but in a few cases individual CBD agents did not have foaming tablet or were in short supply of condoms. Stock-outs were mainly due to general national stock-outs. The success of the supply system depended to a great degree on the commitment of the manager.

CBD agents and husbands had much influence over contraceptive acceptability and the choice of method.

Administration and Management

CBD records were not kept properly nor consistently. This results in inaccurate national health statistics and an unreliable way to track clients for follow-up for either possible medical problems or unnecessary contraceptive discontinuation.

Supervision of CBD agents was irregular and inadequate due to insufficient material and human resources and/or lack of commitment of some CBD managers, supervisors and District Health Officers.

Mechanisms to Encourage Continuation of Contraceptive Use

Resupplying oral contraceptive users was, for the most part, carried out, but not in the most efficient and consistent manner. There was no systematic mechanism to follow-up potential clients who had been visited once but had not accepted contraceptive use on the first visit nor a system to follow-up contraceptive drop-outs. While there was a mechanism to make referrals to the reference clinic, there was little coordination between the provider and CBD agent to follow-up on referrals.

Many pill clients did not go to the clinic for the required physical examination for reasons including the distance from the village, fear of the examination, and lack of adequate clothing. The CBD agents continued to resupply pill users even though they did not present for their physical examination, so as not to discourage them from continuing use.

Appropriateness and Acceptability of Services

While in general CBD services were considered appropriate and acceptable to the community, accommodations to community needs could be improved. The CBD agents were generally accepted by the community also, but sometimes their level was too low to successfully complete the training.

Integration of family planning and HIV/AIDS

While villagers demonstrated a certain awareness of AIDS, their knowledge was superficial and they had many misconceptions. However, they were interested in learning more. There were two points of view concerning the appropriateness of CBD agents giving both family planning and HIV/AIDS messages, one was that it is perfectly acceptable and a good idea. The other was that it is inappropriate for one person to talk of both subjects because AIDS concerns promiscuity and family planning is a family matter. A multifaceted approach to community AIDS education is necessary.

The relation of the community to the CBD Project

The community network was vital to the success of a CBD program, but there were many weaknesses in the links which should hold it together. This resulted in lack of commitment of key players which frequently led to lack of necessary support for the CBD projects.

Sustainability

Sustainability of CBD projects was greatly hampered because all the projects depended on external funding and current economic conditions indicate that this dependence is likely to continue. There was no national budget for CBD program, as well as a lack of resources on district or local level to support CBD program. There was little commitment on village level to support CBD program.

Although the CBD agents were volunteers their drop-out rate was very low because they were highly motivated by their perception of the importance of family planning. However, they tended to slacken the pace of work as time went on and did express the desire for some material incentives as well.

Recommendations

Detailed recommendations are given at the end of the report for each dimension of quality studied.

LIST OF ABBREVIATIONS

CBD	Community Based Distribution
CHAM	Christian Hospital Association of Malawi
DHO	District Health Office
JSI-STAFH	John Snow Incorporated-Support to AIDS and Family Health
MOWCACS	Ministry of Women, Children Affairs and Community Services
MOH	Ministry of Health
NFWC	National Family Welfare Council
NGO	Non-governmental Organization
SDA	Seventh Day Adventists
SEATS	Family Planning Service Expansion and Technical Support

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SECTION ONE - INTRODUCTION

I. BACKGROUND

Access to Family Planning services has been a problem in Malawi. In response, a program to bring basic contraceptives (oral, foam and condoms) to rural areas through community based distribution (CBD) agents was initiated in 1991 by the SEATS project. The initial sites were started by the Christian Hospital Association of Malawi (CHAM) two hospitals, one in Malamulo in Thyolo district in the southern region and the other in Ekwendeni in Mzimba district in the northern region. In October 1991, a training of trainers was held at Malamulo hospital conducted by SEATS with fifteen trainers from the Ministry of Health (MOH), the Ministry of Women, Children Affairs and Community Services (MOWCACS) and participating NGO's.

As of January 1995, a total of eighteen CBD programs were being implemented throughout the three regions. The programs had similar structures. Each had a family planning clinic within the vicinity of the CBD catchment area which functions as a reference clinic. They had at least three paid positions, a manager, a supervisor and a family planning provider who worked out of the reference clinic. Sometimes the three positions were held by only one or two people depending on the size of the project. The projects varied in duration from six months to two years, and engaged anywhere from five to 103 volunteer CBD agents for catchment areas of varying sizes.

The CBD agents deliver family planning services mainly to rural communities who comprise 89 percent of the total population. They directly distribute oral contraceptives, condoms and spermicide (foaming tablets) to villagers. They refer potential clients to nearby health centers which offer Depo-provera, IUCD insertions, Tubal Ligations and Norplant where available. CBD agents are selected by the communities they serve and undergo a two week training in basic family planning service delivery. Following their training, the CBD agents are deployed to educate, counsel, screen, provide contraceptives and refer clients to the reference clinic when necessary. The CBD agents are expected to make home visits to recruit new clients and visit oral contraceptive acceptors every three weeks to resupply them and assist with problem solving.

In the beginning of 1995, with the introduction the JSI-STAFH project, additional resources were available to expand these services and plans were being made to develop National CBD Guidelines and a new CBD agent training manual. At that time the National Family Welfare Council (NFWC), and the MOH deemed it necessary to assess the CBD programs so that program expansion would be based on lessons learned from their experiences.

II. PURPOSE

The goal of the assessment was to provide comprehensive information on the selection, functioning and quality of CBD services and to use the findings for improving and expanding services, and as a baseline for future assessments.

The specific objectives were the following:

1. Assess quality of services.
2. Assess program needs.
3. Identify community involvement and the selection process of CBD agents.
4. Identify the referral needs and mechanisms between CBD and clinic based services.
5. Assess the management and administration of the projects concerning contraceptive record keeping, supplies, and supervision and sustainability.

III. EVALUATION METHODOLOGY

A. Scope and Timing

In-depth cases studies evaluating seven of the eighteen CBD projects. They were selected to include projects run by both governmental and non-governmental organizations and to provide an ethnic and geographic representation of the country:

Southern region:	Nsanje (Marie Stopes and DHO) Thyolo (Project Hope) Mangochi (DHO/MOH)
Central region:	Kabudula (World Vision) Salima (DHO/NFWC)
Northern region:	Ekwendeni (CHAM) Sangilo, Karonga (SDA)

The seven case studies took place from February to April, 1995.

B. Data collection

The case studies were conducted by a team of seven researchers using a combination of both qualitative and quantitative data collection techniques. All interviews were in-depth and lasted from one to two hours. Data was collected from the following:

- 22 focus groups comprising a total of 258 participants. In each of the project sites studies one focus group each was conducted of village leaders, male and female community members respectively. (In Thyolo two female community member focus groups were conducted because too large a number of women wanted to participate for one group.)
- 66 observation of CBD agents' consultations with their clients.
- 134 interviews with clients, including those both observed during consultations and unobserved.
- 79 (about 60%) interviews with CBD agents.
- 8 (100%) interviews with family planning services providers in referral clinics.

- 7 (100%) interviews with CBD Managers.
- Examination of records and supplies of CBD agents and the referral clinics.

The research team visited each project site for four days interviewing CBD agents and clients. They also accompanied the CBD agents on household visits where they observed consultations and administered exit interviews with the clients they observed.

To facilitate observations and to systematize the information, a set of data collection instruments were developed including an observation guide for the consultations, separate questionnaires for CBD managers, family planning providers in the referral clinics, CBD agents, CBD clients, two focus group discussion guides for village leaders and for community members respectively and a referral clinic check list for records, service statistics and supplies. (See annex)

C. Conceptual Framework

For the cases studies, eight dimensions of quality of services were examined. Studies have indicated a strong relationship between these dimensions of quality with clients' increased use of services, increased knowledge and satisfaction, and higher contraceptive prevalence.

- Technical competence and safety: capabilities of service providers, including, training, clinical skills, availability and observance of protocols, ability to correctly screen clients for safe contraceptive methods, supervision, etc.
- Information and counselling provided to clients: information given during service contact enabling clients to choose and employ contraception with satisfaction and competence. Information provides the facts that clients need to make decisions; counseling helps clients to make choices in light of their circumstances and reproductive goals;
- Interpersonal relationships: the nature of the communicating between service providers and clients;
- Choice of method: the number and types of modern contraceptive methods available through the CBD agents, and referral systems for methods that are locally available;
- Administration and management: Organization structures, supervision, record keeping.
- Appropriateness and acceptability of services: suitability of the services offered to the client's needs and preference, such as CBD agent/client ratios, convenience of services, venue of service, i.e. home verses clinic and;
- Mechanisms to encourage continuation: provision within the program to promote continued contraceptive use, i.e. return visits by CBD agents or arrangements for client to contact CBD agent, record keeping, etc.;

- (h) Relation of community to CBD program: community involvement in CBD agent selection, planning of program and implementation;
- (I) Sustainability of service/program: provision of financial and human resources made for long term implementation of program including logistics and supplies, budgeting, costs.

In addition to the nine dimensions of quality above, an assessment was made of HIV/AIDS awareness in the CBD catchment area and the role of the CBD agent in providing HIV/AIDS information.

D. Analysis:

Data from the questionnaires and observation guide were entered and analyzed with the use an SPSS statistical package. Focus group data was tape recorded, transcribed and translated. Results were analyzed from within and across projects.

SECTION TWO - EVALUATION FINDINGS

I. TECHNICAL COMPETENCE AND SAFETY

A. Training

All the CBD agents received two weeks of basic training which followed the *Child Spacing Reference Manual for Community Based Distributors*, developed for the Ekwendeni CCAP Child Spacing Project by the SEATS Project in 1991. CBD agents from Thyolo, Mangochi, Kabudula and Sangilo either had finished or were about to attend a refresher course at the time of this evaluation. Refresher courses were three or four days long.

CHART 1 TRAINING OF CBD AGENTS

	CBD agents trained	CBD agents working	Date of training	Refresher course
Nsanje	20	20	1994	0
Thyolo	Mianga 8 Comfosi 12	3 8	1993 1994	1993(all)
Mangochi	22	20	July 1994	0
Salima	13	13	Oct. 1994	0
Kabudula	20	20	Nov. 1994	Mar.6-10,1995
Ekwendeni	108 (female cbd's) 43 (male motivators)	92 32	1992 1993	0
Sangilo	5	5	Aug. 1993	Mar. 5-6, 1995

The CBD agents were asked what other information they needed in order to do their job well. The following were their responses, given in order of frequency mentioned:

Refresher courses or any other information available.

- No more information needed.
- Information on HIV/AIDS and STDs.
- How to administer other contraceptives, especially injections.
- Information during training should be given in more detail or more carefully.
- Visual aids should be provided, such as samples of contraceptives or posters to use during client consultations.

- Constant reminders, more information on how to counsel clients, how to use the tally sheet.

B. Technical skills

According to the *Child Spacing Reference Manual for Community Based Distributors*, the CBD agents must have the ability to:

- Give accurate information on contraceptive methods such as oral contraceptives, Depo-Provera, IUCD, condoms, spermicide, Norplant and surgical options.
- Correctly screen clients for hormonal contraceptives, using the screening check list.
- Correctly prescribe both combined and progesterone-only oral contraceptives.
- Identify side effects resulting from the use of contraceptives.
- Diagnose clients for referral to a health center when necessary.
- Maintain records.

1. Ability to give accurate information given on contraceptive methods

The data suggests that the CBD agents had a very limited knowledge of family planning and modern contraceptives. This limited knowledge was built into the structure of the CBD program because of the limited nature of their training and also because most agents had little or no contraceptive knowledge before being selected as volunteers. Data from the observations of the consultations and the CBD agent interviews revealed that the information which CBD agents gave to their clients was scanty, but mostly correct. The CBD agents were observed giving clients some erroneous information. They were also mistaken at times about what they had learned in their training. Below are some examples of inaccurate and erroneous information given to clients.

a. Oral Contraceptives

Some CBD agents gave confused directions on what to do if two or more pills were missed.

Some agents were confused about the relation of the pill to one's blood, for example:

"The reason for referral to a clinic is to check if the blood is O.K."

"The pill causes excessive bleeding."

"Lofeminol adds blood and vitamins."

There was confusion about when to use Ovrette or Lofeminol.

There were misconceptions about the effect of the pill on the uterus, for example are:

"Uterus can burst if the pill is used."

"The pill works on the uterine wall causing it to become thin."

There was confusion about side effects, for example:

"If you take the pill in the morning it can cause dizziness and nausea, so take it in the evening."

There was about the pill as a preventative for STD's, for example:

"The client should use the pill because she can 'meet' her husband, and it will prevent him from getting AIDS and her from getting pregnant."

There was confusion about the way the pill functions., for example,

"The pill suppresses the development of the male egg."

"Single strength pill increases the milk production for the baby."

b. Spermicide/Foaming Tablet

There was confusion about how to use the tablets and how they function. There was confusion about the amount of waiting time for foaming tablets: 10 hours, 6 hours, 30 to 40 minutes, 1 to 4 hours and its side effects. Examples are the following:

"The foaming tablet closes the cervix to stop the semen from passing through."

"It is inserted in the uterus."

"It is applied to the woman's sexual parts."

"You must wash down before inserting another foam tablet if you need another relation."

"It causes heavy bleeding."

c. Depo-Provera

There were claims that it "lasts for five years."

There was confusion about its effectiveness, for example: "Out of 100 users 4 women may get pregnant on the method." "Out of 400 users 1 may get pregnant." "In every 1,000 only 1 can conceive." "In every 100 only 3 can conceive."

There was confusion about the effect on health and body weight. "Some get healthy and fat." "You get slim, plus you have frequent periods."

"It causes heavy bleeding and dizziness." The CBD agent presented this as though it always happened rather than presenting it as a possible side effect.

d. IUCD

The CBD agent emphasized that the IUCD comes out with heavy bleeding.

"The IUCD is inserted in the vagina and makes it impossible for the sperm to meet the egg."

2. Ability to correctly screen clients for hormonal contraceptives, using the screening list

Three main problems with the screening check list were revealed by the observations of the consultations.

- CBD agents did not always use the screening check list for selection of the appropriate contraceptive.
- When some CBD agents used the check list they did not always read it clearly, and there was indication that they did not necessarily understand the questions themselves.
- They did not always verify that the client had understood the screening questions.

The observations revealed that clients did not always understand the questions in the screening check list. Sometimes they gave a mistaken answer which could have led to pill prescription when it was contraindicated or vice-versa. The CBD agents did not appear able to ascertain the client's understanding.

3. Ability to correctly prescribe both combined and progesterone-only oral contraceptives

The observations of the consultations and the CBD agents' interviews indicated that the agents could accurately explain the difference between Lofeminol and Ovrette and knew how to prescribe them correctly

4. Ability to identify clients' problems resulting from side effects of contraceptive use and refer them to a health center when appropriate.

The observations of the consultations and of the CBD agents' interviews indicated that the CBD agents were not able to handle side effects satisfactorily. They either dismissed them summarily or referred the client to a health center. Below is a summary of the data as reported by the CBD agents showing clients' complaints and the responses the CBD agents said they gave.

CHART 2: CLIENTS' COMPLAINTS ABOUT ORAL CONTRACEPTIVES AS REPORTED BY CBD AGENTS AND THEIR RESPONSES TO CLIENTS *

Clients' complaints	CBD's responses
Irregular menses: Heavy bleeding, spotting.	<ul style="list-style-type: none"> - It's temporary. - Go to the hospital. - If it continues, go to the hospital. - Change method. - Don't worry. - Reassure client and dispel her fears. - I don't know what to tell her. - That's how it's supposed to be. - Encourage her to continue until bleeding stops.
Abdominal pains.	<ul style="list-style-type: none"> - It's temporary. - Go to the hospital. - Encourage her to continue the method. - Not everyone has side effects. - If it continues, go to the hospital and change method.
Nausea.	<ul style="list-style-type: none"> - It's temporary. - Don't worry. - It's temporary, but go to the hospital. - If it continues, go to the hospital and change method.
Headaches.	<ul style="list-style-type: none"> - It's temporary. - Go to the hospital. - If it continues, go to the hospital and change method.
Dizziness.	<ul style="list-style-type: none"> - It's temporary. - It's temporary, but go to the hospital. - It's temporary, but go to the hospital and change method.
Breast milk stops.	<ul style="list-style-type: none"> - Continue breast feeding.
Amenorrhea.	<ul style="list-style-type: none"> - It's temporary, but go to the hospital for reassurance.

*Most frequently mentioned side effects in order of frequency from high to low.

**CHART 3: CLIENTS' COMPLAINTS ABOUT CONDOMS AS REPORTED BY
CBD AGENTS AND THEIR RESPONSES TO CLIENTS**

Clients' complaints	CBD's responses
Bursts.	<ul style="list-style-type: none"> - It's a misconception, a lie. - If condom is examined and put on properly, it won't burst. - Even if it bursts, it still can be removed.
Itches.	<ul style="list-style-type: none"> - Rub it out of your mind, it's a misconception. -- It's caused by the lubricant, but it isn't harmful. - Go to the hospital.
Causes sores or rash on penis.	<ul style="list-style-type: none"> - Don't keep the condom on after ejaculation. - Go to the hospital.
Lack of sensation.	<ul style="list-style-type: none"> - Will get used to it. - Just use it for one week as a back up for the pill. It is important
Not enough supply.	- N.a.
Encourages promiscuity.	- If a person wants to be promiscuous, it's in his heart.
Lubricant unpleasant.	- N.a.
Remains in vagina.	- N.a.
Too small.	- N.a.
Causes rash in vagina.	- N.a.

CHART 4: CLIENTS' COMPLAINTS ABOUT FOAMING TABLETS AS REPORTED BY CBD AGENTS AND THEIR RESPONSES TO THEIR CLIENTS

COMPLAINTS	RESPONSES
Penis itches after intercourse.	- It will heal soon; you shouldn't worry. - If you are allergic, go to the hospital. - Prove that happens first by trying. - Refer to the hospital for another method.
Man can't wait.	- Try to wait. - Continue using the method.
Causes heavy bleeding .	- No response given.
Man wants to have sex more than once.	- Continue inserting the tablets. - Consider changing methods.
Too wet.	- Then it is easy and doesn't need serious concentration.
Causes a rash.	- Go to the hospital.
Causes infertility.	- Go to the hospital.
Men disgusted with smell.	- It's true, but it helps men with warts.

CHART 5: CLIENTS' COMPLAINTS ABOUT TUBAL LIGATION AS REPORTED BY CBD AGENTS AND THEIR RESPONSES TO THEIR CLIENTS

Clients' complaints	CBD's responses
After they have had the operation they tell me their husbands want children.	- I tell her that she and her husband signed a paper beforehand.
Man can't get an erection .	- It's not true.
Women become promiscuous.	- It's not true.
Can die during the operation.	- No reason given.
After operation the wound hurts.	- It will get better soon.
Afraid of surgery.	- I give encouragement.

**CHART 6: CLIENTS' COMPLAINTS ABOUT INTER-UTERINE DEVICE (LOOP)
AS REPORTED BY CBD AGENTS AND THEIR RESPONSES TO THEIR CLIENTS**

Clients' complaints	CBD's responses
String disappears.	- No, it doesn't . - Go to the hospital. - Feel the string everyday and if it disappears, go to the hospital
Disappears in uterus.	- The loop is soft and has strings. It can't disappear.
Perforates uterus.	- There are no problems.
It goes to heart and you can die.	- It's not true.
Goes into stomach.	- It's not true.
Causes promiscuity.	- It's not true.
Causes abdominal pains.	- It's not true.
Husband feels pricks of string.	- It's not true.

5. Ability to diagnose clients for referral to a health center when necessary.

Evidence from client interviews indicated that the CBD agents were not referring clients in all required cases. According to CBD client interviews 51% were referred to a health center and 30.7% were not. 17.5% did not respond to this question. The Depo-Provera clients indicated that they were all referred to a clinic for injections. All pill users were supposed to have been referred for a physical exam, but according to the clients' reports, only 45.6% were. (See section entitled Mechanisms to Encourage Continuation for more information on client referrals.)

6. Ability to maintain records.

See the section on Administration and Management for a discussion of record keeping.

II. QUALITY OF THE CBD-CLIENT CONSULTATION

A. General context and setting of consultation

Community-based family planning consultations were conducted at the home of the client, either on the floor inside the client's small hut or outside on the narrow porch under the eaves of the thatched roof, or on the ground under a tree.

The consultations were not always private nor without interruptions. Often during the consultation the client was nursing one baby and distracting an older toddler, while at the same time trying to concentrate on what the CBD agent was telling her. Sometimes her husband was present. When the consultations were held outside, they were in plain view of neighbors who would greet the client and the CBD agent in passing; these passers-by even requested water or something else from the client, eliciting a response from her. Sometimes a neighbor sat down and joined the consultation either for a few minutes or until the CBD agent asked her to leave.

B. Criteria of Evaluation

To evaluate the CBD-client consultation the "GATHER" technique was used as criteria to judge the performance of the CBD agents. This is the technique taught during training, and it consists of the following instructions:

- G - Greet clients.
- A - Ask clients about themselves.
- T - Tell clients about child spacing.
- H - Help clients choose a child spacing method.
- E - Explain how to use a method.
- R - Return for follow-up.

This section of the report is based on the observations made of a total of 69 consultations conducted by 34 CBD agents. One research assistant observed each consultation, using a check list and taking notes of the counseling and information-giving interaction. Any non-verbal communication was noted, as well as other things that might have occurred during the consultation.

C. Comparison of quality of consultation by project

1. Project scores of quality of consultation

In order to compare the quality of consultations by project, a score was derived for each dimension of the "GATHER" process based on the observations of consultations. A point was given to each positive action observed based on the observation check list. The points were totalled under each dimension of quality and an average score for all agents in each project calculated. Below are two tables summarizing the scores. The first table contains scores for first-time visit consultations, and the second table for follow-up visit consultations.

TABLE 1: FIRST-TIME VISITS

CBD Project	Greet client (High score=6)	Ask client about themselves (High score=7)	Tell about methods (High score=10)	Help choose method (High score=8)	Explain method & refer (High score=11)	Total (High score=42)
Sangilo	3.86/ 64.3%	1.43/ 20.4%	5.86/ 58.6%	3.29/ 36.5%	5.57/ 32.8%	20.01/ 47.6%
Ekwendeni	4.0 / 66.7%	1.33/ 19.0%	5.67/ 56.7%	1.0/ 11.1%	4.33/ 25.5%	16.33/ 38.9%
Salima	3.5 / 58.3%	2.0/ 28.6%	4.5/ 45.0%	1.5/ 16.7%	4.0/ 23.5%	15.5/ 36.9
Kabudula	4.5/ 75.0%	2.25/ 32.1%	8.5/ 85.0%	5.75/ 63.9%	9.5/ 55/9%	30.5/ 72.6%
Mangochi	5.75/ 95.8%	5.0/ 71.4%	8.25/ 82.5%	5.0/ 55.6%	9.0/ 52.9%	33/ 78.6%
Thyolo	3.33/ 55.6%	1.33/ 19.0%	1.33/ 13.3%	1.67/ 18.5%	4.33/ 25.5%	11.99/ 28.5%
Nsanje	4.6 / 76.7%	1.5/ 21.4%	4.0/ 40.0%	2.5/ 27.8%	3.5/ 20.6%	16.1/ 38.3%
Total	4.33/ 72.2%	2.0/ 28.6%	5.39/ 53.9%	3.09/ 34.3%	5.52/ 32.4%	20.33/ 48.2%*

*average overall score for all projects combined

The data from the above table indicates several interesting findings.

1. The overall average score was low, 20.3 or 48.2% of the highest possible score.
2. The range of overall average scores was very wide from 28.5% to 78.6% of the highest possible score indicating quite a large difference in the overall quality of the consultation among projects. .
3. There were differences within each project of the scores for the specific performance indicators in the "GATHER" process which suggests uneven quality within a project.
4. There was a wide range of scores between the different performance indicators. The highest average score for all projects was "greeting clients" (72.2%), and the lowest average score for all projects was "ask clients about themselves" (28.6%).

2. Factors which influence quality of the consultation

a. Supervision

Quality of supervision appears to have had a strong influence on the quality of the consultation, especially frequency of supervision and the level of the supervisor. Mangochi and Kabudula had the highest overall scores and were the only two projects for which the CBD agents were supervised regularly two to three times a month by HSA's and at least once a month by the managers of the project who were also trained family planning providers. These managers also closely supervised their HSA's. In Thyolo with the lowest score, at the time of the study, the CBD agents had not been supervised by the manager for five months and the manager was not aware of when the Health Surveillance Assistants (HSA's) had last done any supervision.

b. Interval between Training and Fieldwork

The data suggests that the interval between training and the quality of performance are related. In the two projects with the lowest scores, Thyolo and Ekwendeni, there was a longer time interval between the time of the last training and the observations of consultations than in the other projects.

c. Commitment of Manager

Data from the in-depth interviews and observations of how the managers worked, strongly suggested that the personal commitment and interest of the manager to the project had an important effect on the quality of the work by the CBD agents and the two managers of the projects with the best consultation scores were both extremely committed and interested in their projects. Whereas the manager of the project with the lowest score had become frustrated and did not show much genuine interest in the project.

3. Factors which did not influence quality of the consultation

a. Education

Educational level of the CBD agents was not a clear indicator of the quality of their work as they all had about the same level. However, during the observations, it was possible to perceive quite a difference in their comprehension level by the quality of the information given

b. Gender

Gender of the CBD agents did not seem to influence the quality of the consultation as some of the best consultations observed were carried out by both male and female CBD agents.

TABLE 2: SUBSEQUENT VISITS

CBD Program	Greeting	Info/problems/diff method/stop/help	Total (High score=13)
Sangilo	4.00/66.7%	4.00/80.0%	8.00/61.5%
Ekwendeni	2.33/38.9%	2.33/46.7%	4.66/35.8%
Salima	5.0 /83.3%	4.0 /80.0%	9.0/69.2%
Kabudula	4.0 /66.7%	2.8 /56.0%	6.8/52.3%
Mangochi	1.0 /16.7%	2.67/53.3%	3.67/28.23%
Thyolo	3.43/57.1%	0.43/ 8.6%	3.86/29.7%
Nsanje	4.17/69.4%	1.5 /30.0%	5.67/43.61%
Total	3.38/56.4%	1.88/37.7%	5.26/40.5%*

*average overall score for all projects combined

D. Evaluation of Quality of Consultation by CBD agent

1. Greeting clients

The table below summarizes the data concerning the quality of the greeting and confidentiality.

TABLE 3: PERCENT OF CONSULTATIONS OBSERVED

	Yes	No	No answer	Total
Full attention	61/88.4%	4/5.8%	4/5.8%	69/100%
Polite	66/95.7%	0/0%	3/4.3%	69/100%
Greeted client	61/88.4%	3/4.3%	5/7.2%	69/100%
Introduced her/himself	34/49.3%	30/43.5%	4/5.8%	69/100%
Assured confidentiality	12/17.4%	47/68.1%	10/14%	69/100%
Privacy	31/44.9%	26/37.7%	12/17.4%	69/100%

The above data is from 69 observations of the consultations of 35 different CBD agents from all projects, and it demonstrates that the CBD agents were polite, greeted clients appropriately and gave them full attention. CBD agents did not always introduce themselves to new clients because they usually lived in the same village and already knew each other. When they did not

know a client they introduced themselves. Only two CBD agents were observed to abruptly begin the consultations without the proper introductions.

CBD agents assured their clients of confidentiality in only 12% of the consultations observed. Furthermore, they did not always hold the consultations in a place where there could be auditory and visual privacy. There was auditory privacy in only 44.9% of the consultations. While a private place was difficult to find in the village setting, the CBD agents could hold their consultations inside clients' houses. In addition, they could find polite ways to ask on-lookers to leave. There was no apparent reason not to have assured the client of confidentiality. In 22% of the consultations observed the husband was present. In these cases, the husband frequently dominated any discussion, and the wife looked on.

2. Ask clients about themselves

The table below summarizes the data on client information obtained during the observations of first-time visits.

