Technical Report 5: Assessment of Community-Based Distribution in the Republic of Ghana

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I. Introduction

In order to achieve its goal of increasing the availability of family planning services in the country, the National Population Council and the Ministry of Health propose to develop a national strategy for CBD and commercial distribution of contraceptives and other RH/MCH products/services. As a basis for that strategy, a nationwide assessment of existing CBD services was planned and conducted for the purpose of collecting data on CBD program services, supervision and training.

The assessment coordinated and supported by USAID/Ghana and financially and technically assisted by INTRAH/PRIME was conducted in Greater Accra, Volta, Ashanti and Northern regions from March 18, 1996 to April 19, 1996. The INTRAH team worked with representatives of PPAG, GRMA, GSMF, the Institute of Adult Education and the MCH/FP Unit of the Ministry of Health to prepare and conduct this assessment under the auspices of the National Population Council.

II. Background Of The Assessment

More than 20 Ghanaian non-governmental organizations (NGOs) are currently involved in the distribution of non-clinical contraception. Because each organization has a unique mandate, focus, structure and approach to CBD, and due to time constraints, a detailed review of all 20 agencies was not possible during the present assessment. The following organizations were selected among the most active NGOs:

The Planned Parenthood Association of Ghana (PPAG), which is the largest NGO provider of family planning services in Ghana, and the oldest agency engaged in CBD activities in seven regions of the country.

The Ghana Social Marketing Foundation (GSMF), which is the largest provider of private sector contraceptives in Ghana, and which distributes short-term methods through 18 local NGOs involved in CBD programs throughout the country. CBD activities of five of these NGOs were assessed: the 31st December Women Movement, Amasachina Self-Help Association, the Muslim Family Counseling Services, the Mayday Rural Project and the Christian Council of Ghana.

The Ghana Registered Midwives Association (GRMA) which is a professional organization involved in safe motherhood and integrated family planning services throughout the country, and which plans to start a CBD program in the future.

In addition, the two organizations from the public sector, which implement non-clinic-based service delivery activities were assessed:

The Ministry of Health for its Traditional Birth Attendants (TBAs) program.

The Institute of Adult Education, a semi-autonomous body of the University of Ghana, which has recently started a non-clinic-based program through facilitators of literacy programs in three regions.

Finally, information was collected on the National Population Council, which is the coordinating body in charge of the implementation of the National Population Policy.

III. Purpose And Objectives

The purpose of the assessment was to provide background information on CBD activities in Ghana for the development of a national CBD strategy.

The objectives of the assessment were:

1. To describe the organizations sponsoring/implementing CBD activities in Ghana and their CBD strategies;

2. To describe current CBD programs including training, supervision, service delivery, referral, logistic, pricing and reporting systems, CBDs and supervisors profiles, and current roles and tasks;

3. To formulate recommendations for the development of a national CBD strategy.

IV. Methodology

The methodology used for implementing this assessment included interviews, observation in real or simulated situations, document review and analysis and Focus Group discussion. Interviews were conducted at headquarters of Institutions/ NGOs implementing/supporting CBD programs and at worksites for various categories of field workers. Similarly, observations were made at the worksite of the same categories of field workers and document analysis was used for different target groups of the assessment. Focus group interviews were conducted in the field for CBDs, clients and community leaders.

A. Targets

Include:

- Key officials at headquarters of Institutions and NGOs involved in the implementation/support of CBD programs in Ghana (NPC, GSMF and supported NGOs, MOH, MCH/FP Unit, PPAG, IAE, GRMA).

- CBDs including:

- PPAG and GSMF CBDs
  IAE facilitators working as CBDs
  MOH TBAs who are involved in RH/FP activities

- GRMA MW Assistants expected to integrate RH/FP and First Aid activities in the nearest future

- CBD supervisors
- RH/FP service providers at CBD referral points
- Opinion leaders, clients (males and females) where CBD agents operate.

In this report under "CBDs" are included the categories of community workers already performing CBD activities (i.e. PPAG, GSMF agents and the IAE facilitators, the MOH TBAs and the GRMA Midwife Assistants).

B. Study Design, Location And Sampling

Cross-sectional and descriptive, the study was designed to provide baseline information on the current CBD program in Ghana. In addition to information provided by key officials at headquarters and management level of NGOs and Institutions, it was necessary to conduct field visits and collect complementary/additional data in order to:

1. Complete information collected from key individuals
2. Describe specific areas such as RH/FP knowledge and skills, working conditions and work environment for field workers as well as their personal characteristics.
3. Collect qualitative data from community about its involvement and the level of satisfaction about services received.

The sample size and study location were conveniently determined based on the time allotted for data collection, the desire to have different parts of the county represented (North, Central and South), the desire to have descriptive data on implementing and supporting institutions and the possibility of having access to the different target groups at accessible sites. Also, the field data collection targeted rural as well as urban areas.

A purposive sampling technique was used for selecting districts with regard to the possibility of having all targeted groups in the same areas of each region (Ashanti, Northern and Volta regions).

The location of CBDs was the first step of the sampling and, consequently, CBD supervisors and service providers at referral points were identified.

The number of CBDs and other community workers was determined with regard to available human resources for data collection and estimated time needed for conducting interviews and observation of interviewees. However, it was

recommended that as many as possible of each of the 5 categories of target groups be included in the sample (see number targeted and achieved in Table 1 pg. 9)

C. Data Collection Instruments

The following instruments were used for data collection:

1. Interview guide for key management individuals at headquarters and NGO levels

2. Knowledge questionnaire for

    2.a CBD agents
    2.b Supervisors of CBD agents
    2.c Service providers at referral points

3. Skills assessment checklists for:

    3.a CBD agents
    3.b Supervisors of CBD agents
    3.c Service providers at referral points

4. Working conditions instruments for:

    4.a CBD agents
    4.b Supervisors of CBD agents
    4.c Service providers

5. Work environmental factors interview guide for CBDs

6. Focus Group guide for:

    6.a Female and male clients of CBD agents' services
    6.b Community leaders
    6.c CBD agents

Draft instruments were developed by the entire assessment team with regard to the objectives of the assessment. Some of the instruments were adapted from existing instruments used in Ghana and by INTRAH/Lomé. The drafts of Focus Group discussion guides were developed by independent researchers based on expected outcomes and in consultation with the assessment team.

Apart from the Focus Group discussion guides and the interview guide for key individuals, other instruments were pre-tested in Accra Metropolis with CBD

agents, supervisors, TBAs and MW Assistants. All instruments were finalized by the assessment team except the guides for focus group discussions.

D. Assessment Team Organization

The assessment team was composed of representatives from all the participating agencies (MOH, PPAG, GRMA, GSMF and IAE) and INTRAH consultants and staff. The team was divided into 3 groups of 4 members each to visit 3 regions (Northern, Ashanti and Volta regions). For the Greater Accra region, the entire team was involved in the field work. A specific group conducted Focus Group discussions in East Akim and Upper Manya Krobo. Specific field tasks were assigned to each data collection group.

E. Data Management And Analysis

The data from the field was assembled and reviewed for completeness and consistency. Data on working conditions, work environmental factors and personal characteristics were edited, coded and entered into the computer with the assistance of a computer specialist. Tabulations, calculation of mean percentages and frequencies were generated. Data collected on knowledge and skills was manually corrected and scored and summarized on summary sheets before they were entered into the computer to generate totals and percentages. Software used were EPI-INFO versions 5 and 6, Excel and Lotus 1-2-3. The qualitative data from focus group discussions was analyzed and used to complement quantitative data. A specific report was written by the group which conducted the discussions in the field.

F. Limitations Of The Assessment

A major limitation of the study was the fact that the team was not able to work with a statistically representative sample. The group worked with a sample which would allow [???] to complete information collected through interviews with program managers. A major constraint was time limitation, which made it difficult for the team to work with a larger sample. Since the purpose of field data collection was to complement and supplement data collected from organizations, this limitation did not affect the quality of the field data and their utilization.

V. Assessment Outcomes

A. Summary Of Achievements

The achievements of the assessment team are described in the following Table:

Table 1: Number of CBD agents for whom data collection was completed

Regions	NORTHERN		ASHANTI		VOLTA		GREAT ACCRA		TOTAL		%
Institutions	E([1])	A([2])	E	A	E	A	E	A	E	A	
PPAG CBDs	10	11	10	11	0	0	10	10	30	32	106.7
GSMF CBDs	5	5	5	6	10	10	10	10	30	31	103.3
IAE CBDs	0	0	0	0	10	10	0	0	10	10	100.0
MOH TBAs	0	0	5	5	0	0	3	2	8	7	87.5
GRMA MWAs	5	4	2	2	1	1	5	3	13	10	76.3
TOTAL	20	20	22	24	21	21	28	25	91	90	98.9
% Per REGION	22.2		26.7		23.3		27.8		100.0		

Table 2: Number of health providers at referral points and CBD supervisors for whom data collection was completed

Regions Targets	NORTHERN	ASHANTI	VOLTA	GREAT ACCRA	TOTAL
SUPERVISORS	5	7	2	1	15
HEALTH PROVIDERS	8	6	5	4	23
TOTAL	13	13	7	5	38
% PER REGION	34%	34%	19%	13%	100%

E = Number expected
A = Number interviewed

As shown in the Tables above, a total of 90 CBDs including 7 TBAs and 10 midwives' assistants, 15 supervisors and 23 service providers were assessed. There was no assigned quota for health providers and supervisors. Their number depended on where CBDs were located and to which health facilities they would refer.

Concerning focus group discussions, three categories of people were targeted: CBDs, CBDs' clients and opinion leaders. A total of 10 PPAG CBDs and 11 GMSF CBDs participated in 2 Focus Group discussions. Two other Focus Group discussions were organized for 7 females and 9 males separately. Ten opinion leaders from Oyoko participated in another session of Focus Group discussion.

In each region, at least one key person at management level underwent interview guide [???] for NGOs. In the same way, 1 to 2 people were interviewed for each of the following institutions: NPC, PPAG, GSMF, MOH, GRMA and IAE.

B. Overview Of Institutions Involved In CBD Activities In Ghana

Key program managers from selected institutions involved in CBD activities were interviewed. They provided information on their institutions and their CBD program including program objectives; CBDs' jobs and tasks; CBDs' deployment; strategies for CBDs' selection, training, supervision, compensation and motivation, service delivery, referral, supply and pricing, community involvement, sustainability, evaluation and MIS. General information is summarized in the description of each organization below. Other information related to key program elements is described in the following sections.

1. Ghana Registered Midwives Association

The Ghana Registered Midwives Association (GRMA) is a decentralized professional non-governmental organization established in 1935 and officially recognized by the Government of Ghana in 1953. GRMA is made up of 355 private midwives/practitioners and 157 midwives in public health institutions providing essential maternal and child health services throughout the country.

In 1987, GRMA received assistance from the American College of Nurse Midwives (ACNM) through a grant with USAID/Ghana. The objectives of the project were a) to strengthen the institutional building capacity of the GRMA; b) to develop family planning training courses and continuing education programs; c) to provide family planning commodities; d) to provide information, education and communication (IEC) support and material and e) to develop a research and evaluation system. Other cooperating agencies also provided technical assistance including Columbia University, Johns Hopkins University, John Snow Inc. and GSMF.

The GRMA program focuses on MCH services and since 1987 on integrated FP services. GRMA works throughout the country, operating basically through private clinics managed by midwives who are members of the association and are assisted by maternity assistants. About 65% of the clinics are located in rural areas and 35% in urban areas.

GRMA support to its members includes supervision at three levels: national, regional and clinics. The national secretariat supervises the regional representatives (at least 4 regions) and especially newly trained midwives in the regions on at least a quarterly basis. The regional representatives supervise and monitor midwives and assistants on a regular basis. At the peripheral level, midwives supervise their assistants. Supervision/monitoring checklists are used at national and regional levels only. A feedback mechanism exists through regular meetings and reporting systems.

Currently, GRMA has no CBD program. The Association plans to start CBD activities in the near future in order to provide services to under-served communities where private clinics are located. Maternity assistants who have had on-the-job training in safe motherhood and first aid have been identified as potential CBD agents. GRMA plans to train the midwives and maternity assistants in FP, selected reproductive health issues, counseling, supervision record keeping and reporting in the form of basic, refresher and on-the-job training. Training strategy will be based on a needs assessment and the outcome of the National CBD program assessment. Under the proposed CBD program, at least one assistant per midwife will perform activities in the current clinic setting as well as in the community. Maternity assistants are currently paid staff of the midwives, although payment differs from one midwife to another. Under the proposed CBD program, they are expected to earn commissions on sales of contraceptives in addition to their regular wages paid by the Midwife. Communities will not be involved in the monitoring and compensation of the assistants.

2. Ghana Social Marketing Foundation

The Ghana Social Marketing Foundation (GSMF) is a non-profit organization incorporated in May 1993. It receives funding through a bilateral agreement between the Government of Ghana and the US government though its Agency for International Development (USAID). The organization uses the techniques of social marketing to create demand for family planning and related services. In line with its mandate to increase the availability and use of modern family planning methods, GSMF has expanded its distribution system beyond traditional commercial channels such as pharmacies, chemical sellers, etc., to include non-traditional outlets such as bars, petrol stations, supermarkets, etc. GSMF has already trained 4,000 chemical sellers, 500 pharmacists, 100 private medical

practitioners and a number of retired nurses and hairdressers in FP and related interventions.

Its community-based distribution program is another effort to fulfill its mandate under FPHP. Specifically, the goal of the CBD program is to take FP and related services and products to remote, hard-to-reach areas and to special interest groups such as religious bodies and adolescents. Under the FPHP, GSMF recruited 18 local non-governmental organizations as partners and provided funding for training, basic equipment for CBD agents and limited allowances to cover NGOs' direct costs related to management of the CBDs. A total of about 68 trainers, 65 supervisors and 624 community-based distributors were trained.

These are now providing counseling services and selling GSMF brand of contraceptives in their communities. The training was done using GSMF/PPAG training materials and PPAG and MOH trainers. It should be noted that the above number of supervisors is not equally distributed amongst the NGOs.

Among the local NGOs supported by GSMF, the following were assessed during this exercise:

a) 31st December Women's Movement

the 31st December Women's Movement (31st DWM) is a non-governmental organization created in 1982 that aims at providing a forum for all women and conducting advocacy on women's common problems. the 31st DWM has a membership of approximately 1.5 million women and has branches in all 10 regions and 110 districts of the country. the 31st DWM is organized in headquarters, and regions, districts, zones and branches headed by Organizers. Activities of the Movement include establishment of child day care centers, non-formal education and training for members, health and nutrition, family planning, environmental protection, and income-generating activities such as bakeries, cassava processing and pottery making.

In 1994, the 31st DWM started a CBD program in Volta and Ashanti regions with GSMF support. The main goal of the project was to take family planning services to women at the grassroots, where the Movement had already established activities, where population density was high (Ashanti) or FP acceptance was low (Volta). Originally, in the needs assessment, the 31st DWM identified the training needs for CBDs, counselors/motivators, CBD trainers, and drama troupes. As the program moved along, and due to funding restrictions, most of the volunteers trained as CBDs are now performing the above functions. Main tasks include the distribution of non-clinical family planning products, education of rural communities on family planning, AIDS, child care and diarrhea disease control, and performance of community theater at the grassroots.

The selection of the communities was made following GSMF guidelines (two CBD agents per district) and in consultation with the community leaders, Ministry of Health personnel and PPAG workers in the region. After the training, CBDs were provided with IEC materials, bags, bicycles and the first stock of contraceptives. The 31st DWM is responsible for collecting contraceptive replenishment from GSMF wholesalers and for reporting on sales to GSMF headquarters on a monthly and quarterly basis.

CBD agents are supervised on a monthly basis by part-time supervisors running the day care centers. The community is responsible for monitoring the CBD agent in the field. CBD agents receive a travel and transportation allowance of ¢5,000 on a quarterly basis. In addition, they benefit from recognition by the movement.

CBD agents distribute GSMF condoms, pills and foaming tablets applying [???] GSMF price list. CBDs conduct home visits and group discussions. They refer clients to the closest health center using referral forms provided by GSMF.

Sustainability is a main concern for the movement, whose activities are currently supported through income-generating activities by the women. the 31st DWM plans to involve the district assemblies in the project in order to integrate the cost of the CBD program into their mainstream funding sources.

b) Amasachina Self-Help Association

The Amasachina Self-Help Association is a non-governmental organization created in 1967 that implements health, education and other development activities in all districts of the Northern Region. The main goal of the association is to instill a self-help spirit into communities by assisting them with development projects and activities.

With GSMF assistance and funding, Amasachina began a CBD program in August 1994, focusing on health education, family planning, HIV/AIDS control, prevention of diarrhea diseases and malaria. the program started with the training of 16 CBD trainers. Actual training for the 105 CBD agents started in 1995 in 3 batches. Selection procedures are well-structured. Nominations of CBDs are received from communities. A panel interviews nominees and successful candidates are informed about their selection in writing. The final responsibility for selection, however, rests with Amasachina and GSMF.

Training lasted for 12 - 14 days for CBDs and TOTs. Curriculum and timetable were developed jointly with Amasachina, PPAG Regional Office and GSMF final input. Training materials were prepared by PPAG initially for the TOT and subsequently by Amasachina trainers under the supervision of the PPAG Regional Office. A maximum of 45 participants participated in each training session. No refresher training has been conducted yet. in addition, Amasachina has no plans

to train new CBDs. In addition to modest incentives, Amasachina provides bicycles, rain coats and Wellington boots to CBDs. Amasachina also plans to provide CBDs with a monthly allowance which will cover the maintenance of the bicycles/motorcycles.

Currently, the 16 trainers serve as supervisors, one per district and 4 in the headquarters/secretariat. Supervisors work on a part-time basis and are responsible for overseeing the CBDs operating in their district. Only one supervisor has been formally trained in supervision, so plans are to train the 16 trainers/supervisors formally. There are no supervision protocols. Supervisors visit CBDs twice a month. They report on activities of CBDs using the GSMF reporting format. Feedback between the supervisors and CBDs is practiced during the monthly visits and the quarterly review meetings. Most Amasachina supervisors have been supplied with bicycles. The main constraint facing the supervisors is lack of remuneration and other logistic support such as rain coats, umbrellas and Wellington boots.

Apart from the Saboba district, Amasachina provides services in urban and rural Northern region, solely through CBDs. All CBDs operate within communities, each CBD having approximately 15 communities assigned. All areas of their operation are under-served for FP/MCH services. They perform counseling and IEC activities, including home visits, group talks and community motivation activities. They distribute non-clinical contraceptives and first aid drugs. Their intervention areas cover HP, HIV/AIDS< malaria and oral rehydration therapy. CBDs make referrals to the nearest health centers (public and private) using a referral booklet provided by GSMF.

Amasachina has yet to receive funding support from the regional/district administrative structures for their program. In addition, the organization is in the process of soliciting financial and logistic support from other donors such as the Japanese, UNFPA, etc.

c) Christian Council of Ghana

The Christian Council of Ghana (CCG) is a national church agency, created in 1961, that aims at promoting Christian teaching on sex, marriage and family life in both physical and spiritual perspective. Main sources of funding include the World Council of Churches (Geneva), Bread for the World and Christian Aid.

The Council started a CBD program in Volta region in 1994 with GSMF assistance and funding. Seventeen (17) providers were selected by the regional committee of churches amongst social workers working in the public sector or for local NGOs. They were trained during two weeks with PPAG assistance. CBDs are located in Ho, Kpandu and Hohoe districts where they conduct home visits, counseling and first aid activities, and distribute condoms and VFTs. Clients are

referred to CCG clinics at Ho or Hohoe or other public and private clinics in the area, using a referral booklet provided by GSMF.

Only one supervisor working as an administrative assistant at the Regional Branch of the Council is in charge of the 17 CBDs. She received training in supervision and is responsible for conducting supervisions visits to the CBDs on a monthly basis and for collecting the reports. The supervisor is paid a modest allowance for performing supervisory tasks. She does not receive transportation means and relies on public transportation for the visits to the CBDs. In addition, there are no supervision protocols and no specific format for the supervision reports.

The CCG procures contraceptives from DANAFCO Tamale distributor. Stocks are kept at the CCG clinic where storage conditions are very poor. Contraceptives are distributed to the CBDs as needed and during the monthly supervision visits.

d) The Muslim Family Counseling Services [3]

The Muslim Family counseling Services (MFCS) was established in 1990 to respond to social problems, such as illness, poverty, illiteracy, teenage pregnancy, and drug abuse in Muslim communities. Their activities have included seminars for imams, a drama group for community social and health education, a small eye clinic at Nima providing curative services, a small community-based distribution program for non-clinical family planning products, and cooperation with the Ghana Red Cross for AIDS education. As part of their effort to build community understanding and support for the need for family planning, they have trained 60 imams with the help of UNFPA, and have plans for training more in Family Planning policy issues in a Koranic context.