TABLE 4: CLIENT INFORMATION OBTAINED

<u>Client Information</u>	<u>Number/percent of consultations</u>			
	Yes	No	Blank	Total
Age	17/51.5%	15/45.5%	1/3.0%	33/100%
Marital Status	14/42.4%	19/57.6%	0/0%	33/100%
# of Pregnancies	9/27.3%	23/69.7%	1/3.0%	33/100%
# of Births	1/37.5%	22/54.3%	1/3.0%	33/100%
# of Living Children	1/37.5%	22/54.3%	1/3.0%	33/100%
FP Use	5/15.2%	27/81.1%	1/3.0%	33/100%
Basic Medical Info.	2/6.1%	31/93.9%	No	33/100%

CBD agents were supposed to obtain the following specific information on all new clients: age, marital status, number of pregnancies, number of births, number of living children, family planning use, and basic medical information. The data shown on the above chart from the 33 observations of new clients revealed that the CBD agents did not collect the client information in any systematic way and left out much of it. As most of the information is supposed to be on the client card, this negligence resulted in incompletely filled out cards.

3. Tell clients about family planning

According to the *Child Spacing Reference Manual for Community Based Distributors*, the CBD agents are supposed to give the following information on family planning to the new clients during the first visit:

- Tell which methods are available.

- Tell where the method can be obtained.
- Ask clients what they already know about the methods.
- Correct clients' misinformation.
- Describe each method the client wants to hear about.
- Use visual aids and/or show examples of each contraceptive.
- Explain how the method works.
- Explain the advantages and benefits.
- Explain the disadvantages.
- Explain possible side effects.

The table below summarizes the data from the research assistants' check lists which they used when observing the consultations of CBD agents' first-time visits with new clients. A "yes" indicated only that the CBD agents said something under the rubric. It is not indicative of the depth or detail of the information.

**TABLE 5: INFORMATION GIVEN BY CBD AGENT
(NUMBER/PERCENT OF CONSULTATIONS)**

	Yes	No	Partial	No Ans.	Total
Methods available	30/90.9%	0/0%	3/9%	0/0%	33/100%
Where available	29/87.9%	2/6.1%	2/6.1%	0/0%	33/100%
Methods known	18/54.5%	15/45.5%	0/0%	0/0%	33/100%
Corrects client misinformation	11/33.3%	13/39.4%	1/3%	8/24.2%	33/100%
Describes method	20/60.6%	8/24.2%	2/6.1%	3/9%	33/100%
Visual aids	28/84.8%	4/12.1	1/3%	0/0%	33/100%
How works	20/60.6%	8/24.2%	3/9%	2/6.1%	33/100%
Advantages	12/36.3%	17/51.5%	4/12.1%	0/0%	33/100%
Disadvantages	8/24.2%	23/69.7%	1/3%	1/4.2%	33/100%
Side effects	3/9%	27/81.8	2/6.1%	1/4.2%	33/100%

The above chart demonstrates that in almost all the consultations information about which contraceptives were available (90.9%) and where they could be obtained (87.9%) was given. CBD agents did not explain all the methods in every consultation (see the section entitled Choice of Method). In only 60% of the consultations observed did CBD agents give any description of the methods or explain how they worked. In 54% of consultations the CBD agents asked clients

which methods they knew, and in the remaining consultations the agents merely gave out information without referring to any previous knowledge on the part of the client.

The CBD agents were weak in correcting misinformation or discussing the advantages and disadvantages of family planning and possible side effects. In 33.3% of the observed consultations the CBD agents corrected misinformation. In 36.3% of the consultations they discussed the advantages of family planning methods, and in 24.2% of the consultations they told of the disadvantages of the methods. CBD agents were observed discussing side effects in only 9% of the consultations.

In 84.8% of the consultations the CBD agents were observed using visual aids. This mainly consisted of showing samples of the methods they carried with them which were sometimes dirty and unattractive looking. Some of the CBD agents carefully showed the samples to the clients while others showed them quickly without paying much attention to whether or not the client had seen them or understood what they were looking at. Other types of visual aids were not readily available. When they were, the CBD agents did not use them very well.

The following tables show the information given on each method as reported by the clients.

TABLE 6: CLIENTS' REPORTS OF WHAT CBD AGENTS TOLD THEM ABOUT CONDOMS DURING THE CONSULTATION

Information reported	Number/percentage of clients
Client volunteered no information about condoms.	54/40.2%
Husband puts it on.	47/35%
CBD agent gave no information. Client said she wasn't interested or forgot.	11/8.2%
Condoms protect against leakage. Check for hole, pinch the end before putting on.	7/5.2% **
Condoms prevent semen from passing through.	6/4.4%
Use a condom only once.	5/3.7%
Throw it away (in toilet, dig hole).	5/3.7%
Use it as back-up for the first two weeks of taking pill.	5/3.7%
Man wears it when erect.	4/2.9%
Prevents pregnancy.	4/2.9%

*41% Responses total more than 100% because respondents gave more than one answer. **5 of these responses were given by alleged condom users.

TABLE 7: CLIENTS' REPORTS OF WHAT CBD AGENTS TOLD THEM ABOUT THE IUCD DURING THE CONSULTATION

Information reported	Number/percentage of clients.
Only said "You get it in the hospital."	17/12.6%
Just mentioned the name or showed it.	7/5.2%
No information given and was not shown it.	6/4.4%
Told "Inserted in the uterus in the hospital."	4/2.9%
Forgot.	4/2.9%
Inserted in the uterus.	3/2.2%

TABLE 8: CLIENTS' REPORTS OF WHAT CBD AGENTS TOLD THEM ABOUT FOAM TABLETS DURING THE CONSULTATION

Information reported	Number/percentage of clients
Didn't tell me anything.	11/8.20%
Insert it into vaginal canal.	10/7.46%
Clients gave various confused information.	9/6.71%
Insert in vaginal canal and wait 10 minutes/short time.	6/4.47%
I forgot.	5/3.73%

TABLE 9: CLIENTS' REPORTS OF WHAT CBD AGENT TOLD THEM ABOUT DEPO-PROVERA DURING THE CONSULTATION

Information reported	Number/percentage of clients
One injection every three months.	33/24.6%
Get it at the hospital.	14/10.4%
Forgot.	6/4.47%
She doesn't give it out.	4/2.9%
Shown vial but given no information.	4/2.9%
Other.	8/7.46%

TABLE 10: CLIENT'S REPORTS OF WHAT CBD AGENTS TOLD THEM ABOUT THE PILL DURING THE CONSULTATION

Information reported	Number/percentage of clients
Clients volunteered no information about pills.	37/27.6%
Only explained "take one pill daily".	26/19.4%
"Take one daily, and if you miss one you can take two the next time".	19/14.1%
"Take one pill daily" and one other item: ex. follow the arrows, use condom as back-up, side effects, miss a pill and will get pregnant."	13/9.5%
"Take one pill daily" and two other items: ex. two kinds of pills and use condoms as a back-up; two kinds of pills and if you miss take two the next time; follow the arrows and if miss take two the next time."	4/2.9%
"Take one pill daily" and three other items.	3/2.2%
Other (doesn't include any of the above).	15/11.19%

Tables 6, 7, 8, 9 and 10 suggest that either the clients remembered very little of what they were told about each method, or that they were told very little. However, it is interesting to note that there were a few exceptional CBD agents who gave much accurate information during the first-visit consultation. This suggests that other CBD agents may actually have the same ability to do so. Also note that the clients mainly remembered the way to use oral contraceptives which is the most essential information needed by pill users.

4. Help clients choose the method

According to the training manual, in order to help clients choose a suitable contraceptive, the CBD agent is supposed to ask the client if there is a particular method she would like to use. In order to determine if the choice is appropriate, the CBD agent is supposed to ask about the client's current family situation. The CBD agent is supposed to take similar steps when the client does not know which method she wants or if she is uncertain about the future. The agent is also supposed to ask which contraceptive is preferred by the person with whom the client has sexual relations. The table below shows the extent to which the CBD agents collected this information from the perspective clients.

**TABLE 11: QUESTIONS ASKED NUMBER/
PERCENT OF CONSULTATIONS**

	Yes	No	No answer	Total
If want specific method	30/90.9%	39.1%/	0/0%	33/100%
Plans/fam	14/42.4%	15/45.5%	6/18.1%	33/100%
Current Fam. Sit.	5/15.2%	22/66.7%	6/18.1%	33/100%
Partner wants	3/9%	24/72.7%	6/18.1%	33/100%

The observations of the consultations of first-time visits, as shown in the Table 11, revealed that the CBD agents usually asked which method the client wanted, but very frequently neglected the other questions. They did not try to determine if the method was appropriate for the particular social situation of the client. The open ended interviews and informal discussions suggested that the CBD agents assumed that the client would probably choose the pill. The reason CBD agents did not ask many clients the contraceptive preference of their husbands was that in half of these first-time consultations observed, the husbands were present. In these cases, she addressed both husband and wife together and then one or the other responded.

In general, the observers commented that the CBD agents were not asking for feedback from the clients to insure that the clients understood the family planning information. CBD agents asked clients if there was anything they didn't understand in only 27.2% of the first-time consultations.

The CBD agents are supposed to screen clients who choose a hormonal method in order to identify any contraindications. If the first method is determined to be unsafe, the agent should help the client choose another method. Generally, the CBD agents did use the screening check list for those clients who chose to use the pill. Observation of the consultations showed that in only 2 cases (8.3%) clients who had selected the pill were not screened as they were supposed to be. In these cases the CBD agent just gave the client a cycle of pills and told her she would return when the blister pack was almost finished.

In the consultations where the client had a contraindication the CBD agents did try to explain why the method was not safe. In a little over half of these consultations, they tried to help the client select a different method. However, the CBD agents had difficulty in effectively helping clients select a different method if the pill was not satisfactory. They did not give much information about the other methods and did not adequately discuss the situation with the client (See the section entitled Choice of Method).

5. Explain how to use a method

After the choice was made the CBD agent was supposed to give specific instructions on how to use the chosen method or how to obtain it if the agent did not have it. The data revealed that 70.8% of the new clients observed who chose a method chose the pill. 8.3% chose condoms as a method, 12.5% chose Depo-Provera, 4.1% chose spermicide and 4.1% chose tubal ligation.

In the cases where the client chose the pill, the CBD agents explained to the client how to take it. In 87% of the consultations observed, the explanation on use was correct, while in 16.7% some erroneous information was given (See section on Technical Competency).

6. Return visit for follow-up

The data indicated that in the majority of the consultations observed, the CBD agent told the client who had accepted the pill when he or she would return with a resupply. However, there was a strong tendency to say nothing about a return visit if the woman visited had not yet accepted a method. . The CBD agents also tended not to tell the client who chose Depo-Provera when to go for her injection or when to expect another visit. (Return for follow-up is further discussed in the section entitled Mechanisms to Encourage Continuation.)

III. CHOICE OF METHOD

The study revealed that all CBD project sites exhibited a bias toward oral contraceptives. They were more consistently available than other contraceptives and more information was given about them than any other method.

A. Contraceptive supply

1. Procurement systems

In all projects the contraceptive supply source was the District Health Office. If the District Health Office was in short supply, the CBD project would be affected. The CBD projects could have avoided some shortages by planning procurement ahead of demand and maintaining a buffer stock. But most of them did not plan ahead in any systematic way. Thus they did not always have condoms and foaming tablets on hand. However, the CBD agents generally had sufficient supplies of oral contraceptives; they only had severe stock-outs in 1994 when there was a problem in the entire country.

Projects implemented directly by a district hospital procured their supplies directly from the hospital stores. Sometimes no clear distinctions were made between contraceptives designated for the CBD project or for other service delivery points. For example, in Nsanje the CBD manager, who was also the District Community Nurse and the Family Planning Coordinator, took contraceptives from the hospital stores without designating whether they were for the static clinic or for the CBD project. In other cases a CBD project would request supplies specifically for itself, and the district hospital stores maintained separate procurement records for it.

In CBD projects implemented outside a district hospital, orders were made separately. The CBD project thus maintained its own supply obtained from the DHO upon need, and the project manager delivered them to the project office as well as to individual CBD agents.

Contraceptives were supplied to CBD agents in three ways:

- The supervisor brought the supplies to the CBD agent when on a supervisory visit. Supplies were issued either on a regular monthly basis when the supervisor "topped up" the CBD agents' supplies or upon request by the CBD agent.
- The CBD agents would attend a monthly meeting at an under-five mobile clinic where their supply was topped up. Supplies were brought from the project office or referral clinic by the CBD manager or other supervisor.
- The CBD agents would go to the project office or referral clinic when they needed a resupply.

2. Contraceptive supplies on hand at time of study

Table 12 indicates the number of cycles of combined pills and progesterone-only pills that the CBD agents had in their bags at the time of the interviews.

TABLE 12: NUMBER OF CYCLES OF ORAL CONTRACEPTIVES IN POSSESSION OF THE CBD AGENT AT THE TIME OF THE INTERVIEW OR VISIT

Number of cycles	0	1-3	4-9	10-20	21+	No Ans.	Total
Combined pills	8/ 10.1%	2/ 2.5%	21/ 26.5%	27/ 34.7%	5/ 6.3%	16/ 20.3%	79/ 100%
Progesteron e-only pills	8/ 10.1%	4/ 5.1%	18/ 22.8%	30/ 38%	3/ 3.7%	16/ 20.3%	79/ 100%

According to reports by the CBD agents, 50.6% perceived they had sufficient supplies, 10.1% reported they did not, and 39.2% did not answer this question. 72.2% of the CBD agents reported that they had no difficulty in getting resupplies, 16.5% reported having difficulties, and 11.4% gave no answer. CBD agents from Ekwendeni reported having more difficulty in obtaining supplies than agents elsewhere. Those who reported problems gave the following reasons:

- The supervising HSA did not bring enough supplies when he/she came to see the CBD agent.
- The supervisors did not always make their monthly visit because of lack of transport.
- The supervisor only brought supplies when requested. This resulted in a gap between the time the order was made and when it was filled.
- It was often very far for the CBD agent to walk to the referral clinic to obtain supplies. The CBD agent was required to go to the referral clinic when he/she had missed the supervisor's visit or when the supervisor had not come or where the regular procurement system required that the supplies be obtained from the referral clinic.

The data did not show any relationship between the distribution system and the supply the agents could maintain. In each of the projects where CBD agents were found without oral contraceptives, different distribution systems had been used.

TABLE 13: NUMBER OF CONDOMS AND FOAMING TABLETS AMONG CBD AGENTS AT TIME OF INTERVIEW OR VISIT

Number of pieces	0-10	12-30	40-70	80-101	150-300	No answer	Total
Condoms	16/ 20.3%	10/ 12.7	12/ 15.2%	19/ 24.1%	6/ 7.6%	16/ 20.3%	79
Foam tablets	36/ 46%	9/ 11.4%	9/ 11.4%	7/ 8.9%	1/ 1.3%	17/ 21.5%	79

An analysis of Table 13 reveals that the CBD agents were not carrying enough condoms or foam tablets/spermicide to assure a continuous supply for new or continuing clients. According to the CBD interviews, 34% of the agents gave out 10 condoms at a time and 48% gave out 20 condoms at a time. The data in the above table indicates that 48% of the CBD agents carried only enough condoms to distribute 20 each to fewer than 4 people; they could give out 10 condoms each to fewer than 8 people. The situation was worse for spermicide. CBD agents had even smaller supplies of foaming tablets, and 32.9% of the agents had none at all.

3. Contraceptives in stock at referral clinic

Table 14 on the following page indicates the following:

- The best supplied contraceptive methods were condoms and oral contraceptives, including combined and progesterone-only pills. All the clinics had them in stock. Except for Nsanje, however, there was only one formula of each oral contraceptive available. Thus if the particular formulas of Lofeminol or Ovrette were not satisfactory for a woman, there was no alternative, and she might discontinue using a contraceptive.
- Depo-Provera was the next best supplied contraceptive, although it was not available at Mangochi district hospital which has a very large catchment area. On the other hand, there were 900 vials of Depo-Provera at the smaller Kabudula Rural Health Center which has a smaller catchment area.
- Foaming tablets were not available in three health centers: Mangochi, Nsanje and Ekwendeni, while Thyolo district hospital had over 1,000.
- IUCDs were not available at two clinics. In all clinics family planning providers said there was little demand for them. Some had not inserted one for such a long time that they were not sure they still had the skill to do so.
- Norplant was only available at Ekwendeni.

TABLE 14: CONTRACEPTIVES IN STOCK AT REFERRAL CLINIC AT TIME OF STUDY

	Sangilo ¹	Mango-chi ²	Kabu-dula ³	Thyolo ⁴	Nsanje ⁵	Salima ⁶	Ekwe-ndeni ⁷
Lofeminol (Cycles)	300	1,100	423	262/74	784	210	100
Ovrette (Cycles)	75	9,200	634	900/253	3,158	412	600
Microgynol (Cycles)	0	0	0	0/0	60	0	0
Condoms (Pieces)	200	59,500	232	300/168	11,584	516	2,100
Depo-Provera (Vials)	219	0	904	89/19	21	149	116
IUCD (Ctu)	20 (expired)	80	34	0/0	20	10	21
Foam tablets (Pieces)	150	0	200	1,200/60	0	498	0
Norplant	0	0	0	0/0	0	0	16

1Sangilo Health Center, 2Mangochi District Hospital, 3Kabudula Rural Health Center, 4Thyolo District Hospital/Mianga Health Center, 5. Nyamithuthu Health Center/Salima District Health Center, 7Ekwendeni Family Planning Clinic in Mission Hospital

B. Number of contraceptives CBD agent gives

The amount of contraceptives given to a client at one time influences availability which in turn influences choice. On the first visit the CBD agent usually gave one cycle of pills to clients who selected oral contraceptives as a method. On subsequent visits the agent sometimes gave more. There was a tendency to continue to give only one cycle and to visit the client each month. This could have accounted for the small number of pills the agent had at any one time.

Giving only one cycle at a time could have important implications on contraceptive continuation. It could have a negative influence, as it requires monthly visits. If the CBD agent missed a month, and the client did not go to the CBD agent herself, she might discontinue use. In addition, if the CBD agent spent all her time resupplying clients monthly, she would have little time to visit potential new users or to make return visits to interested people who had not yet made the decision to start use. Further data is needed to confirm whether or not this affects the currently high discontinuation rates.

The CBD agents had been instructed to give new acceptors of oral contraceptives either 10 or 20 condoms at a time as a backup method during the first two weeks. They gave the same number of foaming tablets.

C. Methods used by clients

85% of the CBD clients interviewed were using a method, and 15% were not. The table below shows their contraceptive use by method.

TABLE 15: CONTRACEPTIVE USE OF CBD CLIENTS INTERVIEWED

Method used	% of clients interviewed using method	% of clients told about method
Non-users	15%	--
Pills	59.7%	72.00%
Depo-provera	16.4%	63.00%
Condoms	5.2%	59.00%
Tubal ligation	1.5%	12.00%
Foam tablets	0.7%	34.00%
Norplant	0.0%	04.00%
Diaphragm	0.0%	01.00%
Vasectomy	0.0%	.74%
Female condom	0.0%	.74%
IUCD	0.0%	40.00%
Status unknown	1.5%	1.5%
Total clients interviewed	100.00%	100%

D. Factors influencing clients' choice of method

1. Influence of CBD agent on choice of method

There is evidence that the structure of the CBD program as well as the CBD agent her/himself has much influence on the client's choice of method. CBD clients chose the pill most frequently, while according to national statistics, Depo-Provera is the method of choice in static clinics. The data suggests the following reasons for this:

- According to the interviews with CBD clients who use contraceptives, 34.2% chose the pill either because it was the only method they were told about or given, or because it was available. 26% chose it either because it was easy to take or they like it. 7% reported they chose it because it is effective.
- The data suggests that the information given influenced the choice of method. Table 15 indicates that the information the CBD agents gave was biased towards the pill, and that was the method most frequently selected by clients. In order of frequency, clients reported being given information about pills (72%), Depo-Provera (63%) and condoms (59%). This was the same order of frequency for method choice. The only exception was that 40% of the clients reported being told about the IUCD, but none of them used it. The observations of consultations indicated that the actual information given about the IUCD did not encourage use, as CBD agents would usually just show a dirty IUCD to the client which he/she carried around in her bag as a sample and tell her it is inserted into the uterus.
- The visit of the CBD agent appeared to have a strong impact on the initiation of contraceptive use by the clients. 86% of the CBD agents reported that their clients had not chosen a method before their visit. Only 8.8% of clients had already chosen a method. The client interviews indicated that 76.3% of clients using contraceptives began using them when the CBD agent visited them. 40% of these reported that they decided to use a method at the time of the CBD visit; the remaining 36% had already decided to use a method, but selected and began its use as a result of the CBD agent's visit. Only 11.4% of the contraceptive users reported that they had already begun using a method before the CBD agent's visit. 39.5% of the contraceptive users reported that they would not have started using contraceptives if not for the visit of the CBD agent, and 35% said that they would have started using them, but took advantage of the visit to begin their use of contraceptives.
- Most CBD clients had chosen the pill, but at the static clinics most clients have opted for Depo-Provera. This suggests that the choice of method was influenced by the direct availability of the pill. It is not clear whether more CBD clients would have selected Depo-Provera if CBD agents were able to give the injection at the client's house.

2. Influence of others on contraceptive choice of CBD clients

Clients were asked who influenced them the most in their decision to use contraceptives. Their responses are shown in Table 16.

TABLE 16: THE PERSON WHO INFLUENCED THE CLIENT THE MOST IN HER DECISION TO USE CONTRACEPTIVES

Most influential person	Contraceptive users
Myself	34/29.8%
Husband	18/15.7%
Decided together	14/12.8%
CBD agent	25/21.92%
Clinic/other health personnel	12/8.7%
Friend	8/7%
Other (radio, mother, aunt, sister)	6/5.2%
Total	114/100%

The responses of the contraceptive users indicated that in addition to the client's own decision making power, the CBD agent and the clients' husbands had more influence than clinic or other health personnel, friends or relatives.

Of all contraceptive users, 92/80.7% discussed contraception with their husband before they began a method, and 8/7% did not. Of the eight clients who did not discuss contraception with their husband, five reported that their husband did not know they were using contraceptives, one reported that her husband was aware of her contraceptive use, and the other two did not respond to this question.

The number of non-users in the population interviewed is too small to make generalizations about them. Of those who were not currently using and who did not intend to start using in the near future, 4/28.5% reported that they had not used contraceptives yet because they had not discussed it with their husbands.

IV. ADMINISTRATION AND MANAGEMENT

A. Administrative structure and commitment to CBD project

All the projects had a basic administrative structure consisting of a CBD manager or coordinator, CBD supervisor(s), usually HSA's and CBD agents. Each clinic is required to have a family planning reference clinic in the vicinity of the CBD catchment area where the CBD clients are referred when necessary. In all projects there was a direct hierarchical link between the manager, supervisors and agents respectively. In most of the projects there was also a direct link between the CBD manager and the family planning provider in the reference clinic..

The structure of the projects did not vary enough to allow the assessment of the influence of institutional structure on quality of services. However, the data clearly suggested that those projects where the project managers and their superiors, had much personal commitment to the value of the CBD program, more resources and time were allocated to the program and it functioned better than where there was little commitment. In addition, where family planning providers had an active role in the administrative structure of the project, especially functioning as supervisors to the HSA's and directly to the CBD agents, , the quality of services was better than where they only played a peripheral role.

B. Record keeping problems

CBD agents of all the projects were supposed to keep the following records: register book, tally sheet, client card and referral letter. (See annex for copies of all but the register book.) They had many difficulties with all of these, and they are discussed below.

1. Register book

The register book is the document for recording all client consultations. It has columns for the client number, name, contraceptive chosen, number and type of contraceptives dispensed, and date for return visit.

In order to determine the effectiveness of the CBD agent, the interviewers were asked to record from the CBD agents' register books the distribution of contraceptives for the last three months. In almost half of the instances, 47%, it was not possible to do so accurately because of the incomplete records found in their registers. Such insufficient data on this level will result in the impossibility of compiling accurate contraceptive health statistics on the district and national level. Table 17 shows the degree to which the charts could be completed.

TABLE 17: COMPLETION OF CHART OF PAST THREE MONTHS CONTRACEPTIVE DISTRIBUTION

	Chart Completed	Chart Partially completed	Not Able to make chart at all	No Answer	Total
Nsanje	7/70%	1/10%	1/10%	1/10%	10
Mangochi	4/44%	0	2/22%	3/33%	9
Thyolo	2/22%	1/11%	3/33%	3/33%	9
Kabudula	5/38%	2/15%	3/23%	3/23%	13
Salima	4/40%	3/30%	3/30%	0/0%	10
Ekwendeni	5/20%	6/25%	10/41%	3/12%	24
Sangilo	1/25%	1/25%	1/25%	1/25%	4
Total	28/35%	14/18%	23/29%	14/18%	79

Of all the CBD agents interviewed only 35% had enough data in their register book to allow the interviewer to record completely the last three month contraceptive distribution. 17.72% had enough information to partially record the last three month performance. 29.11% had so little information in their register that it was not possible to glean anything accurately on the last three months performance. 17.72% had no answer to this question.

There was a difference of performance between projects. The project with the best performance was Nsanje with a 70% completion rate, followed by Mangochi with 44% completion rate and Salima with a 40% completion rate and Kabudula with 38%. Sangilo with 25% came next then Thyolo with 22% and Ekwendeni which had the lowest completion rate of 20%.

The data suggested that the CBD agents were not aware of these problems with the register book. Although only 35% of the agents filled out their register books adequately, as many as 68% of them reported that they did not have any trouble filling out the books. The widest discrepancy was in Ekwendeni where 70% reported they had no problems, but only 20% of their charts could be completed.

The data also suggested a lack of awareness of this problem on the part of the CBD managers. Interestingly enough, the CBD manager of Nsanje was the only one who reported that the CBD agents had problems with filling out the register although Nsanje had the best performance. The other CBD managers never mentioned any such problems. The CBD manager of Ekwendeni reported that during supervision the register is checked, but she only cited problems with the tally sheet, not with the register.

72% of all the CBD agents kept their record book clean and in good condition, and 87.5% of the books examined were in good condition.

There were many inconsistencies in the filling out of the register book as follows:

- CBD agents did not register every client transaction in the register book.
- CBD agents would register the client in the book but not write in the method chosen.
- CBD agents did not always write in the register book the kind and number of contraceptive actually given to the client. This includes pills, condoms, and spermicide.
- Records were sometimes deliberately not kept of clients who selected Depo-Provera.

The data suggested several reasons for the above inconsistencies such as forgetfulness, simple negligence, and/or a lack of understanding of how to keep the register. One reason reported for not writing the number of condoms distributed was that the person only used it as a backup. Others reported not recording the distribution of Depo-Provera because, "since the client goes to the hospital for the injection, they don't have to keep track of her."

2. Tally sheet

The tally sheet provides a summary of the data in the register book. Clients' names are not entered, but the number of clients and the number of contraceptives distributed per month is recorded. Each CBD agent's tally sheet should be included in the summary of the data for the performance of all the CBD project's agents which is sent to the District Health Office or to the NFWC.

Many CBD agents made errors on their tally sheets. CBD managers reported that there had been some improvement as a result of close supervision. However, if the CBD managers were not aware of the errors and inconsistencies in the register books, they must not have been aware of errors in the tally sheets as well, since the tallies were summaries of the records in the register book.

3. Client Card

On the client card is registered the name, address, age and parity of the client and name of the CBD agent. Also registered is the screening check list, the date of current and subsequent visit, the method chosen, and referral.

The client keeps the card herself. Observations of the consultations indicated that the CBD agents did not always fill out the client card.

4. Record Keeping for Referrals

The following were the two main problems with record keeping for referrals. A more detailed discussion of referrals is found in the section entitled Mechanisms to Encourage Continuation.

- The CBD agents did not have a system for registering in their record book when they had referred a client to a clinic and whether the client had actually gone to the clinic or not. This was only indicated on the client card which the client kept herself.
- Except for Ekwendeni, referral clinics did not keep separate records of CBD referrals. Thus there was no way to ascertain from clinic records the number of CBD referrals. When a client came with a CBD card and/or referral letter it was merely returned to the client to bring back to the CBD agent.