MFCS has emphasized a grass roots approach targeted at Muslim areas, with services in the Eastern and Ashanti regions in addition to its activities in the Greater Accra area. They are currently discussing invitations to expand to other regions, possibly in collaboration with UNFPA, the GNFP Secretariat and PPAG.

e) May Day Rural Project

May Day Rural Project, a private voluntary rural development organization, operating mainly in the Ga Rural district of the Greater Accra Region of Ghana, has presented the Futures Group (FUTURES) with a proposal to fund the training of 30 community-based distributors. These distributors were selected to assist in the delivery of family planning and related health services, including HIV/AIDS education, control and prevention of malaria and diarrhea diseases.

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[3] *Institutional assessment has not been done. Information extracted from GSMF document on "Profile of NGOs working with GSMF of the FPHP of Ghana"*

Under a rural development and sanitation project, May Day Rural currently provides health services to over 160,000 rural people. It has hooked into the Ghana Social Marketing Foundation (GSMF) distribution network to supply non-clinical contraceptives to its clients.

May Day's major strength is in the sound infrastructure it already has in place within the communities it serves. May Day Rural Project has a number of projects funded with assistance from UNFPA and others.

3. Institute of Adult Education

The Institute of Adult Education (IAE) is a semi-autonomous body of the University of Ghana, with a goal of carrying the University outside its walls all over the country. The main functions of the Institute are three-fold: teaching, research and service. IAE has regional offices in the ten regional capitals as well as two district offices at Bawku and Tema. In addition, the Institute has 4 Workers' Colleges at Accra, Kumasi, Takoradi and Tamale and one Adult Residential College at Tsito. Main sources of funding are Government subventions, as well as grants from the Canadian International Development Association (CIDA), Canadian Organization for Development and Education (CODE), United Nations Population Fund (UNFPA), German Adult Education Association (DVV), and Danish International Development Agency (DANIDA).

IAE is currently implementing a UNFPA-funded Population Education Project (Mass Media Support for Adult Population Education Project) in three districts in each of the following regions: Volta, Upper West and Upper East regions of Ghana, and 4 Workers' Colleges as part of its service function to the community. The project is focused on three broad intervention areas: Family Planning, HIV/AIDS, STDs and Women in Development (WID) with two distinct components, the urban oriented Workers' College programs and the rural based community programs. MMSAPE has two target audiences: (1) young adults registered with the Workers' colleges (2) adult learners registered with adult literacy classes.

MMSAPE, in collaboration with GSMF, PPAG and MOH, began a CBD program as part of the rural-based programs in December 1994, through selected facilitators in charge of adult literacy classes. The CBD program has the following goals: (1) to make contraceptive supply readily available at the doorstep of the targeted audience and (2) to support awareness creation with commodity supply. to date, 99 facilitators operate as CBD agents in these regions (11 facilitator/CBDs per district). the facilitators were identified by the Institute's regional program managers in consultation with the opinion leaders of their respective communities. As part of the CBD program, IAE developed a CBD Training Curriculum based on baseline study, literature review and a needs assessment survey and pre-tested it during the three regional trainings of the

facilitators. A 4-day refresher course was organized for the CBDs after one year of operating in the field. In addition, the Institute has trained 13 people (one national coordinator, three regional coordinators and nine district supervisors) in collaboration with GSMF and using PPAG trainers.

GSMF provided the first stock of contraceptives to IAE. Stock replenishment is the responsibility of IAE and is done on a regional basis from accredited GSMF distributors and the MOH Regional Medical Stores. Appropriate reports are sent quarterly to GSMF for their brands of contraceptives sold.

IAE's CBDs are volunteers who are supported with incentives such as bicycles, raincoats, torch-lights, and IEC bags. The CBD program has a built-in supervisory and monitoring system. The CBDs meet monthly at district levels and quarterly on a regional basis. At these meetings, feedback mechanisms (contraceptive report forms, IEC progress books, and referral and follow-up forms) are discussed with the CBDs as well as supplies to be given out to them. In addition, regional and head office staff visit the CBDs in their communities on a regular basis to monitor the progress of the work.

4. Ministry of Health

The MCH/FP unit was established in 1976 as part of the Public Health Division of the Ministry of Health. The Unit has to set policies and guidelines for MCH/FP activities under the direction of the head of the unit. At regional, district and sub-district levels, Public Health Officers coordinate the MCH/FP activities.

The TBA project started in 1989 and is aimed at training 600 TBAs per region to give quality services to mothers and children. Funding came from USAID, UNICEF and UNFPA. Actually, most regions have surpassed their goal. Although the TBAs program ended at the national level, it continues at the regional level. Traditional birth attendants selected by the community conduct MCH/FP activities at the community level, including antenatal and postnatal care, deliveries, family planning, counseling, health education on environment, immunization and referrals. TBAs facilitate the links with health clinics, organize women on the clinic days and take part in clinic activities such as antenatal care, deliveries, etc.

Training of TBAs includes theoretical and practical sessions. So far, more than 6,000 TBAs have been trained. Originally, two refresher courses per year were planned but only one was conducted in a year. Referral was one of the training goals. During training, TBAs were introduced to clinical staff in the nearest referral center. They have to use referral cards. The cases referred by TBAs are documented in a register at the health facility. The performance of TBAs was assessed during training through demonstration and role play, and after training through supervision. In addition, external and internal evaluations of the program

have been conducted.

5. National Population Council

The National Population Council (NPC) was established in May 1992 and was officially recognized two years later. This is a parastatal body directly linked to the Office of the President of Ghana. The NPC acts as the focal point in the formulation, coordination, management and evaluation of population programs and activities throughout the country. Specifically, its mandate is to recommend, interpret and review population policies; coordinate internal and external resources to support population policies and program implementation; guide and promote the implementation of a comprehensive population program; set operational targets for program performance and expected impact and recommend strategies for their attainment; and coordinate and monitor population programs of other organization, both public and private, within the country.

The NPC Secretariat is headed by an Executive Director who is a member and secretary to the Council. The Secretariat is comprised of the Executive Director and four Directors (Finance and Administration, Program and Research, Training and Family Planning, and IEC). Of the four Directors, only two are currently at their posts. Each region is supposed to have a population office managed by an Assistant Population Officer. The NPC has established five multi-sectional/multi-disciplinary technical advisory committees to reinforce the technical base required for its decisions. A technical coordinating committee harmonizes and coordinates the work of the various technical advisory committees.

In line with government policy on decentralization, the NPC Secretariat works closely with the political and administrative units of the country, especially the District Assemblies and the various communities to design and implement population programs and activities. The NPC also works with field agencies including NGOs, the National Development Planning Commission, and government agencies.

6. Planned Parenthood Association of Ghana

The Planned Parenthood Association of Ghana (PPAG) is a non-profit, non-governmental organization established in 1967 and affiliated with the International Planned Parenthood Federation (IPPF). Funded at 82% by IPPF, PPAG received also support from the US Agency for International Development (USAID), Postal Savings for International Voluntary Aid (POSIVA), World Bank, Japanese Organization for International Cooperation in Family Planning (JOICFP), German Agency for Technical Cooperation (GTZ), Access to Voluntary and Safe Contraception (AVSC), funds generated from local sources and support from the Government of Ghana.

PPAG consists of volunteers and paid staff. The volunteers formulate policies and volunteer their time and expertise for the promotion and achievement of the Association's goals. The staff are the paid full-time workers of the Association in charge of the design, planning, implementation, supervision and evaluation of the programs initiated by the Association.

The PPAG office is headed by the Executive Director and includes a Program Department, a Finance/Administration Department and a Research/Evaluation Unit. PPAG has branches in seven of the ten regions of the country (Northern, Eastern, Ashanti, Brong Ahafo, Greater Accra, Central and Western Regions). Regions are divided into three zones headed by Area Managers. Each regional office is managed by a Program Coordinator.

The goals of the Association are: a) to assist national efforts aimed at improving the socio-economic and political life of the population; b) to promote the physical health of families, especially children, through better spacing of births; c) to promote better health and nutrition of families, especially children; and d) to initiate and promote education and other programs aimed at responsible family life for adults and youth. PPAG is currently implementing several projects including: family life education for the youth (Greater Accra, Eastern, Central, Western and Ashanti regions), sexual health (Ashanti region), community-based family planning services (all 7 regions), integrated family planning services (all 7 regions); voluntary surgical contraception (Greater Accra); and integrated family planning, nutrition and parasite control (Central region). PPAG is also involved in MCH/FP service provision through 42 clinics (22 in urban and 20 in rural areas) and one mobile clinic in the Northern region. Services provided include family planning, maternal and child health, pregnancy testing, sub-infertility counseling, immunization, and counseling on STDs/AIDS.

Regarding its CBD program specifically, PPAG started a CBD approach in the Eastern region in 1974. The goal was to ensure wider availability and easy access to quality family planning services to men and women of reproductive age, especially in rural areas. CBD agents were volunteer males and females of different age groups form various occupational categories and identified within the communities. After four years of successful efforts, the CBD project was expanded in six other regions of the country. CBD agents' main tasks include IEC activities (counseling, lectures, group discussions), home visits, sales of non-prescription contraceptive methods and re-supply of pills and first aid services in some cases. PPAG has trained 60 CBD trainers at national levels, 30 staff and 29 part-time supervisors, and 672 CBD agents in the seven regions. Over 470 of the 672 providers (70%) are living in rural areas. To date, PPAG estimates that 11% of its CBD agents dropped out as a result of transfers, migration to urban centers, and loss of interest because of inadequate incentives.

The CBD agents can be divided into three categories: a) those who were deployed mainly to disseminate family planning information and services to the communities; b) those who, in addition to the above function, were trained to provide first aid and sanitation services; and c) those who were also trained to provide education on environmental sanitation (Greater Accra region). In the future, PPAG plans to train an additional 385 providers and to provide refresher training to 300 providers.

Supervision of CBD agents is currently performed on a monthly basis by PPAG full-time paid supervisors and volunteer part-time supervisors identified in the community. Both full-time and part-time supervisors were trained in a 2-week session organized at the national level. Training included topics such as family planning, IEC, first aid, treatment of minor ailments, logistics, record keeping and referral. It should be noted that neither the CBD agents nor the supervisors received refresher training.