C. SUPERVISION

In all the CBD projects the project manager or coordinator supervised the field supervisors who directly supervised the CBD agents in the villages where they worked. In all the projects, except Ekwendeni, the supervisors on the village level were HSA's. In all the projects but Sangilo, the CBD managers were trained nurses of varying levels with some family planning training. In Sangilo, the clinical officer was officially the CBD manager, but at the time of the study, he had recently arrived and was not involved in the CBD activities at all. SDA was managing the project from their hospital in Malamulo in Thyolo District. The CBD supervisor was a Home Craft Worker who had been trained with the CBD agents and had an additional training in supervision at the same time.

According to the interviews with the CBD managers, all the CBD agents were supposed to be supervised by someone on the level of the CBD manager or family planning service provider at least once a month and by the HSA's a few times a month. In Sangilo, the Home Craft Worker functioned as a higher level supervisor although she did not have the qualifications.

1. Quality of supervision

For this study, the quality of supervision will be defined according to the ratio of supervisor to CBD agents, the qualifications of the supervisor, the type of supervision (group or one to one), the frequency of supervision and the type of interaction which occurs between the supervisor and CBD agent and the content of the interaction.

Chart 7 shows the ratio of supervisors to CBD agents, the qualifications of the supervisors, the type of supervision (group or one to one) and the frequency of supervision as reported by the CBD managers.

CHART 7: SUPERVISION AS REPORTED BY CBD MANAGERS

	Ratio Sup/CBD	Type of super-visor	Mobile clinic (group)	One to one	Frequency
Sangilo	1:4	HCW*		X	1 x wk.
Ekwendeni	1:51.5	1 mgr.** 1 prov.***	X		1 x mo.
Salima	1:2.6	2 HSA 1 mgr./ 1 prov.	X	x	1 x mo. 1 x mo.
Kabudula	1:4	3 HSA 1 mgr./ 1 prov.	X	x X (at mobile clinic)	2-3 x mo. 1 x mo
Mangochi	1:5	4 HSA		X	2-3 x mo.
Thyolo	1:2.6	5 HSA 1 mgr.		X X	CBD mgr. does not know -- 5 mos. ago.
Nsanje	1:6.6	2 HSA		X	1 x mo

* HCW = Home Craft Worker ** mgr = manager *** prov. = provider

a. Ratio of supervisor to CBD agents

The above table shows a wide range of ratios between number of supervisors and CBD agents: the highest ratio was 1 supervisor per 2.6 CBD agents; the lowest ratio was 1 supervisor per about 51 CBD agents. The majority of projects had ratios between 1 per 4 and 1 per 6.

b. Qualifications of supervisor

According to the CBD managers the CBD agents were supervised by various combinations of CBD managers, family planning providers, Health Surveillance Assistants (HSA's) and a Home Craft Worker. In Salima, Kabudula and Thyolo the CBD manager or a family planning provider and HSAs were reported to supervise the CBD agents directly. In Mangochi and Nsanje only the HSAs were reported to supervise the CBD agents directly, the CBD managers supervising the HSAs. In Ekwendeni only the CBD manager and a family planning provider supervised the CBD agents. In Sangilo a Home Craft Worker provides supervision of the CBD agents.

The CBD agents were also asked what the position was of the person who supervised them. The table below summarizes their answers.

TABLE 18: SUPERVISORS POSITIONS AS REPORTED BY CBD AGENT

FP PROVIDER	CBD MGR	HSA	NO ANS.	TOTAL
10/12.6%	12/19%	38/48%	17/24%	79/100%

According to the interviews with CBD agents the largest percentage of them, 48%, were supervised by HSA's 27.8% were supervised by a higher level person, either a family planning provider or the CBD manager. The CBD agents at Sangilo must not have been aware that their supervisor was a Home Craft Worker, as two indicated that they were supervised by a family planning provider. The answers reflected the CBD agents' perception of the qualification of their main supervision.

c. Frequency of supervision

The data revealed that supervision on the level of CBD manager or family planning service provider was irregular. In Thyolo and Salima the CBD managers reported gaps of two to five months in their supervisory visits. In Nsanje and Mangochi the CBD managers reported they did not supervise the CBD agents directly. They only supervised the HSA's.

74.6% of the CBD agents reported in the interviews that they had ever been supervised, and 11.3% reported they had never been. (14.1% of the CBD agents did not answer this question.) This lack of supervision was reported in Sangilo (1/25%) and in Ekwendeni (33.3%). In Sangilo this report contradicted that of the CBD supervisor who indicated that she supervised all four of her CBD agents. In Ekwendeni the CBD manager was concerned that many CBD agents were not being supervised. Either they didn't come to the mobile clinic or she could not go all the way to their villages because of the distance, bad roads and lack of transport.

The reports of the CBD agents confirm a greater frequency of supervision from HSA's than from CBD managers/providers. This suggests that the system of HSA supervision was functioning as planned by the project management. According to the CBD manager reports, all CBD agents, except those in Ekwendeni, were supervised by someone at least once a month. In cases where HSA's were supervising, the frequency was greater than once a month. 41% (n=33) of CBD agents reported being supervised within the past two weeks. Of those, 87% (n=29) had been supervised by an HSA, whereas only 12% (n=4) had been supervised by a CBD manager or family planning provider. Those supervised the least frequently were in Ekwendeni where HSA do not carry out supervision.

d. The type of interaction and content of supervision

According to the CBD managers, CBD agents received supervision on a one to one basis or as a group, or both. In Salima and Kabudula the agents had both group and one to one supervision by the managers and HSA's. In Thyolo the same was supposed to occur, but the CBD manager had not supervised for over 5 months. In Ekwendeni CBD agents only had group supervision implemented by the CBD manager or provider. In Mangochi and Nsanje supervision was done on a one to one basis by the HAS. In Sangilo supervision was provided by a Home Craft Worker on a one to one basis.

The data indicated that the supervision was useful. When asked to evaluate the supervision, 81% of the CBD agents reported it was helpful and 82.2% reported that they told their supervisor about problems they had encountered and she/he helped to solve them.

The table below indicates what the supervisor did when he/she came to supervise as reported by the CBD agents.

TABLE 19: WHAT SUPERVISOR DID ACCORDING TO CBD AGENT

TASK CARRIED OUT	NUMBER/PERCENTAGE OF CBD AGENTS GIVING RESPONSE
Resupplies contraceptives	21/26.5%
Checks record books, register and/or tally sheet	20/25.3%
Discusses problems	18/21.5%
Accompanies CBD agent on home visit	13/16.4%
Collects reports	12/15.1%
Finds out number of clients CBD agent has seen	12/15.1%
Takes stock of contraceptives	7/8.8%
Other	7/8.8%
Gives various messages	5/6.3%
Signs register or visitor book	2/2.5%
Corrects report/shows how to write report	2/2.5%
Has not done anything	1/1.2%

The most frequently mentioned activities of the supervisor were resupplying contraceptives, checking the register book and tally sheet, and discussing problems. Very little instructional feedback was indicated. Only 16.4% of the agents reported being accompanied on home visits. This implies very little control on the quality of the actual consultation.

The data suggests that the supervision has not been very effective in solving record keeping problems. Although CBD agents reported that the supervisors checked their records, they must not have been doing it very carefully or they did not understand how to do it themselves. This also suggests that the HSA's who did most of the direct supervision need more instruction on record keeping and on effective supervisory techniques. Also, there was no difference in the frequency of supervision reported by the CBD agents and the accuracy of record keeping in the different projects.

However, the frequency of supervision did seem to have a direct effect on the quality of the observed consultations. Those projects with the best quality consultations were supervised more frequently than those with the least frequent supervision. (See section on the quality of the consultation.)

2. Problems of supervision reported by CBD managers

Several problems which limited supervisory activities were given.

- Lack of transport was cited most frequently as the major cause for weaknesses in the supervision. Vehicles which were to be made available for the CBD project's use were frequently used for other NGO or DHO activities. Where priority was not given to the CBD project, the vehicle was not allocated often enough to the CBD project. Those projects implemented by the District Health Office which were strongly supported by the District Health Officer had more frequent use of a vehicle than did other projects which had only a little support.
- During the rainy season roads to some villages in the CBD catchment areas were not passable, and there was no way to supervise the CBD agents or HSA's living in those villages. This was a serious problem for Ekwendeni and Salima.
- Distances between villages in the catchment areas made village-level supervision difficult.
- The CBD managers could not always sufficiently supervise the HSA's in the villages, and thus they could not be assured of the quality of the HSA's supervision of the CBD agents.
- Because of limited transport and the number of CBD agents, CBD managers reported they could not individually and adequately supervise them all.

- In those projects where the manager supervised the CBD agents at the mobile clinics, it was reported that they only had time to give resupplies and were not able to deal with problems.
- When the CBD manager did observe CBD consultations, she could only observe about four agents a month. This resulted in each agent only being observed by her about once in five months.
- In cases where the CBD manager held dual or triple professional positions such as family planning coordinator, community health nurse, and/or family planning provider, she did not have enough time to consistently supervise the CBD agents.
- Because of the many practical problems concerning supervision due to lack of resources, sometimes the CBD managers became discouraged and ceased to continue to put much effort into trying to solve those problems and find ways to carry out their field supervisory duties because of the many practical.

3. Suggestions of the CBD managers to improve supervision are the following:

- The Ekwendeni project trained a selected group of 29 CBD agents to be supervisors. At the time of the study they had not yet started working so their effectiveness could not be determined.
- Sufficient transport should be supplied so that the CBD manager can supervise in the field more frequently.
- Field supervision should coincide with the planned household visits of the CBD agents.
- More HSA's should be assigned to the CBD catchment area and all who work in the district should be trained to do CBD supervision so that they can substitute for each other when necessary.

V. MECHANISMS TO ENCOURAGE CONTINUATION OF CONTRACEPTIVE USE

In order to encourage the continuation of contraceptive use, clients must be followed up systematically. The data revealed several problems in the implementation of follow-up by CBD agents as well as weaknesses in administrative structures for accomplishing it. The first problem concerned the follow-up of clients who had accepted a family planning method as well as those who had been visited but did not accept a method. The second concern was the follow-up on those who had been referred to clinics. The third had to do with following up referred clients who actually had gone to clinics. Systematic follow-up inevitably involves record-keeping for referrals.

A. Follow-up of acceptors and non-acceptors

To adequately follow up clients the CBD agents are supposed to : 1) directly resupply the clients with their chosen methods (pills, condoms, spermicide); 2) ensure that clients who choose other methods obtain them from a clinic; 3) ensure that those clients continue to obtain their methods from the clinic. The mechanisms for following up on pill users functioned properly, but CBD agents tended to neglect following up on clients who used other methods.

According to the *Child Spacing Reference Manual for Community Based Distributors*, the CBD agent is supposed to give the client the date of their next contact and explain the importance of follow-up. Both active clients and drop-outs are supposed to be followed up, with names and dates specified in the agent's records. If the client wants to change the contraceptive method, the CBD agent is supposed to provide assistance and record the reason for the change.

1. Evaluation of the extent to which the CBD agents implemented the above guidelines.

a. Gave date of next contact

According to the observations of consultations, CBD agents did not consistently tell clients when they would make the next visit. Forty observations were made of consultations with contraceptive users. In 47.5% of the observations, clients were told the date of the following visit and in 37.5% they were not told. In 15% of these consultations no record was made of this particular observation. For all non-acceptors dates were not set for revisits.

For oral contraceptive users sometimes there was indication by non-verbal communication. This appeared to be an assumption that the CBD agent would return when the pill blister pack was finished. The data also suggested a definite need for the CBD agents to be more consistent in their appointment making. CBD clients suggested that the CBD agents make appointments beforehand to ensure they would be home when the CBD agent arrived.

b. Followed up active clients and drop outs.

For oral contraceptive users, the vast majority of the CBD agents were consistent in resupplying their clients. However, some clients reported that the CBD agent didn't visit them when they had completed a blister pack, and they had to find the CBD agent themselves for their resupply.

The CBD agents are supposed to follow up on drop-outs and non-acceptors who have already been visited, encouraging them to accept a method. The data revealed that no specific system was used to ensure that such follow-up steps were taken. This was indicated by the wide variety of answers given by the CBD agents when asked how often they visited a household and how they chose new households to visit. The data indicated the following:

- 35.4% of the CBD agents said they went to households of couples of child bearing age.
- 25.3% reported they went from house to house following either a system where they had divided the village into three areas and did one area at a time, or just started wherever they wanted and followed the houses taking the next closest one. They had been instructed at their training to make a map of their village and divide it into sections and then visit households in each section systematically.
- 8.8% chose houses where the couple hadn't started using contraceptives.
- 7.5% reported they used no system at all.
- 6.3% said they went to households where there was a child under five years of age.
- 5.0% went to households to resupply the pill.
- 3.8% said they went to households with a new baby.
- 3.7% reported they didn't visit households, but waited for the women to come to them. These were all in Ekwendeni.
- 2.5% reported that the village headman chose the households for them to visit.
- 2.5% reported they visited households with poorly spaced children or households with problems.

Another indication of the lack of a consistent system used for following up actual or potential clients was that the CBD agents gave many different answers when asked how many times they visited the same household. This suggests that they did not have a clear understanding as to how many times they should visit either a woman who had discontinued use or who was considering starting use. This may be because during their training they were not given clear criteria for determining the number of times they were supposed to visit each household, nor what criteria to use to determine this themselves. The following is a summary of their responses to the question, "How many times do you visit the same household?":

- 34.1% reported they visit the same household every three weeks.
- 13.9% reported they visit the same household either one or two times and did not visit again if the potential clients had refused contraceptive use.
- 11.4% reported they visit the same household three times and did not visit again if the potential clients had refused contraceptive use.
- 5% reported that they visited the same household twice a month.
- 29.1% gave such diverse answers that they could not be categorized. Some examples are: "I visit the same house every four weeks if (the client is) using the pill, and if (the client) refuses I visit the next time I'm in the area"; "I keep visiting as long as they don't understand"; "I visit often when they have problems and less when they don't"; "I visit once every 3 or 4 months"; "I often visit the household where the client has not accepted a method and every week where the client is using a method."

B. Follow-up on clinic referrals

According to the *Child Spacing Reference Manual for Community Based Distributors*, which was used as the basis for the training of the CBD agents, the CBD agent is supposed to refer the client to the nearest health center or mobile clinic for the following reasons:

- a) To receive a physical examination prior to the prescribing of an oral contraceptive.
- b) To consider an alternative method if the client cannot use a method that the CBD agent carries.
- c) To receive a Depo-Provera injection
- d) To undergo a vasectomy.
- f) To seek further consultation if the client has experienced problems with a method used.

The CBD agents were all aware that they could refer for tubal ligation and did so when appropriate.

In the manual there are no clear instructions about what a CBD agent was supposed to do if the client did not go for her physical examination when oral contraceptives were prescribed. In practice the CBD managers generally instructed their CBD agents to give one cycle of pills initially and then were to tell the client to go for the examination. If the client did not go, the CBD agents were being advised by their manager to, nevertheless, continue resupplying the client while encouraging her to go for the physical exam. If the client developed any problems, the CBD agent was supposed to be even more emphatic about the necessity of the examination. This general practice of resupplying oral contraceptives, whether or not the client actually went for the physical exam, was the CBD managers' response to the fact that many clients never went, and the managers did not want to discourage contraceptive use among acceptors.

1. Referral of clients

Evidence from the client interviews as well as CBD project statistics reported to the NFWC indicates that CBD agents were not referring clients in all the cases they should have. According to the interviews of clients who are using contraceptives, 59/51% were referred to a health center, and 35/30.7% were not. 20/17.5% did not respond to this question. Depo-Provera clients responded that they were referred to a clinic because the CBD agents did not give the injections themselves. All pill users were supposed to have been referred for a physical exam, but according to the clients' reports only 45.6% were. This is further corroborated by the CBD project statistics collected by the NFWC. According to these project records the total number of new pill clients in 1995 was 1,787 but only 825, or 46.1%, were referred.

2. Attendance/non-attendance at clinics by referred clients

In the interviews, 83.1% of those who had been referred said they would be able to go to a clinic. When asked if it was a problem to be referred, 62.7% responded it was not and 23.7% said it would be. The main reason given was the long distance to the clinic and the lack of any transportation. Clients were obligated to spend several hours walking to the clinic which could be as far away as 20 kilometers. This was a big problem for clients both in Salima and Mangochi. As the referral clinics were nearby in Sangilo and Kabudula, the clients said it was easy for them to walk there. Other reasons given were that clinics' services were poor and that the clients did not have time to go.

The CBD agents cited many more specific reasons that the clients had given them for not going to the clinic for their referral check up. Table 20 indicates the reasons according to frequency mentioned.

TABLE 20: CLIENTS REASONS FOR NOT GOING TO CLINIC

NUMBER/PERCENTAGE*	REASON FOR NOT GOING TO CLINIC
18/22.8%	Too busy with domestic or income generating activities.
11/13.9%	Fear of physical examination/doctor/hospital.
10/12.7%	Long distance to the health facility.
9/11.4%	Illness (client/husband/child).
7/8.9%	Attending funeral.
5/6.3%	Client too lazy.
4/5.1%	Not sick so why go.
4/5.1%	Feel ashamed because they consider their clothes inappropriate or dirty, and they have no soap.
4/5.1%	Others will know that the client is on family planning. (Those agents who reported this were from Ekwendeni where reference was made in the community that there is a relationship between promiscuity and women using family planning. The latter are perceived by some as loving sex and therefore are immoral or bad.)
5/6.3%	Other.
2/2.5%	No answer.
Total:	79/100%

*Number/percent of CBD agents giving this response

The clinic providers and project managers also reported that not all clients who were referred went to the clinic. It was reported that no referrals had come to Sangilo. In Kabudula the manager reported that clients went for referral because the CBD agents accompanied them. This was also the case in Nsanje, but, according to the manager and provider, clients only came to obtain a method that the CBD agent did not have. In Ekwendeni, the manager reported that the clients only came if they had a problem. Reports from Mangochi indicated that clients did not always go for their physical exam; furthermore, they did not go for their subsequent injections of Depo-Provera either. In Thyolo the clinic provider reported that clients did not come because they were afraid of the physical exam.

C. Follow up and record-keeping on referred clients

The CBD agents did not have an effective way to keep track of referrals: there was no system for registering in the record book when a client has been referred to a clinic and whether the client has actually gone to the clinic. The clinics themselves, except for Ekwendeni, did not keep records of CBD referrals. There was, therefore, no way to keep track of referrals either on the clinic or village level.

The CBD agents did have referral letters which they were supposed to give to the client to take to the clinic. These were to be signed by the family planning provider when the visit is made. The client was also supposed to give the family planning provider her client card to fill out. The client was then supposed to take the referral letter back to the CBD agents along with the client card so that they will know she went. Most, but not all, of the CBD agents did issue this referral letter. The CBD managers and providers reported that clients did not always bring the letter back and that not all of them had their client cards. Clinic referrals by CBDs were supposed to be listed on their monthly tally sheet, but no individual client numbers or names are entered.

Whether or not the CBD agent followed up on the referral was left more to the CBD agent as an individual than to a viable established system. Some of the more conscientious CBD agents remembered the situations of their individual clients and asked them if they went to the clinic. They asked to see the referral letter and noted if the client card was filled out by the family planning provider or not.

VI. APPROPRIATENESS AND ACCEPTABILITY OF SERVICES

A. Size of Catchment Area

It was difficult to ascertain the size of the catchment areas. According to the *Child Spacing Reference Manual for Community Based Distributors*, the first task of the CBD agent is to conduct a community study which includes taking a census of their target area obtaining information on the number of women of reproduction age and the number of households to visit. However, many CBD agents did not thoroughly carry out this task because it was too difficult and time consuming especially in the catchment areas where the villages and households are very far apart. Therefore, the information given by the managers and CBD agents were estimates either based on partial community studies or other sources.

From observation of the sites of the CBD projects, it was easy to recognize that catchment areas of the different CBD projects varied in size. The CBD managers and agents knew the boundaries of the catchments areas, but they were not certain of their size either by population or number of households. In Ekwendeni and Sangilo the managers were not able to give an estimate of the number of households or the number of women of reproductive age in their catchment areas. In the others, the number of households reported varied from forty to over one hundred households per CBD agent. The number of villages covered by each CBD agent, according to their reports, varied from one to three.

B. Number of days worked per week

The CBD agents reported working from one to four days per week. Over half (58.9%) reported working two days per week. The differences between projects were not great. In Salima, Kabudula, Mangochi and Thyolo, the CBD agents mainly reported working two days a week. In Nsanje, 75% reported working three days a week and the rest two days. In Sangilo, two of the agents reported working two days and the other two reported working three days a week. In Ekwendeni, 59.1 % of the CBD agents reported working only one day per week and 36.3% reported two or three days.

C. Number of households visited

1. Number of households visited per day

According to the CBD managers in Thyolo, Salima and Nsanje, the number of households per day each CBD agent was supposed to visit was not specified during the training. In Mangochi and Kabudula, the managers indicated that the CBD agents should visit two to three per day. In Ekwendeni, the manager reported they were supposed to visit ten to fifteen per day, but the CBD agents actually visited from four to five. In Sangilo, the CBD manager specified five houses per day.

Over 80% of the CBD agents said they had not been taught the number of clients or households to visit per day or per week. 73.9% of the CBD agents reported visiting from two to four

households per day. The CBD agents from Ekwendeni appeared to be confused when asked how many households they visited, giving answers ranging from two to twenty-eight households!

2. Total number of households visited by CBD agent since beginning work as volunteer

The CBD agents were unclear as to the total number of households they had visited since they had begun work. They reported anywhere from three to 200 households. Since their register books were not consistently kept it was difficult to determine the number from their written records. However, according to the responses they did give, the average of the total number of households reported to have been visited was 32.55 per CBD agent. While there were differences between projects, the figures were too in-exact to make accurate comparisons. It is interesting to note that the average number of visits calculated based on the reports of the CBD agents is similar to the figure, 30.47 clients per CBD agent, which was calculated based on the reports sent to the National Family Welfare Council of new and subsequent clients in 1995..

D. Acceptance of visit by the CBD agent as reported by clients

Overall, home visits were appropriate and acceptable to the villagers who were interested in family planning because the majority of clients in all the projects reported that the visit was helpful and they wanted to be visited again.

TABLE 21: CLIENTS' ASSESSMENTS OF CBD VISITS

	Yes	No	No ans.	Total
Visit was helpful	79/69.3%	7/6.1%	28/24.6%	114/100%
Want to be visited again	90/78.9%	2/1.8%	22/19.3%	114/100%

1. Reasons visits were helpful

Several reasons were given for why the visit was helpful. The main reason was that the CBD agent supplied the client with a contraceptive method; the second reason was that the agent taught contraceptive methods and explained them well; the third reason was that now she could rest and space her children; fourthly, by her using contraceptives her children would be more healthy and could grow. Examples of such positive responses were the following:

“The visit was helpful by giving me pills and now my problems with my husband are gone -- no more sleeping around.”

“...now I am able to look after my child properly.”

“It was helpful because I learned how to take the pill and to follow up on how things are going, such as having side effects or regular periods.”

"I feel the CBD agent should try to speak to my husband."

2. Reasons visits were not helpful

A few clients indicated that the visit was not helpful. The following are examples of responses:

"No, she just came to ask me if I was taking the pill or not. Then she told me that I should organize a day when to go to the hospital. So I was not really helped."

"I went to the CBD who was not very helpful because she just gave me the pills and told me how I should take them."

"The visit was not really helpful because she did not say much about the methods available."

3. Reasons for wanting revisits

78.9% of the clients reported they wanted to be visited again, mainly to get resupplies. Only 1.8% said they didn't want the CBD agent to return. Reasons given for not wanting to be revisited were that "...she was not on a method and there was no need..." or she "...would go for resupply when the need arose."

E. Appropriateness of system of CBD agent for selecting which households to visit

While both the clients and the focus group participants favored the household visits, they did have many suggestions for improvements. All the suggestions were positive in nature, indicating a strong acceptance of the CBD program by those individuals being served by it.

1. Continue their work

In every CBD project studied, clients indicated they wanted the CBD agents to continue their work.

2. Emphasis on politeness of the CBD agent

In every project clients indicated the importance of politeness on the part of the CBD agents.

3. Visit more often

In all projects but Thyolo clients requested that the CBD agents visit them more often at their homes. In Thyolo the clients indicated that CBD agents frequently did not visit them at their homes but rather the client was obligated to go to the home of the CBD agents to obtain contraceptives. The clients preferred that the agents visit them and suggested this as an improvement.

4. Make advance appointments

In Sangilo, Nsanje, Mangochi, Kabudula and Salima clients suggested that CBD agents make advance appointments so as to be sure to find them at home. This suggestion was not made in Ekwendeni or Thyolo.

5. More information on HIV/AIDS

In every project area except Ekwendeni, clients suggested that more information be given on AIDS. However, there were differences as to just how this information is to be given. (See section on AIDS.)

6. Provide other services

In Nsanje, Sangilo, Mangochi, and Salima, suggestions were made to provide services such as malarial medicine, eye ointment, Depo-Provera and information on child care and home economics. No suggestions for more services were made in Ekwendeni, Kabudula or Thyolo.

7. Suggestions concerning husbands

A few suggestions concerning husbands were given in Mangochi, Sangilo and Kabudula. In Mangochi it was suggested that husbands be present during the home visit. In Sangilo women requested that they be taught something that would keep their husbands from leaving their wives for other women. In Kabudula AIDS messages and condoms were requested specifically for the clients' husbands.

8. More group meetings

In Ekwendeni, Salima and Thyolo suggestions were made for more group meetings to inform villagers about family planning.

F. Acceptance of home visits as reported by CBD agents

The reports of the CBD agents corroborated those of the clients. 83.5% of CBD agents reported that the members of the households wanted to talk to them. 93.67% of the CBD agents also reported that they were well received. However, 36.7% reported that they had problems when they first arrived at a household. The Table 22 summarizes this data.

TABLE 22: CLIENTS' RESPONSE TO CBD AGENTS AS REPORTED BY THE AGENTS

	Yes	No	No ans.	Total
Householder wanted to talk to CBD agent	66/83.5%	8/10.1%	5/63%	79/100%
CBD agent was received well	74/93.7%	1/1.2%	4/5%	79/100%
CBD agent had problems when first arrived	29/36.7%	34/43%	16/20%	79/100%

1. Problems at first visit

There were differences among the projects in their reporting of these problems. The table below summarizes these differences.

TABLE 23: CBD AGENTS' REPORTS OF PROBLEMS AT FIRST VISIT

Project	Yes	No	No ans.	Total
Sangilo	2/50%	2/50%	0/0%	4/100%
Ekwendeni	13/54%	9/38%%	2/8.3%	24/100%
Salima	3/30%	6/60%	1/10%	10/100%
Kabudula	3/23%	7/54%	3/23%	13/100%
Mangochi	1/11%	5/56%	3/33.3%	9/100%
Thyolo	4/44%	2/11%	3/33%	9/100%
Nsanje	3/30%	3/30%	4/40%	10/100%
Total	29/36.7%	34/43%	16/20%	79/100%

In every project CBD agents reported that they had some problems being received at the time of their first visit. However, the frequency of reported problems varied greatly. 50% of CBD agents from Sangilo and 54% from Ekwendeni reported problems on their first visit; 44% in Thyolo reported problems; 30% in both Salima and Nsanje; 23% in Kabudula and 11% in Mangochi.

a. Nature of the problems

Resistance to being visited revolved around the attitudes of the potential clients toward family planning. Where the householders were not interested or were directly opposed to family planning, the CBD agents were not welcomed. The CBD agents reported three types of responses in those cases. They were either politely or aggressively told to leave. Secondly, the householder would allow her/him to give the information but wouldn't pay attention. Thirdly the

household would take the contraceptive offered by the CBD agent and then not use it. In those households where there was an interest in contraceptive use, the householders were pleased to be visited.