C. CBD Program Components Descriptions

1. CBD Agents description and work environment

Ninety (90) CBD agents were assessed throughout the 4 regions of the country. In the following part of the report, CBD agents include the following categories: PPAG CBDs; CBDs of the GSMF-sponsored NGOs' CBDs already providing reproductive health and family planning and First Aid services at community level; and facilitators of the Institute of Adult Education who have been trained to perform CBD activities in Volta. TBAs from the Ministry of Health and GRAM Midwife Assistants are categorized as CBDs, since they provide some reproductive health and family planning services at their worksites and constitute an existing potential for providing services.

The distribution of the CBDs assessed is presented in the following Table.

Table 3: Frequency of CBDs assessed by institution/organization and by region

	IAE CBDs	AMA CBDs	CCG CBDs	31ST CBDs	Moslem CBDs	May BDs	GRMA MWA	MOH TBD	PPAG CBD	TOTAL	%
REGION	10	21	22	23	24	25	30	40	50		
1. Ashanti	0	0	0	6	0	0	2	5	11	24	26.7
2. Greater Accra	0	0	0	0	5	5	3	2	10	25	27.8

3.Northern	0	5	0	0	0	0	4	0	11	20	22.2
4. Volta	10	0	10	0	0	0	1	0	0	21	23.3
TOTAL	10	5	10	6	5	5	10	7	32	90	
%	11.1	5.6	11.1	6.7	5.6	5.6	11.1	7.9	35.6		

The purpose of the next sections is to describe the following:

- Profile, selection and personal characteristics of CBD workers
- Jobs and tasks
- CBD agent deployment
- Compensation and motivation system
- Level of knowledge and skill in reproductive health and family planning and First Aid (treatment of minor ailment)
- Working conditions and work environment factors
- Community perception of CBD services

The description is based on data collected through interviews with key people at the management level of organization (see Table 4) complemented by the results obtained from the analysis of data collected during the field visit.

Table 4: Summary of characteristics of CBD agents per institution

	GRMA (planned)	GSMF	IAE	MOH	PPAG
CBD agent profile	Midwife assistant	Men or women identified in the community by local NGOs	Facilitators of literacy classes	Women performing deliveries in the community and men	Men or women identified in the community
CBD agent type	Paid staff	Volunteers	Volunteers	Volunteers	Volunteers
Selection criteria	Literate, able to carry out safe motherhood activities	Marital status, between 25-45 years of age, residential status, motivated, trusted by community, able to read and write, self-employed, able to keep records and motivate communities	Facilitator in the community	Resident in the community, doing deliveries, between 40-80 years of age	At least some basic education, ability to communicate, motivation, marital status, age, residential status
Mode of selection	selected by midwife owner of the clinic	List proposed by local NGO branch with community opinion leaders' involvement, final vetting by GSMF	Identified by regional offices and approved by community opinion leaders	by community assisted by training staff (vetting)	by community assisted by training staff (vetting)
Jobs and tasks	FP counseling, contraceptive distribution	Group talks, community health education, counseling, first aid, contraceptive distribution	IEC, contraceptive distribution, first aid, PHC, referrals	antenatal and postnatal care, deliveries, FP, IEC and health education, home based and outreach, immunization and referrals	IEC activities, home visits, sales of non-prescription contraceptive methods and re-supply of pills and first aid services in some cases
CBD agent deployment	Nationwide	Nationwide	Volta, Upper East, Upper West (3 districts per region)	Nationwide	7 regions (Northern, Eastern, Ashanti, Brong Ahafo, Greater Accra, Central, Western Regions)
Compensation / motivation system	Commission on contraceptive sales	• Commission on contraceptive sales • Other compensation depends on NGOs' policy and ability • Reimbursement of transportation costs	• Provision of logistics / incentives • Commission on contraceptive sales	• Kits filled with dressing, soap, etc. • Compensation by the community • 50% commission on contraceptive sales	Bags, IEC materials, penis models, notebooks, first aid boxes, bicycles in limited cases T & T and 40% commission on contraceptive sales
Indicator of performance	n.i.	• Products distributed • Cost per CYP	• Products distributed and activity log	• Antenatal registrants • Supervised deliveries • FP device sales	• Products distributed • Activity log

1.1 Profile, Selection and Personal Characteristics

a) Profile

The majority of CBD agents are volunteers and were identified and selected in the community where they live. As discussed above, they include PPAG and GSMF community providers (men and women) already providing outreach services and the IAE facilitators of literacy programs.

The TBAs already operate in the community where they provide safe motherhood services including FP non-prescriptive methods. Midwife Assistants are paid providers working in private and public clinics. They are involved in providing some reproductive health and family planning services.

b) Selection mode and criteria (Table 5)

The most common approach to CBD selection is the involvement of the community (except for midwife assistants who are selected by the owner of the clinic). The approaches vary among organizations. The community is involved in certain phases of the selection such as identification, interviews and approval. (See attached focus group discussion report.)

Selection criteria include a certain level of education or literacy, support by the community leaders and the public, and residence within the community. Ability to communicate, marital status and age are some other criteria for selection used by one of the organizations involved in the CBD Program (PPAG). IAE CBDs were to be performing facilitator activities before they were trained to integrate FP and First Aid into their regular jobs and tasks. A number of the above criteria were used to select them for facilitator tasks. These criteria do not supply to the TBAs as they were practicing long before their training.

c) CBD characteristics as observed by the assessment

Apart from the theoretical criteria mentioned above, it was relevant to describe the actual characteristics of the CBD workers. The information obtained from the analysis of the field data on personal characteristics is presented in Tables 3 to 12 below. It includes a description of CBDs by age, sex, marital status, educational attainment, literacy levels, training status, FP method use and fertility patterns.

* Sex

As shown in Table 5 below, outreach community activities are performed by men as well as women. However, females are over 61% of respondents, while males are 38.1%.

Table 5: Sex distribution of CBD agents per institution and per group

SEX	IAE	AMA	CCG	31st	Moslem	May Day	GRMA	MOH	PPAG	TOTAL	%
MALE	7	2	2	0	2	2	0	0	19	34	37.8
FEMALE	3	3	8	6	3	3	10	7	13	56	62.2
TOTAL	10	5	10	6	5	5	10	7	32	90	
%	11.1	5.6	11.1	6.7	5.6	5.6	11.1	7.9	35.6		

* Age

Nearly 86% of CBD workers are theoretically, of reproduction age (20-49), but the age range is from 21 to 82 years old. Generally the oldest are the TBAs. The mean age for males is 37.8 and 39.5 years for females.

Table 6: Age distribution of CBD agents per institution and per group

AGE	IAE	AMA	CCG	31st	Moslem	May Day	GRMA	MOH	PPAG	TOTAL	%
20 - 24	0	3	0	0	1	0	3	0	0	7	7.8
25 - 29	0	1	2	2	1	0	4	0	4	14	15.6
30 - 34	0	0	1	2	2	0	1	0	8	14	15.6
35 - 39	2	0	2	0	1	2	1	0	8	16	17.8
40 - 44	3	1	1	1	0	3	0	0	6	15	16.7
45 - 49	2	0	3	1	0	0	1	1	4	12	13.3
50 - 54	1	0	1	0	0	0	0	0	2	4	4.4
55 - 59	1	0	0	0	0	0	0	1	0	2	2.2
TOTAL	10	5	10.6	5	5	10	7	32	90		
%	11.1	5.6	11.1	6.7	5.6	5.6	11.1	7.8	35.6		

* Marital status

The distribution by marital status shows that 62.2% were married and 20% were single. The remainder were divided amongst other categories (separated = 3.3%; divorced = 6.7% and widowed = 7.8%)

Table 7: Marital status distribution of CBD agents per institution and per group

MARITAL STATUS	IAE	AMA	CCG	31st	Moslem	May Day	GRMA	MOH	PPAG	TOTAL	%
Married	10	2	5	2	2	5	6	2	22	56	62.2
Single	0	3	4	2	1	0	2	0	6	18	20.0
Separated	0	0	0	1	1	0	0	0	1	3	3.3
Divorced	0	0	1	0	1	0	1	0	3	6	6.7

Widowed	0	0	0	1	0	0	1	5	0	7	7.8
TOTAL	10	5	10	6	5	5	10	7	32	90	
%	11.1	5.6	11.1	6.7	5.6	5.6	11.1	7.8	35.6		

- Educational level, literacy and worksite

All interviewees were asked for their highest level of educational attainment. Respondents were grouped in 8 educational categories (never attended school, some elementary, completed elementary, some secondary, completed secondary, some middle, completed middle, post secondary and above). The distribution shows that only 5.6% percent of 90 respondents did not attend school. Most of them completed elementary school. All interviewees are literate and speak the local language, as they live within the community where they offer services.

Table 8: CBD educational status frequency distribution

EDUCAT. STATUS	IAE	AMA	CCG	31st	Moslem	May Day	GRMA	MOH	PPAG	TOTAL	%
No schooling	0	0	0	0	0	0	0	1	0	1	1.1
Compl. element.	8	1	2	1	1	1	1	0	4	19	21.1
Some secondary	2	0	2	1	2	0	1	0	2	10	21.1
Compl. second.	0	3	4	2	2	0	4	0	6	21	23.3
Some element.	0	0	0	0	0	0	0	5	0	5	5.6
Some middle	0	1	1	2	0	0	2	0	9	15	16.7
Compl. middle	0	0	0	0	0	3	2	1	8	14	15.6
Post sec. & above	0	0	1	0	0	1	0	0	3	5	5.6
TOTAL	10	5	10	6	5	5	10	7	32	90	
%	11.1	5.6	11.1	6.7	5.6	5.6	11.1	7.8	35.6		

Table 9: CBD literacy per institution

LITERATE	IAE	AMA	CCG	31st	Moslem	May Day	GRMA	MOH	PPAG	TOTAL	%
YES	10	5	10	6	5	5	9	2	32	84	93.3
NO	0	0	0	0	0	0	1	5	0	6	6.7
TOTAL	10	5	10	6	5	5	10	7	32	90	
%	11.1	5.6	11.1	6.7	5.6	5.6	11.1	7.9	36		

*Training status and work experience

89.9% (80) of interviewees (n = 89) have attended general training sessions on FP and First Aid. those who did not attend training sessions are eight Midwife Assistants and one TBA. It is important to note that 40% of the 85 respondents were trained 3 years ago while about 30% have been performing activities for more than 3 years. Refresher courses have not been provided to CBD agents until now.

Table 10: Training status frequency distribution

TRAINING STATUS	IAE	AMA	CCG	31st	Moslem	May Day	GRMA	MOH	PPAG	TOTAL	%
YES	10	5	10	5	5	5	2	6	32	80	89.9
NO	0	0	0	0	0	0	8	1	0	9	10.1
TOTAL	10	5	10	5	5	5	10	7	32	89	
%	11.2	5.6	11.2	5.6	5.6	5.6	11.2	7.9	36		

*Contraceptive use

At the time of the assessment, 49.9% of the interviewees were using an FP contraceptive method, although 73% revealed having used a method of contraception in the past. Of those who have ever used contraception (64 out of 89), 67.2% (= 43) are currently using a contraceptive. Both males (61.4%) and females (38.6%) have concerns about their current use of any method.

Table 11: Past & current use of FP frequency distribution of CBDs by institution and NGO

a) Currently	IAE	AMA	CCG	31st	Moslem	May Day	GRMA	MOH	PPAG	TOTAL	%
YES	6	3	4	3	3	3	3	0	19	44	49.4
NO	4	2	6	2	2	2	7	7	13	45	50.6
TOTAL	10	5	10	5	5	5	10	7	32	89	
%	11.2	5.6	11.2	5.6	5.6	5.6	11.2	7.8	36		

b) In past	IAE	AMA	CCG	31st	Moslem	May Day	GRMA	MOH	PPAG	TOTAL	%
YES	9	3	8	5	4	5	3	1	27	65	73
NO	1	2	2	0	1	0	7	6	5	24	27
TOTAL	10	5	10	5	5	5	10	7	32	89	
%	11.2	5.6	11.2	5.6	5.6	5.6	11.2	7.8	36		

Fertility patterns

The mean number of children still alive for all 90 interviewees is 3.056 (male = 3.353 and female = 2.875). 72.2% of all interviewees have at most 4 children alive. Currently the Ghanaian population policy is promoting a number of children less or equal to 4 per family.

Table 12: Children alive frequency distribution of CBDs per institution and NGO

# OF CHILDREN ALIVE	IAE	AMA	CCG	31st	Moslem	May Day	GRMA	MOH	PPAG	TOTAL	%
0 - 4	4	5	9	5	5	0	10	2	25	65	72.2
5 - 9	6	0	1	1	0	5	0	5	7	25	27.8
10 and up	0	0	0	0	0	0	0	0	0	0	0
TOTAL	10	5	10	6	5	5	10	7	32	89	
%											

1.2 CBD jobs and tasks

The CBD agents are requested to provide FP counseling and IEC through group talks. film shows, durbars. Home visits are performed either to provide IEC on Reproductive Health and Family Planning and First Aid, or distribute contraceptives. referrals are made for pill initiation or other methods not available at the CBD level, but also for other FP use-related conditions. TBAs essentially perform safe motherhood activities and provide related IEC.

The analysis of data collected on performed activities confirmed that counseling (63.3%), safe motherhood (31.1%), contraception distribution and sales (84.4%), child growth monitoring (14.4%), and IEC (65.7%) are the most spontaneously mentioned activities by the interviewees. Some of them also mentioned referrals, home visits, primary health care, environmental hygiene and record keeping.

1.3 Agent deployment

The CBD agents were deployed in order to address the problem of getting services to hard-to-reach and under-served communities. Also, the concern of providing IEC services on reproductive health and family planning was one of the rationales for CBD agents' deployment. Midwife Assistants and TBAs (about 6000) are deployed nationwide. In fact, most of the communities benefit from TBA services and Midwife Assistants' work in public and private health facilities throughout the country. There is at least one Midwife Assistant for each of the 355 private Midwife practitioners, members of GRMA. PPAG is operating in 7 regions with 672 CBDs while GSMF covers the 10 regions with 624 trained CBDs. The IAE is operating in three regions (Volta, Upper East and West) with 99 providers.

However, according to the interviewees (see Table 13), motivating factors include not only those mentioned above, but also good working conditions (minimum material for their daily activities, logistics, etc.), training and compensation. Among other motivating factors, recognition of services, involvement of the community and its support, demand for services and supervision system are mentioned by the interviewees.

1.4 Motivation

Apart from the Midwife Assistants paid by clinic owners and TBAs who are compensated by the community, other CBD agents work on a volunteer basis. Their incentive is essentially the commission they receive on contraceptive sales. Other supportive resources, such as bags, IEC materials, notebooks and bicycles, serve as motivations (See Focus group report).

However, according to the interviewees (see Table 13), motivating factors include not only those mentioned above but also good working conditions (minimum material for their daily activities, logistics, etc.), training and compensation. Among other motivating factors, recognition of services, involvement of the community and its support, demand for services and supervision system are mentioned by the interviewees.

Table 13: CBD perception of motivating and negative factors by institution

a) Motivating Factors (n = 84)	IAE	AMA	CCG	31st	Moslem	May Day	GRMA	MOH	PPAG	TOTAL	%
1. Community involvement and support	0	0	0	0	0	0	0	0	1	1	1.2
2. Recognition of services	0	0	0	0	0	0	1	1	1	3	3.6
3. Demand for services	0	0	0	0	0	0	2	0	1	3	3.6
4. Supervision system	0	0	0	0	0	1	0	0	1	2	2.4
5. Compensation	1	1	2	0	1	0	0	0	0	5	6.0
6. Availability/ accessibility of service at referral points	0	0	0	0	0	0	0	0	1	1	1.2
7. Training	2	0	2	2	0	0	1	0	2	9	10.7
8. Good working conditions	6	1	6	3	2	3	3	2	12	38	45.2
9. Others (cultural, religious, traditional)	1	3	0	0	2	1	0	2	13	22	26.2
TOTAL	10	5	10	5	5	5	7	5	32	84	
%	11.9	6.0	11.9	6.0	6.0	6.0	8.3	6.0	38.1		

b) Negative Factors (n = 68)	IAE	AMA	CCG	31st	Moslem	May Day	GRMA	MOH	PPAG	TOTAL	%
1. Poor compensation system	0	1	1	0	0	2	0	0	6	10	14.7
2. Lack of services at referral points	1	0	0	0	0	0	0	0	0	1	1.5
3. Insufficient training activities	0	0	1	0	0	0	2	0	0	3	4.4
4. Poor working conditions	1	1	4	5	2	1	0	5	15	36	52.9
5. Others (cultural, religious, traditional)	2	3	1	0	1	1	1	0	9	18	26.5
TOTAL	4	5	7	5	3	4	5	5	30	68	
%	5.9	7.4	10.3	7.4	4.4	5.9	7.4	7.4	44.1		

Even though more than 70% of interviewees are very satisfied with their work, poor working conditions and poor compensation systems as well as cultural, religious and traditional beliefs, insufficient training and lack of services at referral points are mentioned as negatively influencing the performance of the CBD agents.

Supervision was mentioned as one of the factors that influence the performance of the CBD workers. In fact, 94% of the interviewees said they were visited by supervisors. Supervision is generally done once a month and 96.1% of respondents feel comfortable communicating with their supervisor. Also, 94.7% think their supervisors help in sales reporting, safe motherhood and logistics (see Table 16, "work conditions and environmental factors," pg. 28). According to the data, it seems that the supervisors' technical input on the most important tasks performed by CBD agents such as FP contraceptive distribution, counseling, record keeping and home visit organization is very limited.

1.5 CBD level of knowledge and skills

a) Knowledge

The majority of CBDs were trained in basic Reproductive Health, Family planning and First Aid. During the assessment implementation, they were tested on their general knowledge in 9 areas related to the CBD agent tasks and training curriculum. the group average scores attained by all categories of CBD are presented in Table 14.

Table 14: Level of CBD knowledge on FP and First Aid: mean % by institution and by content

AGENCY QUESTION	IAE %	AMA %	CCG %	31st %	Moslem %	May Day %	PPAG %	MOH-TBA %	GRMA %
1. FP rationale	77.0	76.0	70.0	83.3	92.0	82.0	75.9	28.3	61.7
2. FP methods	57.2	47.6	64.8	43.7	46.2	51.0	49.8	5.2	39.1
3. Counseling	68.3	20.0	10.0	38.9	80.0	40.0	56.3		15.3
4. AIDS / STDs	73.3	66.7	80.0	83.3	100.0	66.7	67.7	16.7	61.1
5. Main tasks	71.1	40.0	74.4	48.1	57.8	55.6	56.9	5.6	35.2
6. Convulsion	70.0	60.0	60.0	83.3		40.0	62.5	16.7	50.0
Diarrhea	90.0	80.0	75.0	91.7	60.0	60.0	75.0	66.7	58.3
Malaria	100.0	80.0	100.0	83.3	40.0	80.0	90.6	50.0	66.7
Drug administration	64.0	48.0	60.0	80.0	80.0	36.0	60.0	6.7	51.7
Record keeping	93.3	60.0	50.0	16.7	86.7	46.7	70.8		30.6
Mean %	76.4	57.8	64.4	65.2	64.3	55.8	66.6	19.6	47.0

There is a significant difference among categories. In fact, CBDs from GSMF, PPAG and the IAE seem to know more than TBAs and Midwife Assistants. The IAE facilitators have a higher score because they were recently trained and have a higher educational level in general. The weaknesses essentially concern counseling and family planning methods. The lower scores of TBAs and Midwife Assistants may be explained by the fact that they have never been formally trained in family planning methods and counseling.

b) Skills

The mean percent scores by institution obtained from the assessment of CBD agent categories in performing seven tasks is shown in Table 15. the data provide a global view of skill level for different institutions. The jobs and tasks concerned were counseling, pill resupply, condom use demonstration, foaming tablet demonstration, ORS preparation and use, and fever and convulsions management.

Table 15: CBD/FP First Aid related skill level by institution (group mean %) and for selected tasks

	GSMF	PPAG	GRMA	TBAs	IAE
COUNSELING	59.0	47	59.3	NO*	76.1
PILL SUPPLY	61.4	75	82.0	NO	NO
CONDOM USE DEMONSTRATION	74.9	72	54.5	27.3	87.3
FOAMING DEMONSTRATION	67.0	66	61.1	11.1	74.4
ORS PREPARATION USE	76.7	73	63.9	51.4	89.2
FEVER MANAGEMENT	56.2	63	60.0	NO	74.3
CONVULSION MANAGEMENT	59.8	56	41.7	NO	62.5

NO: Not Observed

In general, CBDs perform very well at demonstrating condom and foaming tablet use. The level of ORS preparation skill is also high compared to other skills assessed. However, Midwife Assistants and TBAs do not perform well, since they are not mandated to provide such types of services. In addition, TBAs do not perform counseling, pill resupply or fever and convulsions management. Weaknesses have been observed in CBD skills in performing counseling and management of fever and convulsions.