There were four main types of problems encountered by the CBD agents on their first visits which contributed to this resistance. In order of frequency reported they were the following:

- **Misconceptions concerning contraceptives.**
Mistaken notions that contraceptives cause infertility, sores, or are for prostitutes.
- **Basic lack of interest in using contraceptives.**
- **Difficulty of the person in understanding information the first time.**
When the client could not understand, she did not have patience to listen and wanted the CBD agent to leave.
- **Other people were present in addition to the potential client(s).**
Some examples follow. A child was present who would not leave and the parents did not want to discuss family planning in front of him/her. A disapproving husband was present, and the wife did not want him to know she planned to use contraceptives. A relative/in-law was present in front of whom it was not appropriate to talk about contraception, nor was it appropriate to ask him/her to leave.

2. Differences of problems among the projects

TABLE 24: PROBLEMS REPORTED BY CBD AGENTS AT FIRST VISITS

	Miscon- ceptions	Not interested	Diff. to under- stand	People present	Other	Total
Ekwendeni	7/6%	3/25%	1/8%	1/8%	0/0%	12/100%
Kabudula	1/17%	1/17%	2/33%	1/17%	1/17%	6/100%
Sangilo	1/33%	1/33%	0/0%	1/33%	0/0%	3/100%
Mangochi	0/0%	2/50%	2/50%	0/0%	0/0%	4/100%
Nsanje	2/40%	1/20%	0/0%	1/20%	1/20%	5/100%
Salima	1/25%	3/75%	0/0%	0/0%	0/0%	4/100%
Thyolo	2/33%	2/33%	2/33%	0/0%	0/0%	6/100%
Total	14/35%	13/33%	7/17%	4/10%	2/5%	40/100%

Table 24 indicates the following: in all projects, some CBD agents reported that there were householders who did not want to receive them because they were not interested in family planning. In Salima and Mangochi respectively, 75% and 50% of the CBD agents reported this,

while in Sangilo and Thyolo 33% reported it. In Nsanje 20% reported a lack of interest, and only 17% in Kabudula reported this as a problem.

a. Misconceptions concerning family planning

The CBD agents in all projects except Mangochi reported that misconceptions concerning family planning were a problem which influenced the attitude of the householder. No CBD agents from Sangilo, Nsanje and Salima reported such difficulties in understanding explanations about family planning as a problem for a first time visit.

b. Involvement of Community

The data indicated that there was a relation between the involvement of the community in the establishment/implementation of the CBD projects and the acceptance of the agents on their first visit.

- Support of the village headmen appeared to be most important in influencing acceptance by the villagers. Specifically, meetings with village headmen and other leaders and participation of the village headmen in the village health committee was directly related to the rate of the CBD agents' reported problems. In the two projects with the fewest reported problems there was direct involvement before the projects were started. In Mangochi, the project managers held frequent meetings with the villagers and village headmen to discuss family planning and the CBD program. In Kabudula the village headman was the chairman of the village health committee.
- The following were examples where there was lack of support from the chiefs initially -- their support had to be mobilized so that the CBD agents would be accepted into the households. In Ekwendeni, where most problems were reported, the CBD manager explained that church elders preaching against contraceptive use had caused much resistance among villagers to CBD agent visits. The population became less resistant after meetings were held with village chiefs and other influential people to explain the importance of family planning.
- Similar situations occurred at Salima and Sangilo. The chiefs were very resistant to the CBD projects at first, and only after meetings did they begin to support the project. By the time of the study, they had become willing to support the CBD agents when they had problems with villagers. In the Thyolo tea estates, where 44% of the CBD agents reported problems during the first visits, there was very little support or knowledge of the CBD project by the compound watchmen (who are comparable to the chief of a village).

c. Selection of CBD Agents

The data suggested there was no relation between the participation of villagers in the selection of CBD agents and the problems encountered on the first visit by the CBD agents. Among the projects there were few differences in how the CBD agents were selected -- reports from the

focus group discussions whose participants were villagers indicated very limited participation in the selection process.

G. Evaluation of the CBD agents by clients and villagers

The data suggested that the best way to recruit the most capable CBD agents may not be through community selection. In some projects the CBD agents selected did not have sufficient ability to fully understand all the aspects of their training and did not perform their job adequately.

1. Criteria/characteristics of CBD agents

The Manual for CBD Training lists criteria for CBD agents: i.e., male or female, married, at least one child, functionally literate, and residing in the village where they volunteered. To a large degree these criteria were met by the CBD agents interviewed. 69.6% of the CBD agents were female and 30.4% were male. They were all married and all had at least one child. They could all read and write a little, and their educational level ranged from Standard 1 - 8. Most only had schooling on the level of Standard 1 - 4. All the CBD agents resided in the villages where they did their outreach work and were mainly of the same ethnicity as their fellow villagers. They were often directly related or related by marriage to many of the villagers who were their potential clients.

2. Appropriateness of the characteristics of the CBD agent from the point of view of the manager

The managers of the CBD projects were asked if they thought the actual qualities of the CBD agents were appropriate for the work demanded of them. The managers of the projects in Kabudula and Sangilo reported that their CBD agents had the necessary qualities to do the job.

Managers at Ekwendeni, Mangochi, Salima and Thyolo indicated that some agents had the necessary qualities, but many did not. These managers reported that the agents either had too little educational background or lacked the intellectual ability to sufficiently understand the content of training and were unable to give proper information during consultations. The manager in Thyolo reported that the CBD agents had been selected before the specific criteria of literacy or educational level had been established and given to the compound watchmen.

In Nsanje the project manager from the district hospital reported that the CBD agents were too busy carrying out their own petty businesses and as a result were not recruiting many clients. This was also a problem reported elsewhere by project managers. Such a problem brought into question the appropriateness of CBD agents being volunteers.

3. Appropriateness of characteristics from the perspective of the community members and village leaders

Data from the community member and village leader focus group discussions indicated preferences for certain characteristics in CBD agents.

a. Gender

Data from all the focus groups consistently indicated that CBD agents may be male or female. It was preferable that CBD agents visit potential clients of their same sex. However, in Kabudula, Sangilo, Mangochi and Salima the opinion was also expressed that it did not matter if a CBD agent spoke to some one of the opposite sex as long as he/she knew the information well. On the other hand, fears were expressed that if this were to occur the spouses of the client or CBD agent would become suspicious and suspect possible sexual relations or desires between the two. At the time of the study there had been no actual reports of such a problem, but the CBD agents were all sensitive to the need to prepare the spouses for the visits if there was a difference between the gender of the CBD agent and potential client.

b. Age

The participants in all the focus groups indicated that the CBD agents should be of child bearing age, preferably between 18 and 40. In Sangilo, the opinion was expressed that the male CBD agents should be a bit older than the females. In Thyolo, Nsanje and Salima participants also expressed the opinion that age did not matter as long as the CBD agent knew the work well and had adequate knowledge.

c. Marital status

The focus group discussions suggested that marital status in itself may not be an important criteria for a CBD agent. In Kabudula, Nsanje, Thyolo and Mangochi some focus group participants said that the CBD agents should be married; marriage was not mentioned as a criterion in the other projects.

d. Parity

The focus group discussions suggest that parity was not an important criteria for everyone. In Kabudula, Nsanje, Salima and Thyolo, focus group participants specifically mentioned that the CBD agent should have children. In the other projects the preferred age was in the range of child bearing age. Actually having children was not mentioned as a criterion.

e. Education

The data from all the focus group discussions indicated a preference for CBD agents who can read and write. This reflected the same criteria which had been specified by the CBD manager. The opinion was also expressed that actual educational level did not matter as long as the CBD agent had adequate knowledge and was well trained.

4. Other preferred characteristics

The focus group participants also gave opinions on other types of characteristics they wanted CBD agents to have. Those most frequently mentioned were:

- a. Good character
- b. Intelligent
- c. Polite
- d. Able to discuss personal problems with people
- e. Patient
- f. Clean
- g. Can stand a lot of criticism and resentment from those "who are slow to understand family planning."

H. The appropriateness of CBD agents for telling villagers about family planning from the point of view of the villagers

Data from the community member and village leader focus group discussions indicated that generally the CBD agents were appropriate people for telling others about family planning and HIV/AIDS.

In Ekwendeni, however, the fact that the CBD agents were required to reside in the village where they did their work created problems of acceptability. A younger relative was not supposed to discuss issues of sexuality with an older one. A woman may not discuss family planning with her own mother or mother-in-law or older aunts and other types of relatives. Thus there were many people who were deemed inappropriate for the CBD agent to visit. The CBD agents tried to solve the problem by visiting each others' villages where they would not be related to so many people. However, this created difficulties in maintaining consistent visits because it was hard to walk the great distances between the villages.

Opinions concerning gender of the CBD agents varied in different projects. It appeared that having same sex CBD agents and clients was most important in the projects in the Northern Region. In Sangilo and Ekwendeni all CBD agents were women, and they only talked to women. In Ekwendeni male motivators talked to men and promoted condoms.

In the projects in the central and southern region, both male and female CBD agents were selected by the community. The agents themselves worked out a system for visiting different clients of the opposite gender when necessary. For example, in Kabudula, the male CBD agents approached the husbands first. They either tried to set up visits with the couple or arranged a visit with the wife through the husband. This system seemed to work satisfactorily. But in Nsanje, according to the female focus group discussions, there was some discontentment among the women concerning visits from male rather than female CBD agents.

I. Type of person considered best to give information about family planning from the perspective of village leaders and community members

During the focus group discussions the participants were asked who were considered the best types of people to teach about family planning. The following chart summarizes the responses (where at least 2 focus groups agreed).

CHART 8: Preferences expressed about who best should discuss family planning according to social category of the recipient of information in order of frequency.*

	#1	#2	#3	#4	#5
Children	Parents (12)	Teacher (6)	Grand parent (5)	Counselors (3)	Married CBD agents; Aunts/uncles (2)
Unmarried women	Grand parents (7)	Parents (5)	Married CBD agents/ other health workers (4)	Aunts/uncles (3)	0
Unmarried men	Grand parents (8)	Parents (5)	Married CBD agent (4)	Aunts/uncles; Other health workers (3)	Counselors (2)
Betrothed women	Parents(6)	Grand parents; Aunts/uncles (4)	Counselor/ CBD agent (3)	0	0
Betrothed men	Parents (5)	Married men or women (4)	Grand parents; Aunts/uncles; CBD agents	0	0
Married Women	Other health personnel (6)	CBD agents(5); Grand parents (5)	Married men or women (4)	Aunts/uncles; counselors (2)	0
Married men	Health personnel (6) Grand parents/ CBD agent (6)	Married men or women (5)	Counselors (3)	Aunt/uncles (2)	0

* The number in parenthesis indicates the number of focus groups holding a consensus.

The results indicated that CBD agents were mainly preferred as sources of family planning information for married men. For married women, health personnel were preferable to the CBD agents. CBD agents were only the third choice for family planning information for unmarried adults and the least preferred for children. For children and betrothed adults the most preferred source of family planning information were parents. For betrothed men and women grandparents were preferred. Note that teachers were also preferred for children. More research needs to be done to determine why this is so.

J. Attitude toward CBD program/appropriateness of type of program

1. Evaluation of community response to CBD program from point of view of project managers

There was agreement among all CBD managers except for Thyolo that villagers liked being visited or liked the idea of being visited by the CBD agents. The CBD manager at Thyolo said she did not know if the villagers liked being visited or not. The managers went on to explain that villagers who were interested in family planning liked to be visited by the CBD agents, and those who were not interested did not always welcome such a visit, politely telling the agents to go away.

The data expressed in the CBD interviews and focus group discussions indicates that the CBD project managers in the northern region were sensitive to the cultural values of their catchment areas. The managers and CBD agents in Ekwendeni and Sangilo reported that problems arose when the CBD agent was related to a client. In those areas it was not appropriate for daughters to talk to either their own mother or to mothers-in-law about any subjects concerning sexuality such as family planning; nor was it appropriate for any younger woman to talk to an older relative on that subject.

In Ekwendeni and Sangilo the reports of the project managers corroborated those of the villagers and CBD agents. The managers also reported that there was a taboo restricting discussion on family planning or other sexually-related topics between people of the opposite sex. In Ekwendeni the project managers were sensitive enough to this need and established a system in which female CBD agents visited females and male motivators visited males.

The male motivators were trained in giving information about different contraceptives, but they only distributed condoms to men. They told interested male clients to refer their wives to a female CBD agent if they, i.e. the men, wanted other contraceptives. This use of male motivators needs to be looked into further. The data suggested that they were effective in distributing condoms, but their referrals to the CBD agents for contraceptives may not have been functioning effectively.

In the southern and central regions, the prohibition of CBD agents talking to clients of the opposite sex must not have been as strong as in the north. The villagers selected both males and females as CBD agents, and they visited both men and women. However, according to the managers in both Mangochi and Kabudula, this has posed some problems. They reported that

some villagers are suspicious of the CBD agents and think that they will go after the husband or wife of the household they are visiting.

In some project areas specific categories of social groups were resistant to the idea of family planning and were against the CBD agent visits. However, in no case was everyone in a specific category opposed to the visits. In Ekwendeni the CBD manager reported that some church elders, older people and village headmen were against family planning. In Mangochi some village headmen and grandmothers were reported to pose problems. In both Mangochi and Salima Catholic church elders tried to convince villagers to resist the CBD agents. In Mangochi a group of Catholics not only tried to persuade villagers to be opposed to family planning, but they also tried to get Muslim leaders to dissuade their Muslim villagers from using contraceptives.

When specific problems in the villages arose, the CBD managers tried to deal with them by holding meetings with those involved: church leaders, village chiefs or specific villagers. In these meetings they explained the goals of the CBD project and the importance of family planning. After doing this they were able to either gain support of those groups or, at least, the groups no longer aggressively tried to dissuade villagers from accepting the CBD agents or from considering the use of contraceptives.

VII. INTEGRATION OF FAMILY PLANNING AND HIV/AIDS

An assessment was made of the awareness of HIV/AIDS in the CBD catchment areas and the role of the CBD agent in providing information about HIV/AIDS. These findings will be presented as common to all the focus groups because there were not many clear differences among their responses. The few clear differences that did occur, however, will be indicated. The results of the interviews will be stated separately.

A. Knowledge of HIV/AIDS

Interviews with CBD clients and focus group discussions revealed that villagers were aware of AIDS as a problem in their communities and had some general knowledge of it. This knowledge appeared to reflect the information that has been given in the media, in hospitals and at community meetings. There were still many misconceptions, and individuals' specific knowledge of AIDS tended to be minimal.

The following will be a discussion of four aspects of villagers' awareness of AIDS: their concepts of AIDS, its modes of transmission, the difference between HIV and AIDS, and their identification of AIDS based on symptoms.

1. Villagers' concepts of AIDS

Client interviews and focus group discussions indicated a general awareness, but limited knowledge, of the existence of AIDS. During the interviews 95% indicated they had heard about HIV/AIDS. 37.7% described AIDS as a dangerous disease which can be contracted by having much sexual intercourse and also by sharing razor blades and toothbrushes. 24.6% reported that AIDS has no treatment and that people suffer for a long time and eventually die. 7.9% described AIDS patients as people who look thin and pale, lose weight and often have a persistent cough. 3.5% knew that AIDS is a disease which destroys the immune system of the body. 11.4% of respondents, which included clients who had heard of AIDS, could not tell anything about it.

The focus group participants described AIDS as a disease transmitted through sex or the exchange of blood, and for which there is no cure. For example village leaders from Mangochi said, "We just hear about AIDS. There is no medicine. You get it through multiple sexual partners, razor blades." A male villager from Sangilo said, "AIDS is a killer disease because it is incurable." A village leader from Sangilo suggested that "AIDS is a disease that has no treatment."

2. Modes of transmission

There was a general awareness that HIV/AIDS is transmitted sexually or through the exchange of blood. It was not always clear whether people understood that HIV is transmitted only by people who are infected with it, i.e., sero-positive individuals. For example, a village leader described AIDS as "a disease spread by bad sexual behavior." If "bad sexual behavior" means having relations with many people or having extra-marital sex, does this village leader understand that HIV is only sexually transmitted if the partner is infected with the HIV virus?

Another Salima leader said that AIDS can be contracted "...during a fight, if the blood from one person spills onto an injured part of another." Does he think this will always happen, or again, only when a person is infected with HIV?

Despite the generally high level of awareness of AIDS, many misconceptions concerning transmission and prevention remained. Some erroneous beliefs expressed were that AIDS can be contracted through drinking bad water or shaking hands, or that it can be prevented by drinking the medicine *mchape*.

3. Differentiation between HIV and AIDS

Many focus group participants said they did not know the difference between HIV and AIDS. However, there did appear to be some vague understanding of HIV as different from AIDS. For example, in Mangochi, a female villager said "a person with HIV can not be spotted because he looks well...more healthy...than a person with AIDS. In Salima a female villager explained "depending on the strength of your blood, you can have the virus working in your body for three years, then your blood gets weak, you get sick, malaria. AIDS is the actual illness."

The word "virus" has been translated into Chichewa as *kachilembo kachirombo* or into Chitumbuka as *kachibunga* and these terms were used by some focus group participants. Two village women from Ekwendeni described HIV as "a *kachibungu* (very little larva type thing) that travels through the blood," or "a (virus) which goes through the lungs and nerves." A village leader in Salima said HIV is a (germ), "AIDS is a disease." In Kabudula a village leader said "HIV is *Kachilombo ka edzi*." (*Edzi* is the Malawian vernacular term for AIDS.)

4. Identification of AIDS by symptoms

It is important that people do not mistakenly attribute AIDS to patients who have a disease with similar symptoms which can be treated and cured. Such a mistaken diagnosis could lead to neglecting the treatment of a person whose condition could easily be treated. Evidence does indicate that the focus group participants recognized symptoms that are, indeed, associated with AIDS. However, it was not clear whether they all understood that the symptoms of AIDS are syndromic, and that a single symptom is not sufficient to determine if a person is HIV infected.

When asked the symptoms of AIDS, most participants tended to name a single symptom such as cough, headache, diarrhea, bodily weakness, TB, thinness, shingles, anemia, malaria, vomiting, "hair becomes thin like a malnourished person." Others grouped two or more symptoms; "becomes thin and dies," "you never look well until you die," or "headache and cough," "easily gets any disease, and this continues about a year," "swelling and rashes," "vomiting and diarrhea," "on and off illness."

The village leaders in Thyolo grouped several symptoms: "growing thin, then looking all right, diarrhea, vomiting, off and on illness, pale looking, general weakness, shingles, eating only vegetables and *zankhwilu* (a Chichewa word for having an appetite for especially appetizing food), eating small bits of food frequently throughout the day and needing care."

Four of the participants in Mangochi also understood the symptoms as grouped and gave descriptions which correspond to frequent syndromic symptoms. They described a person with AIDS as "having frequent headaches, diarrhea, coughs, hair that becomes red and straight, and the whole body gets thin." A village leader from Nsanje described a person with AIDS in his village as "having raw sores on the body, thinning, didn't eat and died."

B. Perception of risk of contracting HIV/AIDS

Individual participants generally believed that they were at risk of getting AIDS. Both males and females reported the possibility of their spouses having extra-marital sex, and they were concerned about contracting the disease through them. A male focus group participant from Sangilo gave as an example, "My wife could have sex with a vendor in exchange for soap." Focus group participants also explained that they could become infected through the use of razor blades, for example, "when the healer cuts off hemorrhoids."

Many participants reported that condoms could reduce the risk of sexual transmission. Their discussions, however, indicated a controversy over the ability to convince community members to use condoms. The discussions suggested that if the participants did not think they could convince others to use condoms, they should not bother to try.

Interviews with CBD clients as well as focus group participants revealed negative beliefs about condoms even when they had never used them. Such ideas included the possibility of bursting or leaking, lack of sexual satisfaction, and sores on the penis and/or vagina. They also mentioned cultural barriers to condom use, linking condoms with promiscuity. Some wives expressed concern that their husbands only used condoms with other women.

Many of the CBD clients also recognized that condoms were useful in preventing pregnancy and sexually transmitted diseases. Many had no experience with them. Some clients reported using condoms with their spouses in order to avoid the side effects of oral contraceptives and because they were easy to use, convenient and free. They agreed that more villagers themselves would have to be favorable towards condoms before they would be able to convince others to use them.

C. Reported experience with AIDS cases

The perception of HIV/AIDS as a problem in their community by CBD agents and their clients varied. Of the CBD agents interviewed 65.8% reported that AIDS was a problem. However, only 16.7% of the CBD clients interviewed reported knowing people with AIDS in their villages.

The data also indicated differences in the perceptions of the problem by catchment area. AIDS was reported as a problem by at least 75% or more of the CBD agents in the catchment areas of Sangilo, Salima, Ekwendeni, Thyolo and Nsanje. 62.5% of the CBD agents interviewed in Mangochi reported AIDS as a problem, but none reported it as a problem in Kabudula.

The clients' reports of knowing about people with AIDS differed from the CBD agents' reports of AIDS as a problem. More clients reported knowing people with AIDS in Ekwendeni (25.9%), Sangilo (23.8%) and Kabudula (20%), than in Salima (12%), Thyolo (5.3%) and Nsanje (5.3%). No clients knew of any AIDS cases in Mangochi. While over 75% of the CBD agents reported AIDS as a problem in Thyolo and Nsanje, only 5.3% of the clients knew of any cases in those areas. In Kabudula 20% of the clients reported knowing people with AIDS, whereas none of the CBD agents perceived AIDS as a problem there. In Mangochi no clients knew anybody with AIDS, whereas 62.5% of the CBD agents interviewed perceived AIDS as a problem.

Focus group participants were also asked to discuss AIDS cases they knew about. All the village leaders in the Kabudula focus group discussion reported knowing someone who was sick with AIDS. One reported, "Someone injected the wife and sister-in-law and all of them died." Another remarked, "He had shingles first and got very thin and died." Some focus group participants reported that they had no way of knowing if a person was HIV positive until he/she fell sick; some also admitted that they could not say because they were afraid of "being bewitched." Participants identified people suffering with AIDS by symptoms such as wasting, losing hair, having diarrhea etc. However some suggested that other "diseases" such as *tshempo* have similar symptoms and could easily be confused with AIDS.

People with AIDS were described as an economic and emotional burden. Some villagers reported that relatives neglected their gardens to care for sick relatives, and as a result they would have no harvest. It was also reported that family members of those with AIDS became depressed because they knew the person would die. They also felt ashamed when they suspected their spouse of infidelity.

In addition, participants considered that caring for AIDS patients was a potential danger to themselves. They reported touching infected body fluids when helping patients. Caring for those suffering with AIDS was reported as particularly difficult because of the lack of water to properly wash the person or any soiled clothes or blankets.

D. Sources of information

There was a consensus among the focus groups as to actual and preferred sources of information about HIV/AIDS. The actual and preferred source of information differed. While the actual sources of information most frequently cited were from the radio and the hospital, the most highly preferred source of information was from health workers at the village level. Chiefs and clergymen were also suggested as good sources. Other vehicles of information were community meetings, cinema, drama, songs, newsletters and anonymous letters written to friends. Radio was criticized as being too jovial, and it was stated that people were so used to radio that they don't pay attention to its messages.

E. Role of the CBD agents

The data suggested that CBD agents were playing a very small role in AIDS education. The focus group discussions indicated a greater interest in fully trained health workers as a source of AIDS information than CBD agents. The client interviews indicated that few CBD agents were providing information on AIDS during their consultations. Whether or not the CBD agents should provide AIDS information during the consultation was also controversial and will be explained below.

1. Information on AIDS given by CBD agents

84.8% of the CBD agents indicated it was a good idea to give information about HIV/AIDS in addition to family planning during their home visits as they had been instructed to do. According to the clients, however, very few did this. Only 24.6% of the clients reported that the CBD agent gave them information about AIDS during the home visit. 62.3% reported they were not given any AIDS information. The rest, 13.2%, did not answer this question.

Of those CBD agents reported to have given information, it was very superficial and vague. Of the clients who received information on AIDS, the following was reported in order of frequency:

- The agent warned that there was no treatment for AIDS.
- She explained that AIDS kills, and it is better to avoid having many sexual partners.
- She talked about condoms and said they will protect the client from AIDS.
- One client reported the CBD agent told her that if she used a (contraceptive) method her husband would not sleep around with other women.
- Another reported that the CBD agent told her AIDS can be contracted through sharing razor blades, injections, toothbrushes or blood transfusion.
- Lastly, the clients couldn't remember the information.

2. Clients' and villagers' evaluation of CBD agents as a source of AIDS information

73.7% of the clients interviewed reported that it would be a good idea for the CBD agents to give information about HIV/AIDS. Only 6.1% reported that it was not a good idea, and 5.3% didn't know if it was a good idea or not. A smaller number of respondents, 57.9%, were of the opinion that it would be helpful for the CBD agents to give information specifically about the use of condoms to prevent HIV/AIDS. 13.2% indicated it would not be a good idea, and 12.3% didn't know.

Interviews with clients and data from focus group discussions with village leaders and community members revealed four contradictory views of information-giving on HIV/AIDS and family planning.

- The CBD agent should give both types of information at the same visit because the subjects are related.

- The CBD agent should give both types of information, but at separate visits. It is too much for clients to understand both subjects at once, and they will become confused.
- AIDS and family planning are two separate subjects and should be discussed at different meetings. AIDS is related to promiscuity, and therefore immoral, and should not be connected to contraception which is a family affair and therefore morally proper.
- AIDS information should be taught by one person and family planning by another. The two subjects are too big for one person to be able to teach both.

F. Villagers' perceptions of how their village can help with HIV/AIDS

In considering how the village could help with this problem, village leaders in Thyolo and women villagers in Salima indicated that compound watchmen or village leaders should hold meetings to educate community members. Interestingly, in most of the discussions the problem was seen more as an individual matter than as a community responsibility. Accordingly, suggestions were made that individuals should change their behavior.

G. HIV and IEC

The data suggests that at the time of the study, IEC efforts was somewhat effective, but village leaders, CBD clients and other participants in the focus groups indicated they wanted more information about AIDS. Special emphasis should be on community educational meetings given by well informed health workers. They can deal with the subject in depth, dispel misconceptions and answer complicated questions.

A multifaceted approach to village-level education that exploits all possible resources should be taken. Health workers, CBD agents, chiefs, clergy and other village leaders can be utilized. Information can be spread using a variety of vehicles: drama, song, radio and discussions are a few examples. Villagers may suggest new forms that might prove effective in communicating information.

VIII. RELATION OF THE COMMUNITY TO THE CBD PROJECT

A. Community Network

CBD projects operate within a community network. Each element of the network has a role to play within the project, and all elements are interrelated. The nature of the links between the different elements affects the functioning of the CBD project.

Elements of this network included the District Health Office and/or hospital, the CBD project's office, a referral clinic, other health centers, villages within the catchment area of the project and the administrative office of an NGO. In addition, various other players had a part in the network: administrators, project coordinators, family planning providers, village leaders, CBD agents themselves, the villagers, whether they become clients or not, and other volunteers in the area. Below is a description of these elements and their relation to the CBD project.

1. The District Health Office (DHO)

Two of the mandates of the District Health Office were to supply contraceptives to CBD projects and to furnish district level supervision. In Mangochi and Salima the district hospital functioned as the main referral clinic for family planning services which were not available in rural health centers. In each of the other CBD catchment areas there was a rural health center which served as the referral clinic. The major players were the District Health Officer, the community health nurses and the family planning providers.

Relation of the District Health Office to each CBD project

According to the interviews with CBD managers the District Health Offices did supply contraceptives to all the CBD projects. Any shortage at the district or national level would therefore cause the CBD projects to suffer shortages as well. The relationships of CBD projects to their District Health Offices fell into three general categories: integral, partially integral, and separate.

a. Integral relationships

The Mangochi and Salima CBD projects were managed by the District Health Office. The District Health officers were responsible for the projects, but other personnel directly managed them. The data revealed that CBD managers and coordinators filled other time-consuming positions in addition to their CBD responsibilities, and this caused, in effect, a shortage of CBD personnel.

In Salima one individual occupied three positions: CBD Project Manager, District Community Health Coordinator, and Public Health Nurse. In Mangochi the CBD Project Manager also provided family planning services at the district hospital, and another person occupied three positions: CBD Project Coordinator, Community Health Nurse, and District Family Planning Coordinator.

The degree of support from the District Health officers differed. In Mangochi the DHO was very supportive of the CBD project and considered family planning and preventive services a priority. Time and resources were allocated for CBD management activities. In Salima, on the other hand, the DHO put less priority on the CBD project than on curative services. Resources for supervision were not regularly put at the disposition of the CBD manager/supervisor and consequently supervisory activities were inadequate. Both district hospitals in Salima and Mangochi were the main referral clinics for their respective CBD projects. The catchment areas of these projects were from 25 to 45 kilometers away, making clients' visits very difficult.

b. Partially integral relationships

In Nsanje the District Health Office provided the CBD project coordinator, but Marie Stopes International managed the CBD project out of its family planning clinic in Nyamithuthu. The project coordinator took a primary role in field supervision which required cooperation from the District Health Officer, especially to release transport which was a frequent problem. The district hospital functioned as one of three referral clinics for the project.

c. Separate relationships

The Kabudula project was implemented by World Vision, the project in Thyolo was conducted by Project HOPE, and the project at Sangilo in Karonga district was managed by the SDA Head Office in Malamulo. All management was thus completely separate from the DHOs whose chief connection was the provision of contraceptive supplies.

2. The implementing agency

The implementing office designed the project, develops proposals, obtains funds, manages and supervises all aspects of the CBD project. The main players were the project manager and the CBD supervisor. Implementing agencies can be NGOs as well as governmental agencies such as the Ministry of Health, the District Health Office or the National Family Welfare Council of Malawi.

3. The referral health clinic

The referral health clinic delivers family planning services which the CBD agent cannot provide. It also is supposed to provide medical supervision and advice to all CBD clients when needed. Each CBD project had one referral clinic within its catchment area, except for Nsanje which because of its large area has three referral clinics: two rural health clinics and the district hospital itself. The main players were the manager of the health clinic and the family planning providers.

4. Health centers in or nearby the catchment area

Health centers in or nearby the catchment area which do not provide family planning services can refer potential clients to CBD agents. These health centers can also refer potential clients to the CBD referral health clinic. The main players were the managers of the health centers and the health practitioners.

5. Villages in the catchment area

Villages in the catchment are the basic target population for the family planning services provided by CBD agents. They also provided volunteer CBD agents. The village chiefs and other leaders were supposed to provide leadership in the CBD project; for example, they can conduct village meetings to select the volunteers and support them in their work.

6. CBD agents

CBD agents provide the community-based distribution of family planning services. They resided in the village, volunteered their services and are selected by their peers and leaders.

7. Other volunteers who reside in the village

There are other volunteer residents who provided various services in health, agriculture, education, environmental restoration, etc.

B. Community Network Involvement in the Projects

According to CBD guidelines, the community network is supposed to be involved in the development of the CBD project. The degree to which this was actually the case varied from project to project. In all the CBD projects but one, World Vision in Kabudula, the initial idea for establishing a CBD project originated from the implementing agencies without involving other elements of the community network. The following schematic indicates the source of the idea for each project:

CHART 9: SOURCE OF IDEA FOR THE PROJECT

SOURCE OF IDEA	PROJECT
Marie Stopes Head Office, Blantyre	Nsanje/Marie-Stopes Foundation
Project HOPE Head Office, Thyolo	Thyolo/Project Hope
SDA Head Office, Malamulo	Sangilo Mission Health Center/SDA
District Health Officer	Mangochi/DHO
District Community Health Nurses	Salima/DHO/MOH
Medical Superintendent	Ekwendeni Mission Hospital
Input from village mothers as result of Child Survival Project Evaluation	Kabudula/World Vision

It is important to note that service providers were involved in the initial development of the CBD programs in only two of the projects: Salima and Ekwendeni. The involvement of villages mainly occurred after the decision was made to set up a program and after the catchment area was determined.

The community network of Sangilo in the northern district of Karonga was not involved at all in the initial idea or development of the project. The Seventh Day Adventist office in the southern region selected the center as a site for expanding its CBD program, and the Sangilo Mission Health Center was simply informed that the project would be implemented.

Catchment areas were usually determined by the implementing agencies. In Salima, the Community Health nurses selected the area and in Mangochi the CBD manager did so. The SDA administration in Malamulo selected the catchment area for the Sangilo project. In both Kabudula and Thyolo the CBD projects were added to the areas of the child survival projects. In Nsanje, the determination of the catchment area was negotiated by ADRA, Marie Stopes and the District Health Office. The involvement of the so many different leadership organizations in Nsanje caused some difficulties in this negotiation and the ensuing administration of the project.

Some referral clinics set up the CBD programs and selected the catchment areas. This occurred when the referral clinic was part of the implementing agency, such as the District Hospitals in Nsanje, Mangochi and Salima and the Ekwendeni Mission Hospital in Ekwendeni. In the case of Thyolo and Sangilo, the referral clinics were informed of the CBD Project by the CBD management after all decisions about the project had already been made.

At the time of this study, the Sangilo mission health center appeared to be quite isolated from its community network. The health center rarely received supervisory visits from the District Health Office in Karonga, over 70 kilometers away. Nearby health centers were not aware of the project. The family planning providers of those clinics reported that if they had known about the project they would have been glad to refer clients.

C. Selection of Cbd Agents

All the project managers reported that they had requested the chiefs in their catchment areas to hold village meetings to select the CBD agents. They gave the chiefs criteria for selection: the agents had to have some primary school education and be literate. The village leaders confirmed this in the focus group discussions and reported that they did select CBD volunteers. It was also reported that the potential number of candidates, especially among females, was very limited because so few were literate. According to the focus groups with the villagers, the degree to which they themselves were involved varied.

In Ekwendeni, according to the female focus group, the CBD agents were selected at an under five mobile clinic. Those women who happened to be at the clinic on the day of the meeting participated in the selection. Others did not know about it. According to the male focus group, "Everything was organized by Ekwendeni hospital which had told the chiefs to choose the CBD agents."

The project manager at Kabudula explained that there was a village meeting in which the villagers chose as CBD agents most of the same people who were already health volunteers. Most of the community focus groups reported that they didn't know about the meeting or take part in it.

The focus groups in Sangilo stated there was barely any public participation in the selection process. In Mangochi some of the participants in the male and female focus groups reported participating in a meeting to select CBD agents and some did not. In Salima the village leaders reported that they chose the CBD agents. According to the focus groups in Salima, the chiefs chose the CBD agents without consulting the community members.

Village leaders in Nsanje reported they were told to select one male and two female volunteers from each village. The male community focus groups said that the CBD agents were chosen by the chiefs without their involvement. On the other hand, the female community focus groups reported that some of the women had participated in the selection of CBD agents.

In Thyolo, the men in the male community focus group did not appear to know about the CBD program at all, while the women reported a mixture of experiences. Some knew nothing about the selection, some said they heard that CBD agents were selected, and others said they participated in a meeting.

D. Village Involvement in Implementation of CBD Project

The involvement of the village in the implementation of the CBD project was very limited. The CBD agents do not report to anyone within the village structure. They are independent workers under the supervision of the CBD implementing agency.

1. Village Headmen

The support of the village headmen was very important in the implementation of the CBD projects. In Sangilo, Mangochi and Salima many villagers initially resisted the CBD agents' household visits. CBD managers held meetings with the village headmen to explain the importance of family planning, and the headmen then became convinced of its importance. This has led them to convince villagers that the CBD agents be accepted.

By the time this study took place, village headmen in all project areas expressed a strong interest in the CBD project and a desire to help. The following examples of help illustrate that such aid is not constant and there is no system to it. In Kabudula the village headman is the chair of the health committee and helps the CBD agent from that role; in Sangilo one chief helped the CBD agent when the villagers were resistant to receiving household visits, talking directly to them about the advantages of family planning; leaders in Nsanje reported they encourage the CBD agents by having frequent meetings with them to help them with any problems and to know what they are doing.

2. Involvement of villagers

Villagers on the whole had no involvement in the implementation of CBD projects outside of a few who participated in the initial selection of CBD agents. When asked in focus group discussions how they had participated, they either said not at all or that they had received the CBD agent in their home for a consultation. In Nsanje the female focus group members said they had participated by being good clients and by telling others about family planning. In Mangochi they also said they were good clients and respected the work of the CBD agents. The focus group participants in Salima reported they were only involved in the initial selection of the CBD agents and not in any implementation.

3. CBD managers'/coordinators' suggestions

The CBD managers in all the projects suggested that the involvement of the villagers could be improved in several ways. Village headmen could take active roles in the area health committees and could form and chair a family planning subcommittee. They could plan ways to encourage family planning in the villages and could help the CBD agents deal with problems they encounter in their work.

It was also suggested that CBD managers and/or family planning coordinators could hold periodic meetings with the village leaders to exchange information on family planning and discuss concerns of the villagers. The leaders, in turn, could hold meetings with the villagers to deal with those issues and to encourage them to use family planning when appropriate. The use of drama and songs as a means to convey information about family planning could be used. Some of these activities have begun, but only on a sporadic basis.

IX. SUSTAINABILITY

A. Funding status

Financial sustainability of the projects was a serious problem, with most projects functioning on very shaky ground and not knowing where they would get their next source of funding. There was a tendency among the projects not to foresee the expiration of their funding in time to procure further money, thus avoiding a gap between funding periods. Some projects had planned better than others and applied for grants early enough in order to secure continuous funding. However, they could never be sure that they would, indeed, obtain those grants.

The CBD projects fell into four different funding situations:

1. They no longer had financial support and were looking for it. **Ekwendeni, Mangochi, Nsanje**
2. There was support for at least the next few years. **Sangilo**
3. Their donor funding will run out in about 1½ years. **Kabudula, Thyolo**
4. The project was managed completely by the District Health Office and depended on funding from either the MOHP or the NFWC and/or outside donors such as USAID and UNFPA. **Salima**

B. Sustainability from the point of view of the CBD agents

The data suggested that there was not a high turnover rate, and that the majority of the CBD agents were willing to continue to work without monetary compensation. They did, however, want some kind of support, at least a minimal amount of money for soap and/or help with their personal work and with the actual CBD activities. They also wanted praise and assistance in solving problems.

1. Turnover rate

Table 25 indicates turnover rates at all the projects as well as the age (duration thus far) of each project.

TABLE 25: TURNOVER RATE OF CBD AGENTS BY PROJECT

Project	Turnover rate (+ length of project)
Nsanje	0 (one year)
Thyolo	45% total: (Mianga: 5 of 8 in 2 years) (Comfosi: 4 of 12 in 1 year)
Mangochi	9% (2 of 22 in 8 months)
Kabudula	0 (4 months)
Salima	0 (5 months)
Ekwendeni CBD Agents Male Motivators	15% (16 of 108 in 3 years) 21% (9 of 43 in 3 years)
Sangilo	0 (1 year 7 months)
Average for all projects	12.5%

Table 25 also indicates that the average turnover rate for all the projects as a whole was 12.5%. There were significant differences among projects. In four of the projects, Kabudula, Sangilo, Nsanje and Salima, there had been no drop outs. In Mangochi, out of 22 CBD agents only two (9%) dropped out and in Ekwendeni 16 (15%) of 108 dropped out. The highest turnover rates were in Thyolo on the tea estates, 45%, and in Ekwendeni among the male motivators, 21%.

The data did suggest a relation between the frequency of supervision and the turnover rate. CBD agents from the projects with the highest turnover rates reported the least frequent supervision, and those with no turnover rate reported the most frequent supervision.

Thyolo and Ekwendeni reported the least frequent supervision. In Ekwendeni 16.6% said they had been supervised within the previous two weeks; 54% said their most recent supervision had occurred between 3 weeks to over 3 months previously; 29% gave no information on this question. In Thyolo 11.1% reported having been supervised within the previous two weeks; 55% from 3 weeks to over 3 months previously; for 33% there was either no answer or no record in the visitors' book of supervisory visits.

CBD agents from projects with no turnover rates were Sangilo, Salima, Kabudula and Nsanje. 100% from Sangilo, 77% from Kabudula, 60% from Salima and 40% from Nsanje reported having been visited within the previous two weeks. None reported a supervisory visit occurring more than a month before.

Duration of the project was not consistently related to the turnover rate. Both Sangilo and Nsanje had no turnover, yet they had been functioning for one year, and one year and seven months respectively. Mangochi had a 9% turnover rate and had only been functioning for eight months.

The projects in Ekwendeni and Thyolo both had higher turnover rates than average and had been functioning the longest. The CBD manager in Thyolo suggested that the main reason for the high turnover rate on the tea estate was the high mobility rate of estate workers and husbands' disapproval of wives working for free as a CBD volunteer.

2. Attitude toward work

89% of the CBD agents interviewed reported that they would be willing to work as long as they were needed. They demonstrated a positive attitude toward their work explaining that they gained much satisfaction from doing a job that they thought was very important. The interviews suggested that these positive aspects strongly out-weighed the negative. The CBD agents expressed an interest in solving the problems rather than in quitting their jobs because of them.

The negative aspects can be classified into three categories: a) lack of material compensation; b) frustration with the villagers' refusal to accept or understand the need for family planning; c) negative reactions of the villagers to the CBD agents.

a. Lack of material compensation

In all the projects, the most frequently mentioned dislike was the lack of monetary or material compensation. No one expressed plans to quit working because of this, and many who made this complaint had been working for the life of the project. However, they did not all work consistently nor did they visit households and seek new clients on a regular basis. Both informal discussions with the CBD agents and observations of their work suggested that the lack of remuneration may have been a factor that discouraged them from consistent work.

Some CBD agents in Ekwendeni, Kabudula, Sangilo, Mangochi and Salima indicated a conflict between the time spent on volunteer work and that on remunerative work. If the time taken from remunerative work in order to do the volunteer work resulted in decreased revenue, then there was a problem. This suggested that if the other villagers helped the CBD agents with their farm work they would continue to work voluntarily. However, there was little indication that the villagers were willing to do that.

b. Frustration with the villagers' refusal to accept or understand the need for family planning.

During the interviews, the CBD agents were asked to discuss reasons for liking their work. In these discussions they expressed a strong commitment to the importance of family planning among the villagers, and their concerns reflected that commitment. The CBD agents were frustrated when villagers did not understand what they were trying to explain and were unwilling to accept them because of this lack of understanding.

In Ekwendeni, Kabudula and Sangilo CBD agents were concerned when "...Older people discourage the younger ones." In Kabudula a CBD agent said that she felt bad when a client refused to start a contraceptive method and then returned to her later, pregnant, asking for a method. In Nsanje, Thyolo, Kabudula and Mangochi, CBD agents were concerned when women

who wanted to start a contraceptive method didn't because of their husband's disapproval. Others were disconcerted with clients who discontinued methods after having accepted them from the CBD agent; similar frustration was expressed over villagers' refusing contraceptives because they believed they would damage the uterus and the CBD agent's inability to dispel that misconception.

c. Negative reactions of the villagers to the CBD agent.

CBD agents reported stories of being blamed for either real or perceived problems that villagers had with contraceptives prescribed by them. For example, it was reported that a woman was given Lofeminol while she had malaria; she then blamed the CBD agent for her illness. In Kabudula, Nsanje and Salima CBD agents complained of villagers being rude and disrespectful towards them. In Ekwendeni 10 out of 25 CBD agents reported that villagers treated them rudely because they accused the CBD agents of promoting promiscuity.

3. Suggestions for improving the work situation

The CBD agents were asked how they would improve their work situation so as to correct those aspects they did not like. In order of frequency the suggestions were:

- a. salary
- b. community education
- c. bicycles, soap
- d. help from government
- e. uniforms, improved counseling, medicine to use at home and home visits by supervisors
- f. more training for CBD agents

While salary/money was the most frequently mentioned item, it is important to note that only 31% of the CBD agents requested monetary compensation for their work. This excludes responses requesting money specifically for soap. The data indicated differences among the projects as to the importance of money. Table 26 compares the requests for money.

TABLE 26: CBD AGENTS REQUESTING MONETARY REMUNERATION BY PROJECT

Project	No/% of CBD agents interviewed requesting monetary compensation
Sangilo	4/100%
Ekwendeni	7/29%
Kabudula	3/23%
Salima	5/50%
Mangochi	1/11%
Thyolo	2/22%
Nsanje	3/30%
Total	25/31%

69% of the CBD agents interviewed appeared to be willing to continue working without monetary compensation but preferred some aid in kind such as soap or help in their work as mentioned above.

C. Village material sustenance of CBD project

1. Material support

Data from all the focus groups indicated that village leaders and ordinary villagers were not willing to contribute in any material way to sustain the CBD projects. They tended to expect the government to financially support them. Those who were aware of foreign donors accepted or possibly expected that source of funding as well.

2. Non-material support

Several types of non-material support were suggested in the focus group discussions, but there was no clear indication that villagers would actually supply this support. The suggestions are given below.

- a) Chiefs can motivate villagers to seek contraceptives from the CBD agent.**

During focus group discussions with village leaders in Ekwendeni, Kabudula, Mangochi, and Nsanje it was suggested that chiefs could play an active role in the CBD program by motivating villagers to obtain contraceptives from the CBD agent. Some examples of these ideas follow.

"If someone is having many deaths of children, chiefs can tell him/her to go to the CBD agents to be taught about family planning so that the children would be healthy." (Ekwendeni)

"The best thing, you should teach us about family planning and the benefits so that we the chiefs should be holding meetings to tell the people about FP." (Mangochi)

b) Leaders can assist in the organization of the CBD program by holding village meetings.

Village leaders in Nsanje, Ekwendeni and Sangilo recognized the need for their support if the CBD projects were to be maintained. Examples are as follows:

"If government tells us to assist...officially get involved...leaders can hold meetings...If (the leaders don't) support the CBDs, they will get abused."(Nsanje)

"Chiefs should help in organizing things before the CBD agents come." (Ekwendeni)

"Family planning can be maintained if CBD agents and chiefs are helping family planning programs in the villages." (Sangilo)

c) Villagers can be willing to learn from the CBD agents.

In all the projects the village leaders and villagers suggested that one way the community could help the CBD agents was to accept their work. Focus group participants expressed much interest in this idea in Ekwendeni, Kabudula and Mangochi. On the other hand, focus group discussion participants in Sangilo and Nsanje showed very little interest.

Some examples of very supportive groups were in Ekwendeni where village leaders suggested, "When we community members are taught by the CBD agents we should also be teaching our friends so that family planning should be improved." In the male focus groups villagers said, "In villages we can help CBD agents by allowing them to teach us whenever they want to teach us...We should be allowing our wives to go to the village groups to be taught." In Kabudula, village leaders expressed the same ideas and in Mangochi, the participants in the women's focus groups were especially enthusiastic.

The village leaders in Salima had another suggestion, "to help the CBD agents, villagers, especially parents, if they see that their children are spacing children very closely, should tell their own children about family planning." In the female focus group discussions in Thyolo another suggestion was made, "Encourage others who are not using family planning..."

d) Neighbors can help the family of the CBD agent when she's working.

There was very little interest in directly helping the CBD agents with their household or agricultural work so they could be freer to carry out their task as a CBD agent. This idea was only suggested in Ekwendeni and Mangochi. For example, in the Ekwendeni female focus group

discussion it was suggested that, " When she has gone for a refresher course, the community should help her family," or that villagers could "...Help plow his garden."

In Mangochi one suggestion was given by a participant in the female focus group discussion that they could help "...by giving him/her anything in the form of a cup of tea or other food or even a mat."

e) Expressions of inability to give support.

In Ekwendeni, Salima and Thyolo focus group discussion participants also indicated that they did not know ways for the community to help the CBD agents. Some examples follow.

"We don't know how we can help because we don't have CBDs in our area." (Male focus group in Ekwendeni)

"There are no ways how we as community members can contribute to the improvement of the CBD program because they don't visit us, and no one tells us something about the program." (Male focus group in Salima)

"But if they can ask us to give a help, we can help and we can also start using the contraceptives." (Male focus group in Salima)

"We get busy working for food and clothing for children." (Female focus group Thyolo)

"Others discourage CBD agents' work." (Female focus group Thyolo)

D. Villagers' assessment of whether CBD project will last

Data from the focus group discussions revealed little insight concerning people's assessments of whether the CBD projects will endure. The consensus of the discussions in Ekwendeni, Kabudula, and Mangochi was that the projects would last because family planning will be needed for a long time to come. The male focus group participants in Salima simply said that they don't think the project will last because the CBD agents are lazy.

E. Villagers' assessment of what could be done to assure long duration of CBD project.

Focus group discussions revealed many ideas of activities which could be done to assure the long duration of the CBD projects. However, little commitment was expressed on the part of the participants to do anything themselves to contribute to these activities. Below is a list of the suggestions in order of frequency mentioned.

1. Increase the number of CBD agents.
2. CBD agents should be given enough of everything that they need for their work and some remuneration. Remuneration suggested was: monthly salaries ranging from K150 - K300 per month, soap, transport, uniforms.

3. Committees should be formed to educate the community and support the CBD agents. Chiefs can organize this and should be given special training in family planning so that they can assist in the education. Villagers can also encourage each other and prepare their neighbors for the CBD agents' visits.
4. Supervision of CBD agents should be strengthened so that their problems can be dealt with immediately.
5. The government should continue with assistance and provide solutions for problems. It should provide seminars for CBD agents.

F. Actions taken by the village to sustain the CBD project

Data from the focus group discussions revealed that the villagers and their leaders actually do very little to help sustain the CBD projects. The village leaders in Kabudula, Sangilo, and Mangochi reported that they do nothing to help sustain the projects. Those in Ekwendeni, Nsanje and Salima reported that they helped when the CBD agents requested help. However, it was never in the form of material contributions or help with tasks. It was by encouraging villagers to use contraceptives or by solving a problem between a CBD agent and a villager. No one in any of the village member focus groups reported helping the CBD agents other than by allowing them to visit or by taking contraceptives.

SECTION THREE - CONCLUSION AND RECOMMENDATIONS

I. CONCLUSION

The CBD projects were basically effective and contributed positively to the contraceptive prevalence rate in Malawi. The CBD agents exercised a major influence on villagers' acceptance of contraceptive use, and on the whole, were well received by their communities. There were variations in the effectiveness and quality of the different CBD projects mainly due to differences in commitment of the CBD managers, support from the District Health Officer or NGO project managers, the quality of supervision, and sensitivity to specific cultural and geographical characteristics of the CBD catchment areas. Although the CBD agents received little material incentives for their work, there was very low turnover. However, consistency of their work tended to decline after time. Regular field supervision of the CBD agents with corrective feedback by the CBD manager and project supervisor contributed to the continual and effective functioning of the CBD projects.

Sustainability continued to be a serious problem as, while the community members were willing to provide moral support, they were not willing to provide material support and had little means to do so. Projects mainly dependent on the government had difficulties because of the limited governmental resources. Those managers who were skilled in proposal writing and practiced efficient planning were able to procure non-governmental grants on a continuous basis and thus assure the continuity of their projects.

In the light of the positive contribution the CBD projects are making to family planning, it is important to address the following problems to ensure a steady improvement in the quality and effectiveness of the services.

II. RECOMMENDATIONS

Recommendations will be presented for each quality indicator that was discussed in the report. The problem to be addressed will be presented first followed by recommendations.

A. Technical Competence and Safety

CBD agents have many misconceptions about the contraceptive methods. They do not understand enough about side effects to effectively help clients, and they do not sufficiently understand the screening check list to assure that information collected is accurate.

Recommendation 1: The following areas must be further addressed in both training for new CBD agents, in refresher courses, and supervision:

Clarification on oral contraceptives should include the following:

- a. What to do if pills are missed and the relation of missing pills and pregnancy risk. .
- b. Reasons for taking progesterone only pills during lactation.

- c. Differentiation between physiological reactions that are actually attributable to side effects from pills to those that are not.
- d. Confusion concerning the relation of oral contraceptives and blood.

Clarification on amount of time to wait between insertion of spermicidal tablets and intercourse.

Clarification of duration of effectiveness of Depo-Provera.

Clarification of expected side effects of Depo-Provera and distinction between those that are harmful and those which are uncomfortable but cause no harm, and how to manage these problems.

Further explanations of the screening check list so that the CBD agents clearly understand it and can explain questions to potential clients. Emphasis on the necessity of assuring that the client understood the questions asked and gave accurate answers.

B. Quality of the CBD-Client Consultation

The amount of information currently required to be given by the CBD agent during the consultation may be too much. This may result in a first time consultation which is too long to ensure client retention of important family planning information .

Recommendation 1: A review of the structure of the CBD consultation is needed. To reduce the time of the consultation, detailed information on all contraceptives could be given at several community meetings led by family planning providers or community health nurses with family planning training. Then more focused information needed for contraceptive choice, prescription and use could be given at the home visit.

Consultations are not always conducted in privacy nor is confidentiality assured. There are several weaknesses in the consultation which can be addressed by training.

Recommendation 2: Various types of training activities should be held regularly in order to improve the quality of the consultation. For example, one day or even half day refresher workshops could be held by the project managers every few months which focus on one area of family planning that the CBD agents select themselves. These could be held in the same place as the mobile clinic or monthly meetings. Training workshops should address the following:

- a. The necessity of confidentiality and privacy.
- b. The necessity to tell about all contraceptives, not just the pill and Depo-Provera.
- c. The necessity of consistently collecting information on age, marital status, number of pregnancies, number of births, number of living children, family planning use and basic medical information from new clients.
- d. The correction of misinformation.

- e. The need to strengthen the discussion of the advantages and disadvantages of family planning and possible side effects.
- f. The process of helping clients choose a method.
- g. The necessity of the CBD agent to ask for feedback to ensure the client understood the information.

C. Choice of Method

There was a bias toward oral contraceptives in terms of availability and information given. More information was given on pills than any other methods and they were more consistently available than the other contraceptives as well.

Recommendation 1: A review of the information to be given during the consultation should be made to ensure that equivalent information is given about all methods. However, the information session must not be so long that the potential client begins to stop paying attention or cannot internalize the quantity of information given.

Recommendation 2: Depo-Provera, condoms and spermicide must be consistently available. To assure this, HSA 's could be trained to administer Depo-Provera. Increased supplies of condoms and spermicide should be accessible since CBD agents did not have sufficient supplies for either back-up use for all their clients or continual use as a contraceptive.

The various systems for contraceptive procurement used by the different CBD projects all appeared to be viable as long as all the necessary resources were available to implement them, and the managers, supervisors and CBD agents were strongly committed to make the system work. The main problems were that supplies did not always match consumption. Lack of transport prevented supervisors from making monthly supply visits to CBD agents. It was difficult for CBD agents to get resupplied if they missed the supervisors monthly resupply visit. Also, the receipt of condoms by the CBD agent and their distribution to clients was not consistently tracked.

Recommendation 3: An improved procurement system must address the practical problems of implementation and a sense of commitment must be internalized by the CBD managers, supervisors and agents to make it function reliably.

Availability of family planning services to all interested villagers is limited because it is very time consuming for CBD agents to go from household to household to provide family planning services to everyone.

Recommendation 4: Since the CBD agents go to the outreach clinics for monthly meetings to get their contraceptive supplies, their presence could be taken advantage of for family planning IEC activities and contraceptive distribution among the villagers.

Recommendation 5: Villages could set up contraceptive depots from which CBD agents would provide services in addition to the household visits.

High discontinuation rates may be due to side-effects which cannot be resolved because only two formulations of pills are available or because of an interrupted month if the CBD agent does not resupply the client.

Recommendation 6: To assure that clients don't discontinue oral contraceptive use due to side effects of the particular formulas of either Lo-Femenal or Ovrette, the only two brands available, other oral contraceptive formulas should be made available.

Recommendation 7: To assure continuation of oral contraceptive use, CBD agents should give more than one cycle of pills to clients on subsequent visits if the client is not having any side effects. CBD managers need to look into why CBD agents continue to give only one cycle even after the clients have successfully been taking the pills for several months.