Table 16: Frequency distribution on working conditions per institution: visual materials, register and supply

	IAE	MA	CCG	31st	Moslem	May Day	RMA	MOH	PAG	TOTAL	%
HAVE FP VISUAL AIDS											
Yes	10	2	4	4	5	3	9	1	12	50	56.2
No	0	3	6	1	0	2	1	6	20	39	43.8
TOTAL	10	5	10	5	5	5	10	7	32	89	
%	11.2	5.6	11.2	5.6	5.6	5.6	11.2	7.9	36		
TYPES OF AIDS											
Pamphlets	7	2	4	3	3	3	4	0	10	36	72
Posters	10	1	3	4	1	3	4	1	12	39	78
Flip chart	10	0	2	0	1	1	4	0	0	18	37.5
CONTENT OF AIDS (n=50)											
FP	0	0	0	3	1	0	2	0	1	7	14
Available methods	3	0	2	1	2	0	6	0	6	20	40
Cholera	7	2	2	2	0	2	3	1	5	23	46.6
SUPPLY SOURCE (n=30)											
MOH	0	2	0	0	3	0	8	1	3	17	17
International NGO	9	0	0	0	0	0	0	0	3	12	24
Local NGO	1	0	4	4	2	3	1	0	6	21	42
Distribute pamphlets (n=50)	10	2	2	3	5	3	5	0	10	40	80
Not distribute pamphlets: (n=10)											
Don't have	0	0	2	1	0	0	3	1	2	9	90
Not instructed	0	0	0	0	0	0	1	0	0	1	10
FP register updated? (n=49)											
yes	0	1	1	4	0	1	6	1	20	34	69.4
no	0	3	1	1	0	1	1	0	8	15	30.6
Difficult to get commodity/supplies (n=79)											
yes	0	3	2	0	3	2	0	0	8	18	22.8
no	9	2	8	5	2	3	6	2	24	61	77.2

1.6 Working conditions and environmental factors

Questions were asked to get information on minimum support material, such as visual aids, family planning register, contraceptives and on the reporting system and supply of the CBD

agent. Environmental factors were assessed through questions on supervision and motivational factors. Frequencies for these variables related to working conditions and environmental factors are presented in Table 16.

a) Working conditions

Only 56.2% of CBDs (all categories) said that they had family planning visual aids (mainly pamphlets and posters). The most common content of the visual aids is the available FP methods and cholera. in 42% of the cases, visual aids are provided by local (national) NGOs. Among 50 respondents, 40 (80%) distribute pamphlets when available. Providers who said that they did not distribute any pamphlets gave the reason of not having enough pamphlets and other visual materials.

Similarly, almost all respondents (n=49) have a family planning register, updated in 69.4% of the cases, and containing information such as old and new clients' names, date of visit, product provided, referral, and contraceptive sales.

The majority of providers (77%0 don't have any difficulty getting commodities and supplies. However, even though they had a minimal stock of contraceptives (essentially condoms and pills and foaming tablets), some of them were not able to check the expiration date of condoms.

During the assessment, questions were asked on the reporting system and related tools. The results from the analysis of data show that the providers do not have a checklist for pill use and client screening. the FP register contains information on stock of commodities and referrals. A report is submitted almost monthly for the majority of providers. Referral forms are available (74.1% from 81 respondents).

b) Work environmental factors

The assessment of environmental factors aimed to describe variables related to the work environment of CBD agents that may affect program performances apart from those already described previously (i.e., skills and knowledge, personal characteristics, working conditions, motivating factors). They include place of residence, service availability at referral points, supervision and job satisfaction factors.

As already discussed, all providers live in the community in which they work. They are supervised at least monthly. More than 56.4% of respondents claimed to be informed about the date of the visit, but not about the content of the visit.

Although 79.7% of 79 respondents claim to be totally satisfied regarding support provided by the supervisor, it appears that the supervision essentially brings improvement on sales report and safe motherhood (mainly for TBAs and Midwife Assistants). Information on activities is shared often during supervision visits (85.5%) and regular meetings (14.5%).

The results from the analysis of data on working conditions at referral points show that contraceptive methods are available for most of the cases referred by CBD agents (non-available methods at the CBD agent level, other conditions). In fact, COCs, injectables, condoms, IUDs, foaming tablets and progestative OCs are available in most of the health

facilities to which CBD agents refer. The description of the service delivery and referral system (pg. 46) provides more information on service accessibility at that level.

According to the focus group discussion with CBD agents, one of their complaints is the occasional lack of partnership with the health workers (i.e. community nurses). CBD agents think that health workers should recognize CBDs as partners and not as rivals in family planning services (see focus group report, APPENDIX 8).

1.7 Community perceptions of CBD services

Focus Group discussions carried out with clients and community opinion leaders provided qualitative data on views, opinions and perceptions of services provided by the CBD agents. The details are in the attached focus group discussion report. The most important outcomes of the discussions are presented in the following section.

a) Community opinion leaders

The leaders claimed that they are aware of CBD activities in the community and they expressed satisfaction about his/her work that includes discussions on family planning. In short, they have a positive opinion of the CBD agent. Community opinion leaders also said that they are well-informed about the CBDs' problems and what he/she needs to provide better services to the community: transportation, incentives and motivation (such as allowance, torch-light, Wellington boots, salary, raincoat), office accommodation, technical competence, ID cards and IEC materials.

b) Clients

The CBD agents are seen by their clients as confidential and caring. They keep clients' secrets and the latter can confide in them. They are friendly and clients feel free to talk to them. Some clients see the CBDs as people who are "open and prepared to receive them at any time of the day." They are qualified and patient, knowledgeable and able to explain everything, including how to use the contraceptives.

Some clients said that they did not have anything bad to say about CBD, and said they go to them because of their good character.

The fact that CBD agents live amongst their clients (the community) make them easily accessible and always available. The clients appreciate the interesting fact that CBDs do not wait for clients all the time, but come to visit them and to find out if there is any problem.

The clients expressed satisfaction with the role of the CBD. He makes services available and close to clients so that people do not need to travel or deal with service providers with whom they are unfamiliar. However, CBD clients perceive the lack of leaflet or brochure of the method sold to them.

Most clients claim to promote the local CBD activities, for example, by informing their friends and other people about the work of the CBD. Sometimes, they take questions from friends to the CBD or sell some FP drugs for the CBDs. They also think that CBD should be given more

training about other diseases and be paid well. They should be recognized and respected by the chief and the community members.

2. CBD Training Description

The training description will include: main target groups, existing agents, job and task description, pre-training activities, CBD training materials, trainers, and training duration, venue, and content.

2.1 Target groups

Principal target groups involved in implementing CBD programs in the field are:

- CBDs
- TBAs
- MCH / FP service providers at referral points
- Program managers at national, regional and district levels
- CBD supervisors (at regional and district levels)
- Midwife Assistants (MWAs)

The target groups described in this description include CBDs, TBAs and MWAs.

2.2 Jobs and Tasks Descriptions

Jobs and tasks exist for CBDs in PPAG and IAE CBDs training curricula (see Appendices 4 and 5). In the field, there are slight differences in the jobs and tasks between organizations. For example, PPAG CBDs are trained to supply pills, while IAE CBDs are not trained in that.

Jobs and tasks for CBD supervisors exist in the supervisors' training manual developed by PPAG (APPENDIX 6). It seems that the jobs and tasks apply to all organizations involved in CBD programs.

MOH has jobs and tasks for TBAs. The description includes safe motherhood and contraceptive distribution (condom, foam tablets). The reproductive health service Policy and Standards recently developed by MOH with INTRAH assistance includes jobs and tasks for FP service providers. (The reproductive health service Policy and Standards have not yet been disseminated.)

No written job and task descriptions for CBD managers at national, regional and district levels were located.

2.3 Pre-training activities

IAE undertook a baseline study and literature review towards development of a CBD training curriculum. After development of the curriculum, it was pretested at three regional CBD training events.

MOH has a guide for community preparation and assessment, which is used for assessing the training needs of TBAs and community needs for a CBD program.

2.4 Training materials

IAE has a CBD training curriculum, developed with technical assistance from JHU / CCP. the curriculum was pretested during the training of IAE CBDs and then finalized.

PPAG has a supervision training manual which does not clearly reflect training objectives, methodology, standard performance levels, training evaluation approach. This manual only contains information on the subjects listed at the point 2.9 below.

MOH has produced several manuals on safe motherhood training, both for trainers and trainees with ACNM assistance. These materials include:

TBA pictorial record book
Clinic management on safe motherhood
Guidelines for Health Education on safe motherhood
Competency-based training of TBAs on safe motherhood

2.5 Trainers

PPAG provided assistance to the other organization (training materials and trainers) for the training of most CBD agents and CBD supervisors in Ghana.

2.6 Duration of training

PPAG training material calls for a minimum of 14 days training, considering the low-level background of the participants (CBD agents) and taking into account the curriculum content. Due to the rise in cost of workshops, the number of days for training has gradually been decreased to 10 days. This reduction in training time may affect the level of output and skills of CBDs. In training workshop evaluations, the short duration of training was cited by participants as a problem.

IAE training curriculum calls for 11 days training.

2.7 CBD training venue

Training of CBD agents and TBAs is organized in and/or around the communities where they live and is often conducted by trainers identified at the regional level.

2.8 CBD training content

In reference to the CBD training curriculum developed By IAE, training covers the following themes: family planning concept, human anatomy and physiology, infertility and sub-fertility, family planning contraceptive methods, rumors and misconceptions, STD / HIV / AIDS, communication, counseling methods and skills, Primary Health Care services, Women / Population and Development, MIS, community diagnosis.

2.9 Supervision training content

Training covers the following topics: National Policy on Family Planning, Rationale for Family Planning, Benefits of Family Planning, FP service logistic support, HIV / AIDS and STD prevention, Structure and Functions of the Human Reproductive System, Family Planning methods, screening of FP acceptors, contraceptive supply and distribution system, IEC / Counseling, First Aid and supervision of CBDs.