Frequently people who have much influence over a woman's decision to use contraceptives were neglected by the CBD agent in the process of recruiting or maintaining continuation among users. Also CBD agents do not take full advantage over their own positive influence to encourage new contraceptive acceptors. They tend to establish a set of clients who have accepted pill use and continue to visit those while neglecting to make visits to additional households where family planning methods have not been accepted.

Recommendation 8: As husbands had a large influence on contraceptive use and choice, more emphasis should be made on including them in the CBD visit either separately or together with the wife, as appropriate.

Recommendation 9: CBD agents should be encouraged to visit more new households than they currently do, including older women and women, other than those who have new born babies.

Recommendation 10: CBD agents should take advantage of satisfied contraceptive users who are influential among their peers to help increase acceptability.

D. Administration and Management

CBD records are not kept properly nor consistently resulting in inaccurate national health statistics and an unreliable way to track clients for follow-up for either possible medical problems or unnecessary contraceptive discontinuation.

Recommendation 1: First time CBD training, refresher courses and supervision with immediate feedback must emphasize why records must be correctly and consistently kept in a manner that the CBD agents will internalize the importance of doing so.

Recommendation 2: Since many of the CBD agents were not aware of their problems and confusion existed as to how they were supposed to keep the records, field supervision

should especially address this problem and stress those inconsistencies and difficulties which were cited in the text of this report.

Recommendation 3: Because of the high number of incomplete registers and erroneous entries, the entire system should be simplified. The development of any new system should take into account the low level of education of the CBD agents.

Supervision of CBD agents is irregular and inadequate due to insufficient material and human resources and/or lack of commitment of some CBD managers, supervisors and District Health Officers.

Recommendation 4: When designing a CBD program, sufficient financial, material and human resources must be allocated to cover all supervisory needs of projects.

Recommendation 5: Since the effectiveness of the HSA's as supervisor depends on the supervision they receive from the project manager, it is important that the HSA be closely supervised by the CBD manager consistently providing constructive feedback.

E. Mechanisms to Encourage Continuation of Contraceptive Use

Resupplying oral contraceptive users was mainly carried out, but not in the most efficient and consistent manner. There was no systematic mechanism to follow-up potential clients who had been visited once but had not accepted contraceptive use on the first visit nor a system to follow-up contraceptive drop-outs.

Recommendation 1: CBD managers should establish follow-up systems appropriate for each project and train their CBD agents during the monthly meetings. Through supervision, with adequate feedback, they should ensure that all the CBD agents implement that system. Refresher courses and training workshops for new CBD agents should also address this issue. The follow-up systems should all include a mechanism to register all people visited giving the results of that visit and a plan for revisits.

Recommendation 2: As CBD agents often did not find clients home for the revisits, and clients reported preferring appointments, household visiting could be made more efficient if CBD agents made follow-up appointments with their clients which could be written in the client register kept by the CBD agent and on the client card kept by the client.

While there was a mechanism to make referrals to the reference clinic, there was little coordination between the provider and CBD agent to follow-up on referrals and, except for Ekwendeni, the reference clinics had no records identifying CBD clients.

Recommendation 3: A mechanism should be set up in the reference clinic to identify all CBD clients so that these clients can be tracked both by static clinic providers and CBD agents if necessary. There should be a clear place in the CBD register to record the results of a referral rather than leaving the results only on the client card which is kept by the client and not the CBD agent.

Many pill clients did not go to the clinic for the required physical examination for reasons including the distance from the village, fear of the examination, and lack of adequate clothing. The CBD agents continued to resupply pill users, although they did not present for their physical examination, so as not to discourage them from continuing use.

Recommendation 4: The requirement of all oral contraceptive users to have a physical examination needs to be reviewed from a medical perspective taking into account the practicality of this requirement. It may be advisable to require physical examinations as a requisite for hormonal contraceptive use only for clients presenting contraindications before contraceptive prescriptions are made or side-effects after the first month of use. If after the review, a decision is made to continue the examination requirement as a prerequisite to hormonal contraceptive use, then special considerations should be made for the CBD client. For example, the CBD agent could take a group of clients to the referral clinic on a prearranged day where they would be given priority treatment. Where possible examinations could be done at outreach clinics close to the clients villages. If the review determined that a pelvic examination was not necessary, but medical monitoring was desired, the CBD supervisor or manager, if she was a nurse could visit oral contraceptive clients once every three months, take blood pressure and any other measures needed to assure the health of the client.

F. Appropriateness and Acceptability of Services

While in general CBD services are appropriate and acceptable to the community, accommodations to community needs could be improved in several ways. The CBD agents are generally accepted by the community, but sometimes their ability is too low to successfully complete the training.

Recommendation 1: The community could be better accommodated in the following ways:

- a. Advance appointments could ensure the presence of the client when the CBD arrives.
- b. In catchment areas where houses are very far apart, village depots could be set up from where the CBD agent could provide family planning services.
- c. Measures have to be made to take into account the inappropriateness of a CBD agent to provide contraceptive services to certain relatives.
- d. More strategies to involve husbands in family planning should be developed which are appropriate to the specific cultural and social context of the different CBD catchment areas.

Recommendation 2: In order to ensure that the CBD agent would be able to assimilate successfully the CBD training, the villagers should be asked to nominate two or three people for eventual selection. The program manager could administer a short pre-test at the village and the one who did the best is selected to go for the CBD training.

G. Integration of Family Planning and HIV/AIDS

While villagers show a certain awareness of AIDS, their knowledge is superficial and they have many misconceptions. However, they are interested in learning more. CBD agents may be appropriate to give some information concerning AIDS, but the amount they could do is limited. Including family planning and AIDS messages in the same visit may not be acceptable according to some villagers because they associated AIDS with promiscuity and family planning with family life.

Recommendation 1: A multifaceted approach to village-level education that exploits all possible resources should be taken. Health workers, CBD agents, chiefs, clergy and other village leaders can be utilized. Information can be spread using a variety of vehicles: drama, song, radio and discussions are a few examples. Villagers may suggest new forms that might prove effective in communicating information.

Recommendation 2: Community AIDS education should deal with the subject at greater depth than has been done so far and should address specific misconceptions and topics of concern such as:

- a. Misconceptions about modes of HIV/AIDS transmission such as sharing clothes, drinking bad water and shaking hands.
- b. Ways to distinguish between people with AIDS and those suffering with similar symptoms not related to AIDS. This is an important problem because some HIV-negative people may exhibit symptoms similar to those associated with AIDS. They may be denied treatment for their curable disease on the basis that since AIDS is incurable, it is a waste of resources to offer treatment.
- c. Direct discussion of the stigma attached to AIDS should be held so that villagers will be better prepared to deal with both HIV infected individuals and people who are sick with AIDS.
- d. More discussion of condom use is needed to lessen the resistance to using them.

Recommendation 3: A review of methods of communicating information about AIDS should be made. Further understanding of the effectiveness of radio is needed. There is much evidence that it is a very good means of spreading information. However, the meaning of the villagers' statement that "radio is too jovial" or that "we are too used to it," is not clear and may have important implications.

Recommendation 4: Villagers need help in knowing how to care for AIDS patients to avoid possible transmission of the HIV virus. They need information and also some simple materials for protection. Ways to care for incontinent patients or those who vomit frequently when water is scarce must be directly addressed.

Recommendation 5: The interest of the chiefs and other village leaders in community AIDS education should be fully utilized.

Recommendation 6: IEC materials should address the notion that many people perceive themselves at risk for AIDS transmission either through sex or other means. Educators should particularly note that both husbands and wives report the possibility of extramarital sex of their spouses as a means of transmission.

Recommendation 7: A further review of better ways to use CBD agents as AIDS educators needs to be made. Some agents may currently be under-utilized as AIDS educators; on the other hand, they have much work to do in the area of family planning, and they may not be able to do both effectively.

Recommendation 8: Villagers and their leaders currently tend to view AIDS as an individual problem rather than a community one. They need help in changing this perception so that they will begin to think of community solutions rather than personal ones. This is especially important since AIDS is transmitted as a result of social behavior.

H. Relation of the Community to the CBD Project

The community network is vital to the success of a CBD program, but there are many weaknesses in the links which should hold it together. This results in lack of commitment of key players which frequency leads to lack of necessary support for the CBD projects.

Recommendation 1: All the members of the community network should be involved from the onset of any project, in design, introduction, maintenance, and problem solving to strengthen their commitment.

Recommendation 2: There must be enough ground work to ensure that the people who were identified to be involved in the CBD program are those whom the villagers respect. There may be some one, other than a village chief who is held in especially high esteem who should be included.

Recommendation 3: To ensure continual involvement of village leaders, periodic village level family planning IEC activities should be held which involve people on all levels. This includes, on the district level, the community development officer, the health inspector, the agricultural officer; on the area level, the Community Development Assistant and the Health Assistant, HSA, Agricultural Extension Assistants.

Recommendation 4: Suggestions made by the CBD managers should be taken into account, e.g. village headmen could take active roles in the area health committees and could form and chair a family planning subcommittee. They could plan ways to encourage family planning in the villages. They could help the CBD agents deal with problems they encounter in their work. Periodic meetings with the village leaders should be held to exchange information on family planning and discuss concerns of the villagers. The leaders, in turn, could hold meetings with the villagers to deal with those issues and to encourage them to use family planning when appropriate.

Recommendation 5: To increase the sense of ownership of the CBD program, the CBD agents should be accountable to the Area Health Committee and village chief as well as to the CBD manager. The CBD manager along with the Health Committee and village chief should review the work of the CBD agent, provide support and constructive feedback, and help solve problems.

Recommendation 6: To ensure support from the reference clinic and other personnel in health centers in close proximity, the coordinator of the CBD program should be sure to keep them well informed of the CBD activities and include them in appropriate planning activities.

Recommendation 7: In order to ensure a sense of ownership by the village of the CBD program, the CBD agents should be selected by the villagers in such a way, that the villagers perceive that they, themselves, have had an influence on the selection.

Recommendation 8: Managers and family planning providers of CBD programs and static clinics should not perceive themselves as competitors for family planning clients. Rather they should see themselves as complementing one another and should find ways to cooperate.

I. Sustainability

Sustainability of CBD projects is greatly hampered because they all depend on external funding and current economic conditions indicate that this dependence is likely to continue. There is no national budget for CBD programs nor supportive resources on the district or local level. Also there is little commitment on the village level to support CBD programs.

Recommendation 1: The Ministry of Health should develop national plans for establishment and maintenance of CBD programs based on areas not served by static clinics. The CBD program should be part of the budget allocation and a mechanism for continuously seeking funding should be devised. The private sector should also be encouraged to continue the establishment and maintenance of CBD programs which run parallel to the National Program and follow the National CBD guidelines.

Recommendation 2: Other village based services such as TBA's and traditional healers for which people are willing and do pay should be studied to identify motivations behind this willingness to pay for the service.

Although the CBD agents are volunteers their drop-out rate was very low and they expressed as a motivation to continue work their satisfaction and recognition of the importance of increasing contraceptive use among the villagers. However, they tended to slacken the pace of work as time went on and did express the desire for some material incentives as well.

Recommendation 3: High quality supervision with much positive feedback and praise from village leaders and other influential people may be key to high level continuous work.

Recommendation 4: Experiments in income generating activities for CBD agents themselves or village level cooperatives such as flour mills, chicken breeding, etc. where the profits go to pay the CBD agents could be conducted. Systems using revolving funds shared by NGO's or from the Ministry of Health could be explored.

Recommendation 5: The use of other cadres of workers like agricultural extension workers, literacy instructors, community development workers, TBA's to distribute contraceptives on the village level should continue to be explored.

ANNEXES

DATA COLLECTION TOOLS

CBD AGENT INTERVIEW GUIDE

CBD Project identification _____
 Name of interviewer _____ Sex _____
 Date of interview _____
 Time: start _____ finish _____
 Region _____ District _____ Village _____
 Nearest health unit that provides family planning services _____
 Name of CBD Agent _____ Sex _____
 Ethnicity of CBD Agent _____
 Language spoken at home _____
 Other languages spoken _____
 Language of interview _____

1. How many villages do you cover?
 Name them:
Kodi mumayendera midzi ingati?
Itchulani yonse:
2. What is the size of your catchment area?
Kodi dela lomwe m'mayenderalo ndilalikulu bwanji?
3. How long have you been a CBD agent?
Kodi mwakhala pantchito yaulangizi kwa zaka zingati?
4. For how much longer do you think you will continue to be a CBD agent? If answers, for not very long, ask why?
Kodi mukuganiza kuti kutsogoloku mupitiliza kukhala mlangizi kwa zaka zingati? Ngati yankho lake ndi "kwa nthawi yochepa", mufunse chifukwa chake.
5. What do you like about the work?
Kodi pantchito imeneyi chomwe chimakusangalatsani ndi chiyani?
6. What don't you like about the work?
Nanga chimene chimakuipirani pantchitoyi nchiyani?
7. For these things you don't like about the work, are there ways to improve them so you would like it?
Pazinthu zimene zimakuipiranizo, kodi pali njira zimene zingatsatidwe kuti zinthu zikhale monga mufunila?
8. How were you selected to be a CBD agent?
Kodi inuyo mudasankhidwa bwanji kukhala mlangizi wa zakulera?
9. Did you receive basic training? Yes _____ No _____
Kodi mudaphunzirapo zaulangizi wa zakulera?
Inde _____ Ayi _____
10. How many basic trainings and refresher courses have you attended?
Kodi mwachitapo maphunziro angati a zakulera?

	Dates <i>Masiku</i>	No. of Weeks <i>Masabata angati</i>
Basic training <i>Maphunziro oyambirira</i>		
Refresher courses <i>Maphunziro okumbutsira</i>		

11. What did they teach you at the training sessions?
Kodi anakuphunzitsani zotani pa maphunziro anu?
12. What were you instructed to do at each household?

Kodi anakuuzani kuti mudzichita chiyani mukafika panyumba iliyonse?

13. Did the training and/or refresher course give you enough information so that you could do your job well?
Yes _____ No _____
Kodi mukuganiza kuti pamaphunziro anu oyamba ndi okumbutsirawo, anakuphunzitsani zokuthandizani kuti muzitha kugwira ntchito bwino?
Inde _____ Ayi _____
14. What other information do you need?
Kodi chimene chikufunika kuti mudziwenso nchiyani?
15. How often would you like to be trained?
Kodi mukufuna kuti mudziphunzitsidwa pafupipafupi bwanji zakulera?
16. Did you have any problems with the training?
Yes ___ No ___
a. If so what were they?
b. How do you think they could be remedied?
Kodi pali mavuto aliwonse amene mumakumana nawo pamaphunziro anu a zakulera?
Inde _____ Ayi _____
a. *Ngati mavuto amakhalapo, atchuleni?*
b. *Kodi mukuganiza kuti angathe bwanji?*
17. Are you supervised? Yes _____ No _____
Kodi amabwera odzakuyenderani? Inde _____ Ayi _____
18. By whom are you supervised?
Amadzakuyenderani ndani?
19. How often are you supervised?
Amakuyenderani pafupipafupi bwanji?
20. When was the last time your supervisor visited you?
Kodi ndiliti lomwe adadzakuyenderani? (Mupemphe kuti akuonetseni buku losaina alendo ngati lilipo ndipo ngati patsikulo linasainidwa?)
21. When you were supervised, what did the supervisor do?
Kodi nthawi yomwe adadzakuyenderaniyo adachita chiyani?
22. Was the supervisor helpful? Yes _____ No _____
Explain
Kodi mlangizi wanuyo adakuthandizani? Inde _____ Ayi _____
Fotokozani.
23. What could the supervisor do to be more helpful?
Kodi mlangizi wanuyo akadachita chiyani kuti akuthandizeni?
24. Do you tell the supervisor about the problems you encounter as a CBD agent? Yes _____ No _____
a. What problems have you told about?
b. What was the supervisor's response?
c. Did the problem get solved? How?
Kodi mumawafotokozerapo okuyang'anirawo za mavuto omwe mumakumana nawo inuyo paulangizi wanu wazakulera? Inde _____ Ayi _____
a. *Kodi mumawafotokozerapo zamavuto otani?*
b. *Okuyang'anirawo adakuyankhani bwanji?*
c. *Kodi vutolo lidatha? Lidatha bwanji?*
25. What kind of material support to you receive?
Kodi pantchito yanuyi, mumalandirapo chokuthandizani pa moyo wanu?
26. Do you need anything else? If so, what?
Kodi patsiku mumagwira ntchito ya ulangizi wa zakulera maola angati?
27. How many hours per day do you spend working as a CBD agent?
Pa sabata imodzi mumagwira ntchito yaulangizi masiku angati?
28. How many days per week do you spend working as a CBD agent?
Nanga inuyo anakuphunzitsani kuti muzigwira ntchito masiku angati?

Now lets talk about the home visits.

Tsono tikambepo zakuyendera anthu mmakomo.

29. How often do you make home visits?
Kodi anthu mumawayendera pafupipafupi bwanji m'makomo mwawo?
30. How many households have you visited all together?
Kodi chiyambireni, mwayenderapo makomo angati?
31. How many households do you visit in one day?
Kodi mumayendera manyumba angati patsiku?
32. How long do the visits last?
Kodi kuyendera anthuko kumatenga nthawi yaitali bwanji?
33. How do you chose which households to visit?
Mumasankha bwanji nyumba zofunika kuziyendera?
34. How many times do you visit the same household?
Kodi nyumba imodzi mumayiyendera kangati?
35. How do you select new households to visit?
Kodi nyumba zoyamba kumene mumazisankha bwanji?
36. Who do you talk to at each household?
Mukafika panyumbapo mumayankhula ndi ndani?
37. How do you decide who to talk to?
Mumasankhula bwanji ofunika kuyankhula naye?
38. Are other people present during the visit? If yes, is that a problem? Describe.
Kodi anthu ena amakhalapo pamene mukuyendera anthu? Kodi limeneli ndi vuto kwa inu? Fotokozani.
39. When you arrive at a household, how are you greeted?
a. Are there ever any problems when you first arrive? If so, describe them.
b. How do you deal with these problems?
c. Do you need help to deal with these problems? Describe.
Kodi mukafika pakhomo amakulandirani bwanji?
e. *Pali vuto lililonse lomwe mumakumana nalo mukafika pakhomo? Ngati lilipo, fotokozani.*
f. *Mavuto ngati amenewa mumathana nawo bwanji?*
g. *Kodi mumasowa chithandizo polimbana ndi mavuto ngati amenewa? Fotokozani.*
40. Do the members of the household want to talk to you?
a. If no, why?
b. If yes, what are they most interested in?
Kodi anthu a pakhomopo amafuna kuyankhula nanu?
c. *Ngati safuna, nchifukwa chiyani?*
d. *Ngati amakondwera, kodi chimene amasangalatsidwa nacho nchiyani?*
41. Describe exactly what you do at each household?
Fotokozani molongosoka zimene mumachita mukafika pakhomo?
42. How is it decided whether a client will use a contraceptive and which one he/she will use?
Kodi mumaganiza bwanji kuti munthu uyu adzagwiritsa ntchito njira yakulera ndi njira yoyenera iyeyo ndi yakuti yakuti?
43. If a woman or man wants to use a family planning method which you yourself do not supply, what would you do?
Kodi munthu akafuna kugwiritsa njira yolerera yomwe inu simupereka, mumatani?
44. What instructions do you give the client if he/she chooses:
Mumamulangiza zotani munthu akasankha kugwilitsa njira zolerera izi:
a. pills
Mapilitsi
Instructions:
Malangizo:
How many cycles do you give?
Mumapereka mankhwala ochuluka bwanji?
What do you tell the client when she has used up her pills? Describe in detail. (try to get this answer volunteered)

Mumamuza chiyani munthu akamaliza mankhwala olelera? Fotokozani mwatsatanetsatane. (Yankholi ayankhe yekha popanda inu kumuza).

(After she gives the above answer, if she says she tells the client to go for a check-up, ask:

(Funso la mmwambali akayankha kuti amamuza kuti apite ku chipatala mufunse mafunso awa:

v. Do the clients always go for the check-up?

Kodi nthawi zonse amapita kukayesedwa?

Yes _____ No _____,

Inde _____ Ayi _____,

If No:

Ngati yankho ndi ayi:

(1) Do you follow up to see if the client has gone for her check-up? Yes ___ No ___
Mumayang'anitsitsa kuti munthuyo mpaka apite kukayesedwa?

Inde _____ Ayi _____

(2) If yes, how do you follow up?

Ngati ndichoncho, mumaonetsetsa bwanji kuti munthuyo wapitadi?

(3) If she hasn't gone, do you give her more cycles of pills if she has run out of supply? Yes ___ How many? ___ No ___.

Ngati sanapiteko kodi mumampatsa mapilitsi ena ngati anamuthera? Inde _____ Angati _____ Ayi _____ many?

(4) What do you instruct the client when you have given this resupply?

Kodi munthu mukamupatsa mankhwala ena olerera mumampatsa malangizo otani?

(5) Do you find out why she didn't go for her check-up? Yes ___ No ___?

Kodi mudafufuza chifukwa chomwe sadapitire kukayesetsa kuchipatala?

Inde _____ Ayi _____

(6) If yes, what reasons do the clients give for not going for their check-up?

Ngati yankho lake lili inde, zifukwa zomwe adapereka zosapitira kuchipatala ndi ziti?

If the client went for her check-up:

Ngati munthu adapita kuchipatala kukayesetsa:

(7) Which health centre do the clients go to?

Chipatala chomwe adapitacho ndi chiti?

(8) Do the clients get more pills at the health centre? Yes ___ No ___

Kodi anthu olerawo amatenga mapilitsi olerera kuchipatalako? Inde _____ Ayi _____

(9) If yes, how many cycles are they given?

Ngati anthuwa amatengadi mapilitsi kuchipatalako, amapatsidwa ochuluka bwanji?

vi. If a women is breast feeding what would you advise her to do about family planning?

Kodi amai akakhala oyamwitsa mumamulangiza zotani zokhudza kulera?

vii. What types of side effects do the clients tell you about?

Kodi zoipa zomwe amakuuzani zokhudza mankhwala omwe amalandirawo ndi zotani?

(1) What do you tell them about these side effect

Kodi anthu mumawauza zotani zokhudza kuipa kwa:

b. condoms

Mipira ya abambo

Instructions:

Malangizo:

i. How many condoms to you give?

Muwapatsa mipira ya abambo ingati?

ii. Any complaints from clients about condoms?

Pali madandaulo aliwonse omwe olandira akhala akupereka okhudza mipira ya abambo?

- iii. What do you tell clients about those complaints?
Mumawauza zotani anthu pa madandaulo awo?

c. Depo-Provera

Kulera kwa jakisoni

Instructions:

Malangizo:

- i. Any complaints from clients about Depo?
Pali madandaulo aliwonse omwe olandira amapereka okhudza kulera kwa jakisoni?
- ii. What do you tell clients about those complaints?
Mumawauza zotani anthu pa madandaulo awo?

d. IUCD

Lupu

Instructions:

Malangizo:

- i. Any complaints from clients about IUCD?
Pali madandaulo aliwonse omwe oikitsa lupu amapereka okhudza njirayi?
- ii. What do you tell clients about those complaints?
Mumawauza zotani anthu pa madandaulo awo?

e. Tubal Ligation

Kutseka njira ya chiberekero

Instructions:

Malangizo:

- i. Any complaints from clients about tubal ligation?
Pali madandaulo aliwonse omwe otsata njirayi amapereka?
- ii. What do you tell clients about those complaints?
Mumawauza zotani anthu pa madandaulo awo?

f. Foaming tablets

Kuika mapilitsi a thovu mnjira ya amai

Instructions:

Malangizo:

- i. Any complaints from clients about tubal ligation?
Pali madandaulo aliwonse okhudza njirayi? igation?
- ii. What do you tell clients about those complaints?
Mumawauza chiyani anthu pa madandaulo awo?

How many do you give?

Mumapereka mapilitsi angati?

45. What reasons do people you visit give for not using contraceptives:

Kodi anthu amapereka zifukwa zANJI zomwe sagwiritsira ntchito njira zakulera izi?

a. Pills

Mapilitsi

What do you tell them?

Kodi anthu mumawauza chiyani zokhudza mapilitsi?

b. Depo-Provera

Kulera kwa jakisoni

What do you tell them?

Kodi anthu mumawauza chiyani zokhudza kulera kwa jakisoni?

c. Foaming Tablets

Mapilitsi a thovu

What do you tell them?

Kodi anthu mumawauza chiyani zokhudza kulera kwa mapilitsi a thovu?

d. Condoms

Mipira ya abambo

- What do you tell them?
Mumawauza chiyani anthu zokhudza mipira ya abambo?
- e. Tubal ligation
Kutseka chiberekero cha amai
What do you tell them?
Mumawauza chiyani anthu zokhudzanjirayi?
- f. Other(specify)
Njira zina (zitchuleni)
What do you tell them?
Mumawauza chiyani anthu zokhudzanjira zinazo?

RELATION TO COMMUNITY

MAKHALIDWE NDI ANTHU A PAMUDZI

46. As a CBD agent do you encounter any problems? Describe them. What do you do about them.
Inuyo ngati mlangizi wa zakulera, kodi mumakumana ndi mavuto aliwonse? Fotokozani za mavuto onsewo? Mumachita chiyani pa mavuto amenewa.
47. Do you think the people care whether the CBD agent is a man or a woman?
Kodi mukuganiza kuti anthu zimawakhudza mlangizi akakhala wamkazi kapena wamamuna?
- a. men prefer to talk to men and
Amuna amayankhula momasuka ndi amuna anzawo.
- b. women to women,
Akazi ndi akazi anzawo
- c. men to women
Amuna amamasuka kuyankhula ndi amai
- d. women to men
Amai ndi abambo
- e. it doesn't matter
Ziliba kanthu aliyense akhoza kukamba za kulera.
48. For those women who want to use a contraceptive have they usually made their choice of method before you arrive?
Amai amene amafuna kugwiritsa ntchito njira yakulera, kodi amakhala atasankhiratu njira yomwe akuifuna inu musanafike pakhomopo?
49. Are the men that you speak to interested in family planning?
Kodi abambo omwe mumayankhula nawo amakhala ndi chidwi ndi zakulera?
50. What do the men usually want to know about?
Kodi abambowo kwenikweni amafuna kudziwa chiyani pankhani yakulera?
51. Which contraceptives do they want to use?
Ndi njira iti yomwe amafuna kugwiritsa ntchito?
52. What qualities do you think that people would like in a CBD agent?
Kodi anthu amafuna kuti mlangizi azikhala ndi maonekedwe kapena makhalidwe otani?
53. How do you feel about your relationship with the community?
Mumamva bwanji paubale umene ulipo pakati painuyo ndi anthu am'mudzimo?

INTEGRATION HIV/AIDS WITH FAMILY PLANNING

KUPHATIKIZA ZA KACHIRROMBO KA HIV NDI MATENDA A EDZI

54. Do you think AIDS is a problem in this community? Explain in detail.
Kodi mukuganiza kuti matenda a Edzi ndi vuto lalikulu m'mudzi muno? Fotokozani mwatsatanetsatane.
55. What do you think about giving information about HIV/AIDS in addition to family planning when you do your home visits?
Kodi muli ndi maganizo otani pa zofotokozerana ndi anthu za HIV ndi Edzi pamene mukunka mufotokozerana anthu zakulera m'makomo mwawo?

EQUIPMENT AND SUPPLY INVENTORY

ZIDA NDI ZIPANGIZO ZAKULERA

(Verify that the supplies actually exist, if you cannot verify do not tick)

(*Muonetsetse kuti zinthuzo zilipo, ngati simunazione, musachonge*)

1. Bicycle
Njinga
2. Blood pressure cuff
Choyesera kuthamanga kwa magari
3. Stethoscope
Choyesera kupuma
4. CBD record book
Buku la zochitika nkulera kwa kumudzi
5. CBD procedure manual
Buku la dongosolo wakulera kwa kumudzi
6. Contraceptive sample kit
Bokosi loikamo zipangizo zakulera
7. Contraceptive instruction sheet
Pepala la malangizo akulera
8. Pamphlet on benefits of FP
Kabuku ka ubwino wakulera
9. Other (specify)
Njira zina (tchulani)
10. Contraceptive supplies in the CBND's possession (Count them)
Mankhwala olerera omwe anali ndi mlangizi wa zakulera (awerengeni)
 - a. Combined pills:
Mapilitsi amphamvu ziwiri

Brand name:	number of cycles/packets
<i>Dzina/mtundu</i>	<i>kuchuluka kwa mankhwalas</i>
<i>Wa mankhwala</i>	
Brand name:	number of cycles/packets
<i>Dzina/mtundu</i>	<i>kuchuluka kwa mankhwalas</i>
<i>Wa mankhwala</i>	
 - b. Progesterone only pills:
Mapilitsi amphamvu imodzi:

Brand name:	number of cycles/packets
<i>Dzina/mtundu</i>	<i>kuchuluka kwa mankhwalas</i>
<i>Wa mankhwala</i>	
Brand name:	number of cycles/packets
<i>Dzina/mtundu</i>	<i>kuchuluka kwa mankhwalas</i>
<i>Wa mankhwala</i>	
 - c. Condoms
Mipira ya abambo

	Number of single pieces
	<i>Inalipo ingati</i>
 - d. Spermicide
Mapilitsi opha mphamvu ya umuna

	Number of tubes
	<i>Anali machubu angati</i>
 - e. Foaming tablets

	number of tablets
--	-------------------

f. Other (specify)

Mankhwala ena (atchuleni)

Ask the CBD agent if she has enough supplies each month?

Mufunse mlangiziyo ngati amakhala ndi mankhwala olerera okwanira mwezi uliwonse.

Does he/she have any difficulty getting resupplied so that she can keep up her supply? Yes ___ No ___

Kodi pali mavuto aliwonse omwe amkumana nawo akamatenga mankhwala olerera kuti asamuthere? Inde ___

Ayi ___

If Yes, what is the problem?

Ngati mavuto amakhalapo, ndimavuto amtundu wanji?

Any suggestions to remedy the problem?

Pali maganizo aliwonse othandiza kuthetsa mavutowa?

RECORD BOOK

BUKU LOLEMBAMO ZOCHITIKA ZONSE

Ask the CBD agent if you can look at the record book and record the following information:

Mupemphe mlangiziyo kuti akuwonetseni buku lomwe amalembamo zonse za kulera kw a kumudzi ndipo mulembe zinthu izi ngati zilimo:

Ask the CBD agent if he/she has any trouble filling out the record book.

Yes ___ No ___

What are the difficulties?

Any suggestions to make it easier to fill out the record book?

11. Condition of the record book:

- a. Good (clean, readable, no torn pages)
- b. Poor (hard to read, many torn pages)
- c. Very poor (unreadable, very dirty, many torn pages.)
- d. No record book.

12. Abstract and record the following FP statistics for the last three months:

FP Service	Last month	Month before last	Month before that	Last month	Month before last	Month before that
	N C	N C	N C	N C	N C	N C
Progesony						
combined pills						
foam						
referrals						

Ask the CBD agent if he/she has any trouble filling out the record book.

Yes ___ No ___

What are the difficulties?

Any suggestions to make it easier to fill out the record book?

13. Condition of the record book:

- a. Good (clean, readable, no torn pages)
- b. Poor (hard to read, many torn pages)
- c. Very poor (unreadable, very dirty, many torn pages.)
- d. No record book.

14. Abstract and record the following FP statistics for the last three months:

FP Service	Last month	Month before last	Month before that	Last month	Month before last	Month before that
	N C	N C	N C	N C	N C	N C
Progesonl y						
combined pills						
foam						
referrals						

CLIENT INTERVIEW

EXIT INTERVIEW: _____ FIRST TIME VISIT _____
SUBSEQUENT VISIT _____

CLIENT INTERVIEW: _____ VISITED ONCE _____
VISITED MORE THAN ONCE _____

GREETINGS: (Use greeting decided upon during the training.) We would like to improve the FP services by the CBD and would be interested to find out your feelings about the services. Can I ask you a few questions?

(Interview person visited even if he/she did not accept a FP method)

Client number _____ Sex M F
CBD Agent who did consultation _____
Village _____ District _____ Region _____
Date _____
Name of interviewer _____ Sex M F
Duration of interview time started: _____ time ended: _____
Language of interview _____

DEMOGRAPHICS

Ethnicity of client _____
Religion _____
Language spoken by client at home _____
Other language(s) client speaks _____
Highest level of school attended _____
Marital status: single _____ widow _____ divorce _____ married: polygamous _____ monogamous _____
living together _____

Number of living children _____
Would you like to have more children _____

(If yes) How many months from now would you like to have your next child? _____

1. What was the main reason for today's (the last) visit by the CBD agent?

Kodi ndi chifukwa chiani cheni cheni a CBD anabwerera kuno?

- a. FP first visit
- b. Resupply (of which contraceptive) _____
- c. Follow-up
- d. Other (specify) _____

Was this the first time you have ever been visited by a CBD agent?

Kodi aka kanali koyamba kuyenderedwa ndi CBD agent?

- i. (exit and client) How many times have you been visited?
- ii. (client) When was the last time the CBD agent visited you?

2. What do you think about this visit?

Kodi mukuganiza chiani za kubwera kwao?

- a. Which aspects of the visit did you like? Why?
Kodi ndi chiani chimene chakusangalatsani? Nanga ndi chifukwa chiani zakusangalatsani?
- b. Which aspects of the visit didn't you like?
Kodi ndi chiani chimene sichinakusangalatseni. Why?
Nanga ndi chifukwa chiani sizinakusangalatseni?

3. Was the CBD agent polite? Yes _____ No _____

Kodi anakulankhulani mwaulemu?

4. (If no ask) What did she/he do that was not polite?
Kodi anapanga chiani chopanda ulemu?
5. Did you understand what she/he told you?
Yes ___ No ___
Kodi mwamvetsetsa zimene akuuzani?
6. (If no) Did you ask her/him to explain again?
Kodi munawafunsa kuti abwereze?
Yes ___ (go to 7b) No ___ (go to 7a)
- a. (If not, ask this question in a very polite tone of voice.) Why not?
Kodi chinakulepheretsani ndi chiani?
- b. (If yes) Did you understand what the CBD agent said the second time?
Kodi munamvetsetsa m'mene anakubwerezerani?

CONTRACEPTIVE USE

7. Are you currently using a contraceptive method?
Kodi mukugwiritsira ntchito njira yakulera ili yonse?
- a. Yes ___ (Go to question 9)
- b. No ___ (Go to non user section)
8. When did you decide to use this method?
Kodi ndinthawi iti imene munaganizira kuti mugwiritse njira imeneyi
- a. At the time of the visit of the CBD agent. (go to question 28)
- b. I had decided before the CBD agent came, but when the CBD agent came was the first time I started a method. (go to question 29)
- c. I was already using a method before the CBD agent came to my house. (go to question 10)
- d. Other (specify) _____

Already using method before CBD visited him/her

9. Which method?
Nanga njira yake ndi iti?
- a. Pill _____
- b. Condom _____
- c. Foaming tablet/spermicide _____
- d. IUCD _____
- e. Injection (Depo-Provera) _____
- f. Traditional method(Which ones)
- g. Other(specify) _____
10. When did you start to use this method?
Kodi munayamba liti kugwiritsira ntchito njirayi?
11. How did you obtain this method? Where? Describe.
Kodi mudaipeza bwanji njira imeneyi? Kuti? Fotokozani.
12. a. How did you decide to use family planning?
Kodi ndi chiyani chinakupangitsani kuti mugwiritse njira ya kulera?
- b. Why did you chose this particular method?
Chifukwa chiyani munasankha ngira imene mukugwiristirayo?
13. Did you discuss using a family planning method with your husband?
Kodi munayamba mwakambirana ndi amuna anu pa zakulera?
- a. If no ask the following questions: No: _____
- i. Does your husband know you are using a contraceptive method now?
Kodi amuna anu akudziwa kuti muligwiritsa njira yolera tsopano?
Yes ___
No ___ (Ngati simunawauze chifukwa chiani?)

- ii. (If no) How do you keep it a secret? Explain. (Go to question 14)
Nanga mwasunga bwanji chinsinsi chimenechi kwa amuna anu?
- b. If yes ask the following questions: Yes _____
- i. Describe the discussion.
Tafotokozani mmene munakambirana ndi amuna anu pazankhani imeneyi ya kulera.
- ii. What was your husband's opinion about using a method?
Kodi amuna anu anaganiza chiani pankhani imeneyi yolera?
- iii. Did he help you to join family planning. Why
Kodi amuna anu anaonetsa chidwi kuti kukanakhala kwabwino kuti inunso muchite nawo maleredwe. Chifukwa chiani?
- (1) Did he know about the methods?
Kodi akudziwa za maleredwe? Maleredwe woti?
- (2) Did he have opinions about which methods would be good for you? Explain.
Kodi anakuuzani njira imene anaganiza kuti inali yabwino kwa inu? Tafotokozani.
14. Did you talk about family planning methods to anyone else? Who? Explain what you talked about.
Kodi munakambiranapo wina aliyense za maleredwe? Ndani? Muwauza zotani?
15. Who influenced you the most in your decision to use contraceptives?
Ndi ndani anakupangikani kwambiri kuti mutsate njira zamaleledwe?
16. Have you used any other methods?
Kodi munagwiritsapo njira yamaleredwe yosiyana ndi imene mukugwiritsira pano?
- a. (If yes) Which method?
Nanga njira yake ndi iti?
- i. Pill _____
- ii. Condom _____
- iii. Foaming tablet/spermicide _____
- iv. IUCD _____
- v. Injection (Depo-Provera) _____
- vi. Traditional _____
- vii. Other(specify) _____

DESCRIPTION OF VISIT

Now lets talk some more about the visit you just had with the CBD agent.

17. What happened during this visit of the CBD agent? What did she/he tell you? Describe the visit. What was its purpose?
Kodi kunachitika chiani pamene anakuyenderani a CBD? Kodi anakuuzani chiani? Tafotokozani zamachezedwe anu? Cholinga chawo chinali chiani?
18. a. Was the visit helpful? Describe.
Kodi kucheza kwa kunali kwa phindu?
- b. Did the CBD agent take care of your needs?
Kodi a CBDwa anakuthandizani? Anakuthandizani bwanji?
19. Have you had any trouble with the contraceptive you are using now? Describe.
Kodi munapezapo bvuto liri lonse ndi njira ya maleredwe imene muli kugwiritsira nchito pano? Tafotokozani.
- a. Did you tell the CBD agent about that trouble?
Kodi munawauza a CBD za bvuto lanu?
- Yes _____ No _____
- i. (If not) Why?
(Ngati ai) Chifukwa chiani?
- ii. (If yes) How did the CBD agent reply?
(Ngati ndi eeh) Adakuyankhani zotani.

- iii. Was what she said helpful? Explain.
Kodi zimene ananena zinali zothandiza? (Tafotokozani)
20. Did the CBD agent refer you to a health centre?
Kodi anakutumizani kuchipatala?
- a. Yes ENYA
- b. No YAYI
- c. (If yes) Which health center?
(Ngati eeh) Adati mupite chipatala chiti?
- d. Will you be able to go?
Kodi mudzatha kupita?
- e. By what means of transportation will you go?
Kodi mudzapita bwanji?
- f. When will you go?
Nanga mudzapita liti?
- g. Is it a problem for you to be referred to the health centre? Explain.
Kodi ndi kobvuta kwa imu kutuuzani chipatala. Tafotokozani

INTEGRATION HIV/AIDS WITH FAMILY PLANNING

21. a. Have you heard about HIV/AIDS?
Kodi munamvapo zamatenda a AIDS?
- b. What do you know about it? Describe.
Kodi mudziwapo chiyani zamatenda a AIDS? Tafotokozani
22. Do you have people with HIV/AIDS in your community? Explain.
Kodi muli anthu amene ali ndi Edzi mmudzi mwanu? Mungatiuze?
23. What do you think about the CBD agent giving information about:
- a. HIV/AIDS?
- b. the use of condoms for HIV/AIDS prevention as well as family planning?
24. Did the CBD agent talk about HIV/AIDS at this visit?
Kodi a CBD anayankhulapo za Edzi?
- a. If so, what did she/he say?
Anati chiani?
- b. Was it helpful for you? Explain.
Zinali zothandiza? Tafotokozani
25. Would you like the CBD agent to visit you again?
Kodi mungakonde kuti a CBD atakuyenderaninso?
- a. Yes (go to 27)
- b. No Why not? (go to 28)
26. (If Yes) What would you want her to do on the next visit?
Mufuna adzachite chiani atabweranso?
27. Do you have suggestions for how she/he could improve her visit?
Kodi muganiza kuti azichita chiani a CBD kuti kucheza kwawo kukhale kokukomerani?

Comments:

END OF INTERVIEW FOR CLIENT WHO ALREADY HAD CONTRACEPTIVE
 FOR CLIENT WHO GOT HER CONTRACEPTIVE METHOD FROM THE CBD AGENT CONTINUE
 WITH QUESTION 29

28. Do you think you would have started using a family planning method if the CBD agent had not come to your house? Explain.
Kodi mukuganiza kuti mukanyamba kugwilitsa ntchito njira za maleledwe kukanakhala kuti CBD sanabwere ku nyumba kwanu?
29. a. How did you decide to use family planning?
Kodi ndi chiyani chinakupangitsani kuti mugwiritse njira ya kulera?
 b. Why did you chose this particular method?
Chifukwa chiyani munasankha njira imene mukugwiristirayo?
30. Did you discuss using a family planning method with your husband?
Kodi munayamba mwakambirana ndi amuna anu pa zakulera?
 a. No _____
 i. Does your husband know you are using a contraceptive method now?
Kodi amuna anu akudziwa kuti muligwiritsa njira yolera tsopano?
 Yes _____
 No _____ (*Ngati simunawauze chifukwa chiani?*)
 ii. (If no) How do you keep it a secret? Explain. (Go to question 14)
Nanga mwasunga bwanji chinsinsi chimenechi kwa amuna anu?
 b. Yes _____
 i. Describe the discussion.
Tafotokozani mmene munakambirana ndi amuna anu pazankhani imeneyi ya kulera.
 ii. What was your husband's opinion about using a method?
Kodi amuna anu anaganiza chiani pankhani imeneyi yolera?
 iii. *Kodi amuna anu anaonetsa chidwi kuti kukanakhala kwabwino kuti inunso muchite nawo maleredwe. Chifukwa chiani?*
 (1) Did he know about the methods?
Kodi akudziwa za maleredwe? Maleredwe woti?
 (2) Did he have opinions about which methods would be good for you?
 Explain.
Kodi anakuuzani njira imene anaganiza kuti inali yabwino kwa inu?
Tafotokozani.
31. Did you talk about family planning methods to anyone else? Who? Explain what you talked about.
Kodi munakambiranapo wina aliyense za maleredwe? Ndani? Muwauza zotani?
32. Who influenced you the most in your decision to use contraceptives?
Ndi ndani anakupangikani kwambiri kuti mutsate njira za maleledwe?
33. Which methods did the CBD agent tell you about?
Ndi njira ziti za kaleledwe zomwe munaudzidwa?
 a. Pill _____
 b. Condom _____
 c. Foaming tablet _thobvu(thovu)____
 d. IUCD _____
 e. Injection (Depo-Provera) _____
 f. Traditional _____
 g. Other(specify) _____
34. What did she tell you about the:
Anakuzani chiani za izi?
 a. Pill
 b. Condom
 c. Foaming tablet

- d.IUCD
- e.Injection (Depo-Provera) _____
- f.Traditional methods
- g.Other(specify) _____

35. Did the CBD agent show you a sample of each method? (Tick the method she names)
Kodi munaonetsedwa chimodzi kapena zonse za zimenezi?
- a.Pill _____
 - b.Condom _____
 - c.Foaming tablet _____
 - d.IUCD _____
 - e.Injection (Depo-Provera) _____
 - f.Other(specify) _____
36. Which method did she tell you how to use?
Kodi anauzani zitsanzo za kagwiritsidwe kake ntchito?
- a.Pill _____
 - b.Condom _____
 - c.Foaming tablet _____
 - d.IUCD _____
 - e.Injection (Depo-Provera) _____
 - f.Other(specify) _____
37. Which method did you decide to use?
Munatsa njira iti?
38. Why did you decide to use that method?
Nanga ndi chifukwa chiani?
39. Did the CBD agent provide you with that method during the visit?
Kodi munapatsidwa njira imeneyi?
- a. How will you obtain the method?
Mungaipeze bwanji njirayi?
40. Did the CBD agent refer you to a health centre?
Kodi anakutumizani kuchipatala?
- a.Yes _____ ENYA _____
 - b.No _____ YAYI _____
 - c.(If yes) Which health center?
(Ngati eeh) Adati mupite chipatala chiti?
 - d.Will you be able to go?
Kodi mudzatha kupita?
 - e.By what means of transportation will you go?
Kodi mudzapita bwanji?
 - f.When will you go?
Nanga mudzapita liti?
 - g. Is it a problem for you to be referred to the health centre? Explain.
Kodi ndi kobvuta kwa inu kutuuzani chipatala. Tafotokozani
41. a. Was the visit helpful? Describe.
Kodi kucheza kwa kunali kwa phindu?
- b. Did the CBD agent take care of your needs?
Kodi a CBDwa anakuthandizani? Anakuthandizani bwanji?

INTEGRATION HIV/AIDS WITH FAMILY PLANNING

42. a. Have you heard about HIV/AIDS?
Kodi munamvapo zamatenda a AIDS?
- b. What do you know about it? Describe.
Kodi mudziwapo chiyani zamatenda a AIDS? Tafotokozani
43. Do you have people with HIV/AIDS in your community? Explain.

Kodi muli anthu amene ali ndi Edzi mmudzi mwanu? Mungatiuze?

44. What do you think about the CBD agent giving information about:
a. HIV/AIDS?
b. the use of condoms for HIV/AIDS prevention as well as family planning?
45. Did the CBD agent talk about HIV/AIDS at this visit?
Kodi a CBD ancyankhulapo za Edzi?
a. If so, what did she/he say?
Anati chiani?
b. Was it helpful for you? Explain.
Zinali zothandiza? Tafotokozani
46. Would you like the CBD agent to visit you again?
Kodi mungakonde kuti a CBD atakuyenderaninso?
a. Yes (go to 27)
b. No Why not? (go to 28)
47. (If Yes) What would you want her to do on the next visit?
Mufuna adzachite chiani atabweranso?
48. Do you have suggestions for how she/he could improve her visit?
Kodi muganiza kuti azichita chiani a CBD kuti kucheza kwawo kukhale kokukomerani?

Comments:

END INTERVIEW WITH CLIENT WHO GOT CONTRACEPTIVE FROM CBD AGENT.

NON-USER SECTION

49. Are you interested in using a family planning methods?
kodi mungafune maleredwe?
50. Why aren't you interested in using a family planning method? Explain.
Chifukwa chiani simufuna maleredwe? Fotokozani.
51. Yes _____
Then are there reasons for not beginning to use one now?
Kodi pali zifukwa zoti musayambire maleredwe lero?
What are they?
Ndizifukwa zANJI?
52. What happened during this visit of the CBD agent? What did she/he tell you? Describe the visit. What was its purpose?
Kodi kunachitika chiani pamene anakuyenderani a CBD? Kodi anakuuzani chiani? Tafotokozani zamachezedwe amu? Cholinga chawo chinali chiani?
53. Did the CBD agent tell you about family planning ?
Kodi a CBD anakukambilani za kulera?
a. Yes _____
b. No _____
i. What did she/he tell you about?
Anakuuzani kuti chiani?
54. Which methods did the CBD agent tell you about?
Ndi njira ziti za kaleledwe zomwe munaudzidwa?
a. Pill _____
b. Condom _____
c. Foaming tablet _thobvu(thovu)____
d. IUCD _____
e. Injection (Depo-Provera) _____
f. Traditional _____
g. Other(specify) _____
55. What did she tell you about the:
Anakuzani chiani za izi?
a. Pill _____
b. Condom _____
c. Foaming tablet _____
d. IUCD _____
e. Injection (Depo-Provera) _____
f. Traditional methods _____
g. Other(specify) _____
56. Did the CBD agent show you a sample of each method? (Tick the method she names)
Kodi munaonetsedwa chimodzi kapena zonse za zimenezi?
a. Pill _____
b. Condom _____
c. Foaming tablet _____
d. IUCD _____
e. Injection (Depo-Provera) _____
f. Other(specify) _____
57. Which method did she tell you how to use?
Kodi anauzani zitsanzo za kagwiritsidwe kake ntchito?
a. Pill _____
b. Condom _____
c. Foaming tablet _____
d. IUCD _____
e. Injection (Depo-Provera) _____
f. Other(specify) _____

58. a. Was the visit helpful? Describe.
Kodi kucheza kwa kunali kwa phindu?
- b. Did the CBD agent take care of your needs?
Kodi a CBDwa anakuthandizani? Anakuthandizani bwanji?

INTEGRATION HIV/AIDS WITH FAMILY PLANNING

59. a. Have you heard about HIV/AIDS?
Kodi munamvapo zamatenda a AIDS?
- b. What do you know about it? Describe.
Kodi mudziwapo chiyani zamatenda a AIDS? Tafotokozani
60. Do you have people with HIV/AIDS in your community? Explain.
Kodi muli anthu amene ali ndi Edzi mmudzi mwanu? Mungatiuze?
61. What do you think about the CBD agent giving information about:
- a. HIV/AIDS?
- b. the use of condoms for HIV/AIDS prevention as well as family planning?
62. Did the CBD agent talk about HIV/AIDS at this visit?
Kodi a CBD anayankhulapo za Edzi?
- a. If so, what did she/he say?
Anati chiani?
- b. Was it helpful for you? Explain.
Zinali zothandiza? Tafotokozani
63. Would you like the CBD agent to visit you again?
Kodi mungakonde kuti a CBD atakuyenderaninso?
- a. Yes (go to 27)
- b. No Why not? (go to 28)
64. (If Yes) What would you want her to do on the next visit?
Mufuna adzachite chiani atabweranso?
65. Do you have suggestions for how she/he could improve her visit?
Kodi muganiza kuti azichita chiani a CBD kuti kucheza kwawo kukhale kokukomerani?

Comments:

COMMUNITY MEMBER FOCUS GROUP DISCUSSION

Village _____ District _____ Region _____

Date _____

Name of Discussion group facilitator _____

Name of note taker _____

Language(s) in which discussion was held:

Ethnicity(ies) of village _____

Duration of Discussion: Start _____ End _____

Number of participants _____ Gender _____

1. FAMILY PLANNING CONCERNS

- a. What is family planning ?
Kodi munamvapo zakulera? Nanga kulera nchiyani?
- b. Is family planning a concern for you? Describe.
Kodi nkhani yakulera imakukhuzani? Fotokozani.
- c. What is your opinion about family planning?
Kodi maganizo anu ndi otani pankhani ya kulera?
- d. What are methods of family planning? (Include traditional and modern.)
Tchulani njira zakulera. (Mutchule zonse zamakolo ndi zamakono zomwe)
- e. Do you or others use family planning methods? Which ones?
Kodi inuyo kapena anthu ena mumagwiritsa ntchito njira zakulera? Njira zake ziti?
- f. What has been your experience with these methods?
Kodi panthawi yomwe mwakhala mukugwiritsa ntchito njira zakulera, mwakumana ndi zotani?
- g. What have other people told you about their experiences with these methods
Kodi anthu ena akufotokozerani kuti iwo anakumana nazo zotani pogwiritsa ntchito njira zolera?
- h. For those of you who do not use family planning methods, why don't you? Would you like to?
Kwa inu amene simugwiritsa ntchito njira zolera, nchifukwa chiyani simugwiritsa ntchito njirazo? Mungafune kuyamba?

2. HIV/AIDS CONCERNS

ZA KACHIROMBO KA HIV/NDI EDZI

- a. What can you tell me about HIV/AIDS?
Mungatiuzepo chiyani zokhuza kachilombo ka HIV ndi za matenda a EDZI?
 - i. What kind of disease is it?
Ndi matenda amtundu wanji?
 - ii. What are the symptoms?
Zizindikiro zake ndi zotani?
 - iii. Who gets it?
Angatenge HIV kapena kudwala EDZI ndi ndani?
 - iv. How do you get it?
Kachirombo ka HIV kapena EDZI amatenga bwanji?
 - v. Is there a treatment for it? What?
Kodi EDZI ili ndi mankhwala? Mankhwala ake chiyani?
 - vi. Do you know anyone who has it?
Alipo amene m'mudziwa amene akudwala EDZI?
 1. Tell about what happened to that person. to his/her family.
Tatiuzani zomwe zidamuchitikira munthuyo. Nanga abale ake chidawachitikira nchiyani?

- vii. Do you know about the distinction between being HIV positive and being sick with AIDS? What is the distinction?
Kodi mumadziwa kusiyana kwa pakati pa kukhala ndi kachiroombo ka EDZI ndi kudwala EDZI? Kusiyana kwake ndi kotani?
- b. Is HIV/AIDS a problem in this area, in this village? Describe?
Kodi kachiroombo ka HIV ndi matenda a EDZI ndi vuto lalikulu mudera muno? Nanga m'mudzi muno? Fotokozani.
- i. Are there people in this village who are HIV/positive?
Kodi alipo m'mudzi muno amene ali ndi kachilombo ka HIV?
- ii. Are there people who are sick with AIDS?
Kodi alipo anthu ena m'mudzi muno amene akudwala EDZI?
- iii. Tell us about them.
Tafotokozani za anthu amenewa.
1. How are they taken care of?
Amasamalidwa bwanji?
2. How did they get sick?
Anayamba bwanji kudwala?
3. What about the other members of their family?
Nanga anthu ena m'banjamo zikuwakhudza bwanji za matendawo?
4. Will they get better?
Kodi akudwalawa achira
5. Do you think you could get AIDS? Why?
Kodi mukuganiza kuti inunso mutha kutenga EDZI? Chifukwa chiyani mukuganiza choncho?
6. Could the village help solve the problem of HIV/AIDS? How?
Kodi mudzi uno ungachitepo kanthu kuthetsa kapena kuchepetsa vutoli HIV/EDZI?
3. ACTUAL AND PREFERRED SOURCE OF INFORMATION FOR FP AND HIV/AIDS
KOMWE MUMAPEZA UTHENGA WA ZAKULERA NDI HIV/EDZI NDIPO KOMWE MUNGAMAFUNE KUTI MUDZIKAPEZA UTHENGAWU.
- a. FAMILY PLANNING
ZAKULERA
- i. For those of you you know about family planning, how did you learn?
Inu amene mumadziwa zakulera munaphunzira kudzera njira ziti ?
1. Traditional methods
Zamakolo
2. Modern methods
Zamakono
- ii. In this village are people taught about family planning?
Kodi m'mudzi muno alipo amene amaphunzitsa zakulera?
- iii. How and by whom, when? Describe.
Amawaphunzitsa bwanji? Ndani? Ndipo nthawi yanji? Fotokozani.
- iv. Do you think it is good for people to know about family planning? Why?
Kodi mukuganiza kuti ndi bwino kuti anthu adzidziwa za kulera? Chifukwa chiyani?
- v. If you think it is good for people to know, what are the best ways to learn about family planning?
Ngati mukuvomera kuti ndi bwino, kodi njira zabwino zophunzitsira zakulera ndi ziti?
- vi. Who are the best people to tell others about family planning? (Ask open ended question and see if you get aunts, uncles, grandmothers, teachers, health care providers, CBD agents)

Ndi ndani aliwoyenera kufotokoza anthu zakulera?