3. Supervision, Monitoring and Evaluation

The description will include 2 sections covering supervision, monitoring and evaluation. Both sections are synthesized in Table 36.

3.1 Supervision component description

Under supervision are described characteristics and profiles of supervisors, their performance in the executing of tasks and their material working conditions.

In general, CBD supervision is carried out on 2 levels in all the organizations (regional and district levels). the CBD agent supervisors are located at regional and / or district levels. The CBD supervisors ratio varies from 10 to 20 CBDs per supervisor in most institutions. This ratio takes into account factors such as the number of supervisors, the frequency of supervisory visits, the status of supervisors (full or part-time), place of residence of supervisors as regards CBDs. CBD supervisors are supervised by national and regional program managers. Frequency of CBD supervision varies from one organization to the other organization, but is normally carried out on either a monthly or quarterly basis.

a) Profile

Supervisors are either trainers, midwives, regional project coordinators, or CBD agents. they work full-time or part-time as salaried employees or voluntaries. Generally, they are based at the regional and district levels.

b) Supervisors' characteristics as observed by assessment

The majority of respondents (86.7%) were between 35 - 49 years of age. The mean age is 43 years. There were more males (60%) than females (40%). The majority (80%) of supervisors interviewed were married.

All supervisors assessed were literate and can speak the local language of the community. 40% of supervisors assessed completed secondary school. Their tenure in their current position as a supervisor was less than 3 years for the majority (73.3%).

About half of the supervisors interviewed don't live in the immediate area where their CBD agents live. Generally, full-time supervisors are paid and are located at regional levels, while part-time supervisors are paid and are located at regional levels, while part-time supervisors are volunteers operating from and within the CBD community.

All supervisors have been trained in supervision. The majority (80%0 were trained more than one year ago, and none has attended a refresher course in supervision.

All supervisors assessed said they had used a FP method before, and currently 78.6% are using a FP method.

Table 17: Supervisor's Age

	NUMBER	PERCENTAGE
30 - 34	1	6.7
35 - 39	4	26.7
40 - 44	2	13.3
45 - 49	7	46.7
50 - 54	0	0.0
55 - 59	0	0.0
60 - 65	1	6.7
TOTAL	15	100.0

Table 18: Supervisor's Sex

	NUMBER	PERCENTAGE
Male	9	60
Female	6	40
TOTAL	15	100

Table 19: Marital status

	NUMBER	PERCENTAGE
Married	12	80
Single	0	0.0
Separated	1	6.7
Divorced	1	6.7
Widowed	1	6.7
TOTAL	15	100.0

Table 20: Education status

	NUMBER	PERCENTAGE
Completed secondary school	6	40
Post-secondary and above	5	33.3
Completed elementary	3	20
Completed primary school	1	6.7
Some elementary school	0	0
TOTAL	15	100
Able to read and write	15	100
Able to speak local language	15	100

Table 21: Where supervisors live

	NUMBER	PERCENTAGE
In community	8	53.3
Outside	7	46.7
TOTAL	15	100.0

Table 22: Status of supervision

	NUMBER	PERCENTAGE
Full time	7	46.7
Part time	8	53.3
TOTAL	15	100.0

Table 23: Those Trained in Supervision

	NUMBER	PERCENTAGE
PPAG	9	60
Amasachina	2	13
CCG	1	6.6
IAE	1	6.6
31st DWM	2	13
TOTAL	15	100

Table 24: Time Since Training

	NUMBER	PERCENTAGE
Less than one year	1	6.6
One year ago	2	13.0
More than one year	12	80.0
TOTAL	15	100.0

Table 25: Duration at current position as supervisor

	NUMBER	PERCENTAGE
Less than 3 years	11	73.3
3 years	1	6.7
More than 3 years	3	20.0
TOTAL	15	100.0

Table 26: Use of FP methods

	NUMBER	PERCENTAGE
Ever used a FP method	100.0	0.0
Currently using a FP method	78.6	21.4

c) The major supervisory tasks and level of task performance

All supervisors were trained by PPAG and prepared to perform jobs and tasks identified in Table 27 (see also PPAG's supervision training manual).

A study of supervisors' jobs and tasks does not clearly show that supervisors have the responsibility of helping CBD agents perform tasks suggested in the standards and protocols. During the focus group discussion, the CBD agents indicated exactly what tasks their supervisors perform during the supervisory visit.

According discussions held mostly with the PPAG CBDs, supervisors inspect stock, check sales, check progress of work and help them answer difficult questions posed by clients:

"…When P.S. comes to me to work, she collects my returns, inspects my remaining stock, and adds some more contraceptives…"

"…In the way of A.C., her work was similar way… many a time, she would help me answer those difficult questions my clients posed…" [4]

It appears that supervision as conducted now is more administrative than technical.

33% to 60% of the supervisors indicated that they never perform the tasks described below (see Table 27):

- Keeping basic information on the catchment [???] area of operation up-to-date (60%)
- Keeping an activity chart quarterly on all CBD agents for effective supervision (53.3%)
- Organizing monthly CBD review meeting to discuss problems, successes, challenges and achievements (40%)
- Preparing monthly supervisory plan (40%)
- Working also as a CBD agent (33%)

80% to 93% of supervisors indicated that they always perform the following tasks (see Table 27):

- Visiting all CBD agents on monthly basis (93%)
- Collating area record/report for onward submission to the officer responsible at next level (93%)
- Ensuring that CBD agents get all their inputs quarterly (87%)
- Checking whether the record shows clients seen (87%)
- Submitting an area requisition for contraceptives and drugs to the officer responsible (80%)

[4] *See Focus Group report*

Table 27: Regularity of performance of supervisory tasks (total # of respondents = 15)

SUPERVISORY TASKS	I always complete the task	I complete the task sometimes	I never complete the task
1. Ensure that CBD agents get all their inputs quarterly.	(87%)	(13%)	0
2. Coordinate the activities of all CBD agents (10 - 15 providers)	(87%)	(13%)	0
3. Keep an activity chart quarterly on all CBD agents for effective supervision	(33.3%)	(13%)	(53.3%)
4. Visit all CBD agents on a monthly basis	(93%0	(7%0	0
Check whether record shows the following each visit:			
5. Date of reporting	(86%)	(7%)	(7%)
6. Statement of contraceptive received and issued	(80%)	(20%)	0
7. IEC activities performed	(80%)	(7%)	(13%)
8. Clients seen	(87%)	(13%)	0
9. Clients referred	(73%)	(27%)	0
10. Check whether records are in a notebook/file	(73.3%)	(13%)	(13.3%)
11. Organize monthly CBD review meeting to discuss problems, successes, challenges and achievements	(33%)	(27%)	(40%)
12. Collate area record / reports for onward submission to the officer responsible at the next level	(93%)	(7%)	0
13. Submit an area requisition of contraceptives, drugs, etc. to the officer responsible	(80%)	(20%)	0
14. Ensure that CBD agents get contraceptives in good time	(67%)	(33%)	0
15. Prepare monthly supervisory plan	(47%)	(13%)	(40%)
16. Keep up-to-date basic information on the catchment [???] area of operation	(27%)	(7%)	(66%)
17. Work also as a CBD agent.	(33%)	(33%)	(33%)

d) Supervisory Skills (see Table 28)

The assessment included supervisors' skills to perform the following:

- Three of the CBD agents' critical tasks, namely condom use demonstration, ORS preparation and use demonstration, and foaming tablet use demonstration.
- Five of supervisors' job tasks: supervision planning, calendar preparation, supervision implementation, supervision follow-up, supervision report.

Level of skills was relatively high for critical tasks performed by CBD agents, 84.4%, 80% and 74% respectively.

They performed poorly in supervisory skills with specific reference to supervision report documentation (44%) and supervision calendar preparation (33.3%). The levels of skills were 62.5% for supervision planning and 76.8% for supervision implementation and follow-up.

Table 28: Level of supervisors' skills: mean group percentage

SUPERVISORY SKILLS	
TASK	**GROUP PERCENTAGE**
Condom demonstration	84.2
Foaming tablet use demonstration	74.8
ORS preparation demonstration	80.4
Supervision planning	62.5
Supervision implementation	76.8
Supervision follow-up	76.8
Prep. complete supervision report	44.6
Prep. accurate supervision calendar	33.3

e) Supervisory knowledge (see Table 29)

Six areas were assessed:

- Family Planning rationale and advantages
- Contraceptive storage
- Counseling steps
- HIV / AIDS and STDs
- First Aid
- Rationale for supervision

Supervisors performed very well in First Aid (100%), AIDS / STDs (82.5%), and Family Planning rationale and advantages (82.5%). They showed poor performance in rationale for supervision (50%) and counseling (38.9%). The levels of knowledge were 55.6% for contraceptive storage.

Table 29: Supervisory level of knowledge

DOMAINS OF KNOWLEDGE	GROUP SCORE
First Aid	100.0%
FP rationale / advantages	82.5%
AIDS / STDs prevention	82.5%
Contraceptive storage	55.6%
Rationale for Supervision	50.0%
Counseling	39.0%

f) Feedback mechanism (organizational strategy for feedback)

The feedback mechanism (between CBDs and supervisors) exists within all organizations. The CBD agents receive feedback from supervisors essentially during meetings and supervision visits.

The assessment found that CBDs referred clients to the nearest referral point (clinic, health center, health post). However, feedback from health providers at referral points to either CBD agents or CBD agents' supervisors is very weak. Generally, health providers in referral points are not formally involved either in supervision of CBD agents or in their training.

g) Working conditions and factors contributing to work satisfaction / dissatisfaction

Information collected included availability of documents such as CBD jobs and tasks, supervision checklist, supervisory report sheets, and transport means for supervisory visits. In addition, certain satisfaction / dissatisfaction factors in work were assessed. Tables beneath show statistics on this section.

93.3% of the supervisors assessed had supervision report forms, 40% had CBD jobs and tasks lists and only 13.3% had supervision check-lists (see Table 30).

80% (12) of CBDs' supervisors had some means of transport to carry out supervision. 60% (9) of CBDs' supervisors assessed had motorcycles procured for supervision (see Table 30). The maintenance costs are provided by their respective organizations (PPAG, IAE and GSMF).

Table 30: Available resources to facilitate supervision

	No.	%
Have a means	12	80
Means available (motorcycle)	9	60
Copy of CBD / TBA jobs and tasks	6	40
Supervisors' checklist	2	13.3
Supervision report form	14	93.3

86.7% of supervisors assessed indicated that they were satisfied with the supervision visits they received (see Table 31). 40% received supervision visits once a month, 33.3% less than once a

month, 20% once a quarter and 6.7% once a year. They received the supervisory visit from the regional program coordinator, the national coordinator or the deputy director of the project.