- a. *Kodi anthu oyenera kuphunzira zolera ndi ndani?*
- b. *Kodi ndi ndani ali woenera kuphunzitsa magulu awanthu alembedwa munsimu?*

- 1. Children, girls, boys
Ana, asungwana, anyamata
- 2. Unmarried women
Amai osakwatiwa
- 3. Unmarried men
Abambo wosakwatira
- 4. Betrothed women
Amai oyembekeza kulowa m'banja
- 5. Betrothed men
Abambo woyembekeza kulowa m'banja.
- 6. Married women
Amai wokwatiwa
- 7. Married men
Abambo wokwatira

- vii. *What are other good sources of information about family planning?
Kodi njira zina zabwino zomvera uthenga wakulera ndi ziti?*
- viii. *How would you, yourself, like to learn (to have learned) about family planning?
Inu amene munaphunzira za kulera kodi mudakhutitsidwa ndi njirazi? Nanga mudzakonda kuphunzira zakulera kudzera njira iti?*

b. HIV/AIDS

ZAKACHILOMBO KA HIV NDI MATENDA A EDZI

- i. *How did you learn about HIV/AIDS?
Kodi inu munaphunzira bwanji za kachilombo ka HIV ndi matenda a EDZI?*
- ii. *Do other people in the village know about HIV/AIDS?
Kodi anthu ena m'mudzi muno amadziwa za kachilombo ka HIV ndi matenda a EDZI?*
- iii. *Where did they learn about it? Are people taught about AIDS in the village? By whom, how and when?
Kodi anaphunzira kuti zimenezi? Kodi anthu amaphunzitsidwa za kachilombo ka HIV ndi matenda a EDZI m'mudzi muno? Amawaphunzitsa bwanji? Liti?*
- iv. *What do you think is a good source of information for HIV/AIDS.
Kodi mukuganiza kuti kwabwino kokapeza uthenga wazolera ndi kuti?*
- v. *Who are the best people to tell others about HIV/AIDS? (Ask open ended questions and see if you get aunts, uncles, grandmothers, teachers, health care providers, CBD agents)
Ndi ndani aliwoyenera kufotokoza anthu za HIV/EDZI?
Kodi anthu oyenera kuphunzira za HIV/EDZI ndi ndani?
Kodi ndi ndani ali woenera kuphunzitsa magulu awanthu alembedwa munsimu?*

- 1. Children, girls, boys
Ana, asungwana, anyamata
- 2. Unmarried women
Amai osakwatiwa
- 3. Unmarried men
Abambo wosakwatira
- 4. Betrothed women
Amai oyembekeza kulowa m'banja
- 5. Betrothed men
Abambo woyembekeza kulowa m'banja.

6. Married women

Amai wokwatiwa

7. Married men

Abambo wokwatira

- vi. What are other good sources of information about HIV/AIDS?
Kodi njira zina zabwino zomvera uthenga wa kachiroombo ka HIV ndi matenda a EDZI ndi iti?
- vii. How would you, yourself like to learn about HIV/AIDS?
Inu amene munaphunzira za matenda a EDZI kodi mudakhutitsidwa? Nanga mudzakonda kuphunzira za matenda a EDZI kudzera njira iti?

4. CBD PROGRAM

a. KNOWLEDGE ABOUT THE CBD PROGRAM

KUDZIWA ZAKULERA KWAM'MUDZI KOPYOLERA MWA CBD

- i. What do you know about the CBD program in this village?
Kodi mukudziwapo chiyani zakulera kopyolera a CBD m'mudzi muno?

b. COMMUNITY PARTICIPATION

KUTENGA NAWO MBALI PA ZAKULERA KWA M'MUDZI

- i. Did you participate in its initial organization.
Kodi munatenga mbali pomwe kulera kwamudzi kumakhazikitsidwa?
- ii. Did you help to get it going? How?
Kodi mudathandiza kupititsa mtsogolo maganizo okhazikitsa kulera kwa mudzi? Mudathandiza bwanji?
- iii. Did you help select the CBD agents? How?
Mudathandiza nawo kusankha a CBD? Mudathandiza bwanji?
- iv. Do you participate in anything else about the organization and running of the CBD program?
Kodi mumathandiza pakayendetsedwe ka zakulera kopyolera a CBD kumudzi kuno?

c. ACTUAL EXPERIENCE WITH CBD PROGRAM

ZOMWE MWAONA ZOKHUDZA KULERA KOPYOLERA A CBD

- i. Have you ever been visited by the CBD agent?
Kodi a CBD anakuyendelanipo?
- ii. Was it a helpful visit? Why?
Kodi kuyenderako kunali kwa phindu? Chifukwa?
- iii. Would you like to be visited again? Why?
Kodi mungasangalatsidwe kuti a CBD akuyendeleninso?
- iv. For those of you who use or have used contraceptives, was the CBD agent the person who first got you to use modern contraceptives? Explain?
Kwa inu amene mumagwiritsira ntchito kapena munkagwiritsa ntchito njira zolera za makono, kodi a CBD anali oyamba kukuphunzitsani zakulerako? Fotokozani.

d. ATTITUDES TOWARDS CBD PROGRAM

MAGANIZO ANU PAZAKULERA KWA KUMUDZI KOPYOLERA A CBD

- i. Do you think the program is a good idea? Why?
Kodi inu mukuganiza kuti kulera kwakumudzi kopyolera mwa a CBD ndi kwabwino?
- ii. Do you think the CBD program is a useful way to address the subject of family planning?
Kodi inu mukuganiza kuti kulera kwa kumudzi ndi njira yothandiza pa nkhani ya kulera?
- iii. What works well?
Pantchito ya a CBD chomwe chimayenda bwino nchiyani?

- iv. What doesn't work well?
Pantchito ya a CBD chomwe sichiyenda bwino nchiyani?
- v. Are you satisfied with the CBD agents? Why?
Kodi muli wokhutitsidwa nawo a CBD? Chifukwa chiyani?
 - 1. What are their good qualities?
Zingakusangalatseni ndi CBD nchiyani?
 - 2. What are their bad qualities?
Zomwe sizingakusangalatseni ndi a CBD nchiyani?
 - 3. Do they have the qualities you want?
Kodi CBD amayenera kukhala wotani? Nanga a CBD a dela lino ali ndi zoyenera pantchito yawo?
 - (a) Does gender of the CBD agent matter? Discuss.
Kodi a CBD akakhala wamkazi kapena wamwamuna zimakukhuzani?
 - (b) Does age matter? Discuss.
Kodi zaka za CBD zimakukhuzani?
 - (c) Does educational level matter? Discuss.
Kodi maphunziro a CBD amakukhuzani?
- vi. What are problems of the CBD programs?
Kodi mavuto a kulera a kumudzi nchiyani?
- vii. How could these problems be solved?
Kodi mavuto amenewa mungathetse bwanji?
- viii. How could the CBD program be improved?
Kodi kulera kwam'mudzi kungapititsidwe bwanji mtsogolo?
- ix. Are there ways that you as community members could contribute to these improvements?
Kodi pali njira zomwe inu ngati anthu am'mudzi muno mungatsate pothandizila pantchito yakulera kupita patsogolo?
- x. As community members would you like to play a part in the CBD program? Explain.
Inuyo ngati eni mudzi mungafune kuthandizila kapena kutenga mbali pantchito ya kulera kwam'mudzi kopyolera a CBD? Fotokozani.

e. SUSTAINABILITY OF CBD PROGRAM

KUPITIRIZA KULERA KWAM'MUDZI KOPYOLERA KWA CBD

- i. How long has this program been in existence in this village?
Kodi kulera kwam'mudzi kwakhala kukuchitika kwa zaka zingati m'mudzi muno?
- ii. Do you think it will last? Why?
Kodi mukuganiza kuti kulera kwam'mudzi kupitirira? Chifukwa chiyani mukuganiza choncho?
- iii. What could be done to assure that it would last along time? (If the subject of remuneration or incentives is not brought up then introduce the subject here.)
Kodi mungachite bwanji kuti pologalamu ya CBD ipitirire m'mudzi muno kwanthawi yaitali?

5. INTEGRATION OF HIV/AIDS INTO CBD PROGRAM

KUPHATIKIZA NKHANI ZA KACHILOMBO KA HIV NDI MATENDA A EDZI MU POLOGALAMU YA KULERA KOPYOLERA MWA CBD

- a. Do you think it would be a good idea for the CBD agents to tell about HIV/AIDS when they go on their home visits? Explain.
Kodi mukuganiza kuti CBD adzafotokoza za kachilombo ka HIV ndi matenda a EDZI pomwe akuyendera m'makhomo pankhani yazakulera?
- b. What aspects should they tell about?
Kodi ndi mfundo ziti zimene angathekumafotokozera anthu?

- c. What qualities should the CBD agent have who would tell about HIV/AIDS? Anything different than for family planning?
Kodi CBD amene angathe kumaphunzitsa kapena kumafotokozera anthu za HIV ndi EDZI ayenera kukhala wotani? Kodi nzosiyana ndi zomwe a CBD a zakulera a yenera kukhala nazo?
- d. Is it appropriate for the CBD agents to discuss sexual transmission of AIDS and sexual behavior with the members of the household? Discuss. If not them, then whom?
Kodi nkoyenera kuti a CBD a zakulera azifotokoza za HIV ndi EDZI ndi za chiwerewere pamene akuyendera anthu m'makomo? Ngati nkosayenera woyenera kukamba nkhnai ngati zimenezi ndi ndani?
- e. What qualities would a CBD agent need to have to discuss sexual issues concerning HIV/AIDS.
Kodi a CBD a zakulera ayenera kukhala wotani kuti athe kufotokozera anthu za HIV ndi matenda a EDZI?

6. OVERALL RECOMMENDATIONS AND CONSIDERATION
ZOYENERA KUTSATIDWA NDI KULINGALIRA

- a. Please give any other recommendations, suggestions, or ideas you think we need to consider about the CBD project?
Perekani maganizo anu pa zomwe zili zofunika kuzitsata ndikuzilingalila poyendetsa pologalamu ya kulera kwam'mudzi kopyolera a CBD.

VILLAGE LEADERS FOCUS GROUP DISCUSSION GUIDE

Village _____ District _____ Region _____
Date _____
Name of Discussion group facilitator _____
Name of note taker _____
Language(s) in which discussion was held _____

Ethnicity(ies) of village _____

Religion(s) of village _____

Duration of Discussion: Start _____ End _____

Number of participants _____

List positions in village of participants:

For each participant List: demographic variable on other page.

We are here to discuss with you some problems that your village may be experiencing and ways to solve them.

1. POPULATION AND FAMILY PLANNING

KUCHULUKA KWA ANTHU NDI KULERA

- a. To what extent is the increase of population a problem in this village?
- b. *Kodi kuchuluka kwa anthu m'mudzi muno mukubweletsa mavuto otani?*

(Questions for probing)

- i. What is the average family size?
Kodi banja labwino liyenera kukhala ndi anthu angati?
- ii. What is the health condition of mothers?
Kodi moyo ndi thanzi la azimayi wokhuzana ndi kubeleka uli bwanji?
- iii. Can mothers both take care of their children and do all their tasks well?
Kodi azimai angathe kusamalira ana ndipo nthawi yomweyo nkumagwira ntchito yatsiku ndi tsiku?
- iv. What are ways to solve these problems?
Kodi tingatsate njira ziti kuti tithetse mavuto amenewa?
- v. How could the village contribute to the solution?
Kodi mudzi ungathandizepo bwanji kuthetsa vuto limeneli?

c. FAMILY PLANNING

ZAKULERA

- i. What do you know about family planning?
Mukudziwapo chiyani zakulera?
- ii. What is family planning?
Kodi kulera nchiyani?
 1. Tell about traditional methods.
Fotokozani za njira zamakolo.
 2. Tell about modern methods.
Fotokozani zanjira za makono.
- iii. Do you think it is a good idea? Why?
Mukuganiza kuti ndi nzeru kutero? Chifukwa chiyani mwa ganiza choncho?
- iv. Do you think it is a bad idea? Why?
Mukuganiza kuti nzosapindulitsa? Chifukwa chiyani mwaganiza choncho?
- v. Is it a possible solution to some population problems? How?
Kodi kulera kungathandize kuthetsa mavuto ena odza chifukwa cha kuchuluka kw anthu?
- vi. What do you think the villagers think about family planning?
Kodi mukuganiza kuti anthu am'mudzimu amaganiza chiyani pankhani yolera?
- vii. Is family planning practiced here? Describe how it is practiced? Traditional methods? Modern methods?

- Kodi anthu amatsata njira zakulera?*
viii. Are there ways that the village could contribute to family planning?
Kodi pali zomwe mudzi ungachite pa zakulera?

7. HIV/AIDS

ZA KACHIROMBO KA HIV NDI MATENDA A EDZI

- a. What can you tell me about HIV/AIDS?
Mungatiuzepo chiyani zokhudza kachilombo ka HIV ndi za matenda a Edzi?
- i. What kind of disease is it?
Ndi matenda amtundu wANJI?
- ii. What are the symptoms?
Zizindikiro zake ndi zotani?
- iii. Who gets it?
Angatenge HIV kapena kudwala Edzi ndi ndani?
- iv. How do you get it?
Kachilombo ka HIV kapena Edzi amatenga bwanji?
- v. Is there a treatment for it? What?
Kodi Edzi ili ndi mankhwala? Mankhwala ake nchiyani?
- vi. Do you know anyone who has it?
Alipo amene m'madziwa amene akudwala Edzi?
1. Tell about what happened to that person.
Tatiuzani zomwe zidamuchitikira munthuyo. Nanga abale ake chidawachitikira nchiyani?
- vii. Do you know about the distinction between being HIV positive and being sick with AIDS? What is the distinction?
Kodi mumadziwa kusiyana kwa pakati pa kukhala ndi kachilombo ka Edzi ndi kudwala Edzi? Kusiyana kwake ndi kotani?
- viii. Is HIV/AIDS a problem in this area, in this village? Describe?
Kodi kachilombo ka HIV ndi matenda a Edzi ndi vuto lalikulu mudera muno? Nanga m'mudzi muno? Fotokozani.
- ix. Are there people in this village who are HIV/positive?
Kodi alipo m'mudzi muno amene ali ndi kachilombo ka Edzi?
- x. Are there people who are sick with AIDS?
Kodi alipo anthu ena m'mudzi muno amene akudwala Edzi?
- xi. Tell us about them.
Tafotokozani za anthu amenewa.
1. How are they taken care of?
Amasamalidwa bwanji?
2. How did they get sick?
Anayamba bwanji kudwala?
3. What about the other members of their family?
Nanga anthu ena m'mbanjamo zikuwakhuzza bwanji za matendawo?
4. Will they get better?
Kodi akudwalawa achira?
- xii. Do you think you could get AIDS? Why?
Kodi mukuganiza kuti inunso mutha kutenga Edzi? Chifukwa chiyani mukuganiza choncho?
- xiii. Could the village help solve the problem of HIV/AIDS? How?
Kodi mudzi uno ungachitepo kanthu kuthetsa kapena kuchepetsa vuto la HIV/EDZI?

8. SOURCE OF INFORMATION TO LEARN ABOUT FAMILY PLANNING AND HIV/AIDS
 KOMWE MUMAPEZA UTHENGA WA ZAKULERA NDI HIV/EDZI
- a. FAMILY PLANNING
 ZAKULERA
- i. How did you learn about family planning?
Munadziwa zakulera kuchokera kuti ndipo kudzera njira ziti?
 1. Traditional methods
Zamakolo
 2. Modern methods
Zamakono
 - ii. In this village are people taught about family planning?
Kodi m'mudzi muno alipo amene amaphunzitsa zakulera?
 - iii. How and by whom, when? Describe.
Amawaphunzitsa bwanji? Ndani? Ndipo nthawi yanji? Fotokozani.
 - iv. Who are the best people to tell others about family planning? (Ask open ended question and see if you get aunts, uncles, grandmothers, teachers, health care providers, CBD agents)
Ndi ndani aliwoyenera kufotokozera anthu zakulera?
Kodi ndi ndani ali woyenera kuphunzitsa magulu awanthu alembedwa m'munsimu?
 1. Children, girls, boys
Ana, asungwana, anyamata.
 2. Unmarried women
Amai osakwatira
 3. Unmarried men
Abambo osakwatira
 4. Betrothed women
Amai oyembekezera kulowa m'banja
 5. Betrothed men
Abambo oyembekezera kukwatira
 6. Married women
Amai okwatiwa
 7. Married men
Abambo okwatira
 - v. What are other good to learn about family planning?
Kodi anthu oyenera kuphunzira zolera ndi ndani?
- b. HIV/AIDS
 ZAKACHILOMBO KA HIV NDI MATENDA A EDZI
- i. How did you learn about HIV/AIDS?
Kodi inu munaphunzira bwanji za kachilombo ka HIV ndi matenda a EDZI?
 - ii. Do the people in the village know about HIV/AIDS?
Kodi anthu ena m'mudzi muno amadziwa za kachilombo ka HIV ndi matenda a EDZI?
 - iii. Where did they learn about it? Are people taught about AIDS in the village? By whom, how and when?
Kodi anaphunzira kuti zimenezi? Kodi anthu amaphunzitsidwa za kachilombo ka HIV ndi matenda a Edzi m'mudzi muno? Amawaphunzitsayo ndi ndani? Amawaphunzitsa bwanji? Liti?
 - iv. What do you think is a good source of information for HIV/AIDS.
Kodi mukuganiza kuti kwabwino kokapeza uthenga wa matenda a EDZI ndi kuti?

- v. Who are the best people to tell others about HIV/AIDS? (Ask open ended questions and see if you get aunts, uncles, grandmothers, teachers, health care providers, CBD agents)
Kodi ndi ndani ali woyenera kuphunzitsa liri lonse pa magulu ali m'musiwa?
 - 1. Children, girls, boys
Ana, asungwana, anyamata
 - 2. Unmarried women
Amai osakwatiwa
 - 3. Unmarried men
Abambo osakwatira
 - 4. Betrothed women
Amai woyembekezera kukwatiwa
 - 5. Betrothed men
Abambo oyembekezera kukwatira
 - 6. Married women
Amai wokwatiwa
 - 7. Married men
Abambo wokwatira
- vi. What are other good sources of information about HIV/AIDS?
Kodi njira zina zabwino zomvera uthenga wa zolera ndi uti?
Kodi aliwoyenera kuphunzitsa kapena kukambirana za kachilombo ka HIV ndi matenda a EDZI ndi ndani?

9. CBD PROJECT

- a. STRUCTURE AND ORGANIZATION OF CBD PROGRAM/COMMUNITY INPUT.
KAKHAZIKITSIDWE NDI DONGOSOLO LA KULERA KWA KUMUDZI KOPYOLERA MWA CBD.
 - i. How was it started? To what degree was the community involved in setting up the CBD program?
 - ii. How does it work? What is the system/organization of the CBD program that serves this village? How was this decided? Did you have any input?
 - iii. Who are the CBD agents?
 - iv. Are they from this village?
 - v. Do they live in this village?
 - vi. How were they chosen?
 - vii. What are their qualifications?
 - viii. What are they supposed to do? Did you have any involvement in deciding what they were supposed to do?
 - ix. What actions are being taken to sustain the program? (Bring up incentives after they have talked about everything else)
- b. ACTUAL FUNCTIONING OF CBD PROGRAM.
M'MENE KULERA KWAM'MUDZI KUKUYENDERA
 - i. Do the CBD agents actually do their job as they are supposed to? Explain.
Kodi a CBD amachita zonse zomwe amayenera kuchita? Fotokozani?
 - ii. Describe any problems they have doing their job.
Fotokozani mavuto alionse amene amakumana nao akamagwira ntchito yao.
 - iii. How could these problems be solved?
Kodi mavuto amenewa angathe bwanji?
- c. ATTITUDES TOWARD CBD PROGRAM
MAGANIZO ANU OKHUDZA KULERA KWAM'MUDZI KOPYOLERA MWA MA CBD
 - i. Do you think the CBD program is a good idea? Why? (Following are probes after all ideas have been volunteered)

Kodi mukuganiza kuti kukhazikitsa kwa kulera kwam'mudzi ngati kumeneku ndi chinthu chanzeru kapena cha phindu?

1. Do you think it can contribute to solving problems of population increase. How? Why?

Mukuganiza kuti kulera kumeneku kungathandize kuchepetsa mavuto obwela chifukwa cho chuluka kwa anthu? Kungathandize bwanji? Ndipo kungathandize chifukwa chiyani?

2. Do you think it could contribute to improving health of women?

Kodi mukuganiza kuti kulera kungapititse mtsogolo moyo ndi thanzi la azimai?

3. Do villagers like being visited by the CBD agents? Why? Are CBD agents appropriate people to tell others about family planning?

Kodi anthu am'mudzi muno amakondwera a CBD akawayendera? Chifukwa chiyani? Kodi a CBD adzakulera ndi anthu oyeneradi kufotokozero anzawo za kulera?

4. Are you happy with your CBD agents? Discuss.

Kodi ndinu wokondwa nawo a CBDwa? CBD amayenera kukhala wotani?

(a) Do they have the qualities you want?

Nanga a CBD a dela lino ali ndi zoyenera pantchito yawo?

(b) Does gender of the CBD agent matter? Discuss.

Kodi a CBD akakhala wamkazi kapena wamamuna zimakukhuzani?

(c) Does age matter? Discuss.

Kodi zaka za CBD zimakukhuzani?

(d) Does educational level matter? Discuss.

Kodi maphunziro a CBD amakukhuzani?

(e) What are problems of the CBD programs?

Kodi mavuto a kwakulera kwakumudzi nchiyani?

ii. How could these problems be solved?

Kodi mavuto amenewa mungawathetse bwanji?

(a) How could the CBD program be improved?

Kodi kulera kwam'mudzi kungapititsidwe bwanji mtsogolo?

iii. Are there ways that the village could contribute to these improvements?

Kodi pali njira zomwe inu ngati anthu am'mudzi muno mungatsate pothandizila pantchito yakulera kupita patsogolo?

iv. What part as community leaders would you like to play in the CBD program?

Imuyo ngati eni mudzi mungafune kuthandizila kapena kutenga mbali pantchito ya kulera kwam'mudzi kopyolera a CBD? Fotokozani.

c. SUSTAINABILITY OF CBD PROGRAM

KUPITIRIZA KULERA KAM'MUDZI KOPYOLERA KWA CBD

v. How long has this program been in existence in this village?

Kodi kulera kwam'mudzi kwakhala kukuchitika kwa zaka zingati m'mudzi muno?

vi. Do you think it will last? Why?

Kodi mukuganiza kuti kulera kwam'mudzi kupitirira? Chifukwa chiyani mukuganiza choncho?

vii. What could be done to assure that it would last along time? (If it is not volunteered, bring up the subject of remuneration and incentives here.)

Kodi mungachite bwanji kuti pologalamu ya CBD ipitirire m'mudzi muno kwanthawi yaitali?

10. INTEGRATIONS OF HIV/AIDS INFORMATION INTO THE CBD FAMILY PLANNING PROGRAM.
KUPHATIKIZA NKHANI ZA KACHIROMBO KA HIV NDI MATENDA A EDZI MU POLOGALAMU YA KULERA KOPYOLERA MWA CBD.

- i. Do you think it would be a good idea for the CBD agents to tell about HIV/AIDS when they go on their home visits? Explain.
Kodi mukuganiza kuti CBD adzafotokoza za kachilombo ka HIV ndi matenda a EDZI pomwe akuyendera m'makhomo pankhani yazakulera?
- ii. What aspects should they tell about?
Kodi ndi mfundo ziti zimene angathekumafotokoza anthu?
- iii. What qualities should the CBD agent have who would tell about HIV/AIDS? Anything different than for family planning?
Kodi CBD amene angathe kumaphunzitsa kapena kumafotokoza anthu za HIV ndi EDZI ayenera kukhala wotani? Kodi nzosiyana ndi zomwe a CBD a zakulera a yenera kukhala nazo?
- iv. Is it appropriate for the CBD agents to discuss sexual transmission of AIDS and sexual behavior with the members of the household. Discuss. If not them, then whom? What qualities would a CBD agent need to have to discuss sexual issues concerning HIV/AIDS.
Kodi nkoynera kuti a CBD a zakulera azifotokoza za HIV ndi EDZI ndi za chiwerewere pamene akuyendera anthu m'makomo? Ngati nkosayenera woyenera kukamba nkhnai ngati zimenezi ndi ndani?

11. OVERALL RECOMMENDATION
ZOYENERA KUTSATIDWA NDI KULINGALILA

- a. Please give any other recommendations, suggestions, or ideas you think we need to consider about the CBD project.
Perekani maganizo anu pa zomwe zili zofunika kuzitsata ndikuzilingalira poyendetsa pologalamu ya kulera kwam'mudzi kopyolera a CBD.

REPUBLIC OF MALAWI
MINISTRY OF HEALTH

CBD Agent Client and Contraceptive Tally Sheet

D/INA LA MALING'I			MWEZI			YEAR		
NJIRA	WOLERA ATSOPANO		WOLERA AKALE		NJIRA ZI OPIREKEZEDWA			
MAPIRITSI A MPHAWU ZIWIRI	OOOOO	OOOOO	OOOOO	OOOOO	M' modzi amuna pakuti amodzi			
MAPIRITSI A MPHAWU IMODZI	OOOOO	OOOOO	OOOOO	OOOOO	M' modzi amuna pakuti amodzi			
MAKONDOMU	OOOOO	OOOOO	OOOOO	OOOOO	M' modzi ayimuna Makondomu 10			
THOBVU	OOOOO	OOOOO	OOOOO	OOOOO	M' modzi ayimuna Mapiritisi 10			
WOTI MIZIDWA KU CHIPATALA					MAYANKHO A KU CHIPATALA			
WOKAY- ESEDWA A MTHUPI	OOOOO	OOOOO	OOOOO	OOOOO	OOOOO	OOOOO	OOOOO	OOOOO
WOSANKHA NJIRA ZINA	OOOOO	OOOOO	OOOOO	OOOOO	OOOOO	OOOOO	OOOOO	OOOOO
AZOVUTA ZINA	OOOOO	OOOOO	OOOOO	OOOOO	OOOOO	OOOOO	OOOOO	OOOOO

CHIWERENGERO CHA MWEZI ONSE

	ATSOPANO	AKALE	NJIRA	ZOTSALA POTHA PA MWEZI		OTU MIZIDWA ONSE	MAYANKHO ONSE
MAPIRITSI A MPHAWU ZIWIRI					WOKAYESEDWA A MTHUPI		
MAPIRITSI A MPHAWU IMODZI					NJIRA ZINA		
MAKONDOMU					ZOVUTA ZINA		
THOBVU					TOTALA		
TOTALA							

160

C.C.A.P. SYNOD OF LIVINGSTONIA.

EKWENDENI HOSPITAL, BOX 19, EKWENDENI, MALAWI. Tel: 339 222

Chikalata cha kutumila mulwali ku chipatala panji ku kiliniki

Ba C.B.D. bakwenera kulondezga ndondomeko ya kutumira mulwali kuti wakapimike dankha pambere wandalutizge nthowa iyo wasankha, Ba C.B.D. badankhe bafumba mafumbo ya pa chikalata cha ghakiliisiti (checklist) ndipo batumenge mulwali ku kiliniki panji ku chipatala pamoza na Fomu ili:

1. Zina la mulwali-----
2. Muzi-----
3. Chigaba-----

Chifukwa icho mwatumira mulwali muchonge malo yakwenerera

	<u>INYA</u>	<u>YAYI</u>
(a) Kukapimika	-----	-----
(b) Wakukhumba nthowa yinyakhe	-----	-----
(c) Wakukhumba nyereti	-----	-----
(d) Wakukhumba kujaliska mphapo	-----	-----
(e) Wanavisuzgo na nthowa iyo walipo sono	-----	-----
A. Ni nthowa uli iyo yankhwa?-----		
B. Mwamupa mapaketi yalinga?-----		

Zina la C.B.D. -----

Chagaba -----

MALONJE KUFUMA KU KILINIKI PANJI KU CHIPATALA

1. Kupimika -----
2. Nthowa iyo yaperekeka ku kiliniki panji ku chipatala -----
3. Mankhwala ayo yaperekeka -----

Zina la Dokotala panji Nesi:-----

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REPORT SERIES

JSI-STAFH PROJECT REPORT SERIES

Serial no.

Report Title

1. **AIDS in Malawi: an annotated bibliography**
2. **Condom Initiative (Condom, Contraceptive and marriage)**
3. **Family Planning in Malawi: an annotated bibliography**