Table 31: Supervisory visits

	No.	%
Once a month	6	40
Less than once a month	5	33.3
Once a quarter	3	20
Once a year	1	6.7
TOTAL	15	100

	YES (%)	NO (%)
Satisfaction with supervision visit	86.7	13.3

53.3% of supervisors assessed were satisfied with their work as supervisors. On the issues of job satisfaction, self-confidence in the job (85.7%), good training (85.7%) and good communication with CBD agents (71.4%) were major elements noted.

Table 32: Factors contributing to CBD supervisor job satisfaction / dissatisfaction

	YES (%)	NO (%)
Satisfaction in work	53.3	46.7

Table 33: Factors contributing to CBD supervisor satisfaction

	MENTIONED (%)
Self-confidence in job	85.7
Good training	85.7
Good working relationship	71.4
Good supervision	71.4
Good communication with CBD agents	71.4
Needed by the employer	57.1
Needed by the community	57.1
Good working conditions	57.1
Good reception from target group	33.3

46.7% were not satisfied with their work as supervisors. All of them cited poor working relationships (100%) as the main reason for their dissatisfaction.

Table 34: Factors contributing to CBD supervisor dissatisfaction

	MENTIONED (%)
Poor working relationship with their supervisors	100

h) Perception of supervision by CBD agents (Table 35)

- Frequency of supervision received

94% of CBDs declared that they were supervised. 42.2% of CBDs declared that they were supervised more than once in a month and 47.7% declared that they were supervised once a month. From focus group discussion we noted that most PPAG CBDs had efficient supervision, but others do not. For this latter group, they claimed that the last time they saw their supervisor was in June 1995. Many saw their supervisor every other week. From the discussions, it was apparent that some supervisors' support and other expenses incurred during their supervisory visits were not paid, and that was the main reason they dropped out of the program.

- Informed in advance

56.4% of CBDs had declared that they were informed in advance of the supervisory visit date, while only 43.6% declared that they were informed of the content of the visit.

- Feel comfortable with supervisors

96.1% of CBDs declared that they were comfortable with supervisors and 94.7% indicated that they were helped by supervisors during visits. 53.65 of them said supervisors help them with sales reports. During focus group discussions, CBDs claimed that since the supervisors helped them with their work (checking sales, helping them to answer difficult questions posed by clients, checking progress of work), everything should be done to give supervisors incentives to motivate them to do their work. They said their supervisors give them information from the regional headquarters as well as well as from other CBDs, which provided them with encouragement. The CBDs did not have problems communicating with their supervisors when the supervisors came to them.

Table 35: Frequency distribution of CBDs' perception of supervision received (by organization)

INDICATORS	IAE	MA	CCG	31st	Moslem	May Day	RMA	MOH	PAG	TOTAL	%
Receive supervision (n=84)											
Yes	10	5	9	5	5	4	4	6	31	79	94
No	0	0	1	0	0	1	2	0	1	5	6
TOTAL	10	5	10	5	5	5	6	6	32		
No. (n=78)											
> 1 a month	4	3	3	1	3	4	3	1	14	36	42.2
monthly	5	2	2	4	2	0	1	5	16	37	47.7
quarterly	1	0	3	0	0	0	0	0	0	4	5.1
yearly	0	0	1	0	0	0	0	0	0	1	1.3
Informed of date (n=78)											
Yes	6	0	5	2	2	2	4	1	22	44	56.4
No	5	5	6	4	4	1	2	3	14	44	56.4
Informed of content (n=78)											
Yes	5	0	3	1	1	3	2	2	17	34	43.6
No	5	5	6	4	4	1	2	3	14	44	56.4
Feel comfortable while communicating (n=77)											
Yes	10	5	8.1	5	4	3	4	5	30	74	96.1
No	0	0	0	0	0	1	0	0	1	3	3.9
Supervision help (n=75)											
Yes	10	5	5	5	4	3	4	5	30	74	96.1
No	0	0	4	0	0	0	0	0	0	4	5.3
Help in what (n=69)											
1. FP contra. distrib.	1	0	0	0	0	0	0	0	1	2	2.9
2. Report keeping	0	0	1	0	0	0	0	0	0	1	1.4
3. Commun. counsel.	1	0	0	0	1	0	0	0	1	3	4.3
4. Home visit	1	0	1	0	0	0	0	0	1	3	4.3
5. Stock management	0	1	0	0	0	0	0	0	3	4	5.8
6. Sales report	2	0	3	4	3	3	0	0	21	37	53.6
7. Safe motherhood	5	0	0	0	0	0	3	5	1	14	26.3
8. Logistics	0	2	0	0	0	1	1	0	1	5	7.2
TOTAL	10	3	5	5	4	4	4	5	29	69	
%	14.5	4.3	7.2	7.2	5.8	5.8	5.8	7.2	42.0		

3.2 Monitoring and Evaluation

Description of this section mainly reflects the levels of program at which monitoring and evaluation are conducted, some evaluation indicators, and retro-information.

Monitoring and evaluation of CBD programs are carried out at three levels: at the national level, by managers in charge or their collaborators, and at the regional district level by regional coordinators or supervisors.

Process assessment is conducted at region / district and community levels. These assessments are limited to data collection for indicators related to:

a) the quantity of contraceptives (quantity received, quantity distributed/sold)
b) income from product sales (amount of money collected per each type of product sold)
c) the use of contraceptives (new users, old users, number of referrals)
d) other FP activities (number of IEC sessions, home-visits)

At the community level, the CBD agents collect data on a notebook and use a referral form. At the end of each month or quarterly term, supervisors synthesize each CBD agent's data and all CBD agents' data on a sheet. The synthesis of data is then sent to the central level to be processed.

The different CBD programs have no standardized instruments indicators.

According to the nature of data and institutions, data received from the regions enable the calculation of certain indicators such as CYP, increase in the use of contraceptives, the number of distribution points, increase in the income from product sales. lack of clearly defined outputs quantitative objectives for CBD programs at community, district and regional levels does not allow performance evaluation and does not permit easy interpretation of data analysis results.

Data processed at the central level are often disseminated to institution key manager and donors. Retro-information on the results of data analysis is not systematically given to the CBD agents and community. It seems improbable that information (field data) are disseminated among institutions involved in CBD activities.

Table 36: Supervision, monitoring and evaluation

	RMA (current)	GSMF	IAE	MOH	PPAG
Profile of supervisors	Midwives	Part-time staff of NGOs CBD agents	Regional officers	Sub-district supervision team (trainers, midwives, sanitary officers)	Full-time paid supervisors Part-time volunteers CBD agents
Training (venue, duration, curriculum, trainers, training (content))	Midwifery training school	5 days at national level with PPAG / GSMF trainers using curriculum developed with PPAG	At national and regional level	n.i.	2 weeks training at national level using CBD supervisor curriculum developed in 1991
Total number trained	n.i.	65	13 (1 national coordinator, 3 regional coordinators, 4 district supervisors)	n.i.	38
Plans for the future	To be determined	To train more supervisors to achieve 1-10 ratio	To train more supervisors as CBD program expands	No funding for future training of supervisors	Training of part-time supervisors and refresher training of existing supervisors
Support for part-time supervisors	To be determined	To train more supervisors to achieve 1-10 ratio	To train more supervisors as CBD program expands	No funding for future training of supervisors	Training of part-time supervisors and refresher training of existing supervisors
Support for part-time supervisors	To be determined	Bags, bicycles/motorcycles, notebooks, transportation allowances	Bicycles, reimbursement of fuel expenses (proposed)	N/A	Bags, badges, bicycles, notebooks, first aid box, transportation allowances
Frequency of supervision	Quarterly, periodically	Fortnightly, monthly, quarterly, as and when	Monthly, quarterly	Monthly	Monthly
Availability of supervision protocols	Yes	None	None IAE plans to develop one	Yes (Practice for mastery guides)	No

Fee back mechanism	Yes	During supervisory visits, through monthly and quarterly reports, quarterly meetings	Through monthly report forms, during monthly district meetings, at quarterly regional meetings, during supervisory visits	Yes	No
Monitoring system	Yes	Yes	Yes	yes	Yes
Evaluation system	Yes	Yes	Yes	Yes	Yes
	GRMA (Current)	**GSMF**	**IAE**	**MOH**	**PPAG**
Strategy	clinic based and outreach	outreach	adult classes and outreach (mass media, community drama, personal communication)	clinic based and outreach	clinic based and outreach
Service delivery approach	Integrated MCH / FP	FP	FP, HIV / AIDS, STDs and WID integrated into adult literacy programs	Integrated MCH / FP	Integrated MCH / FP
Type of services	Safe motherhood, FP	Contraceptive distribution, first aid, treatment of minor illnesses	Non-prescription contraceptive distribution, PHC, first aid	MCH / FP	MCH / FP

4. Service Delivery and Referral System

The description of the service delivery and referral system is based on data collected through interviews at institutional and NGO headquarters levels and from the analysis of data collected in the field. This section provides background information on types of services offered by community workers, strategies and approaches to service delivery. In addition, the referral system is briefly presented with focus on organization, service availability at referral points, provider's level of FP knowledge and related skills, and working conditions at the referral points.

4.1 Types of services

The different categories of CBD have been assigned various tasks and are providing similar services depending on institutional policy and community needs to be addressed (see Table 37).

Overall, they are involved at various levels in providing services related to:

Counseling (and IEC)
Distribution of non-prescription contraceptives
Management of minor ailments (fever, convulsions, diarrhea, etc.)
Safe motherhood (management of labor and delivery, antenatal and postnatal care, etc.)
Referrals for other FP methods or problems beyond their scope

Some CBDs, especially in the Northern region, give initial supply of oral pills, condoms and foaming tablets.

4.2 Strategies and approaches to service delivery

All organizations involved in CBD program implementation are mainly using community-based services and strategies for outreach outside the community. In fact, most of the community workers, such as CBDs and facilitators, are based in the communities in which they offer services.

However, apart from the outreach activities performed by midwife assistants and TBAs, these categories also provide some clinic-based services like safe motherhood and treatment of some minor ailments (see Table 37).

Almost all CBD implementing organizations use an integrated approach to MCH / FP services and at a limited level include some reproductive health services. The IAE CBDs integrate FP / HID / AIDS / STDs and WID into adult literacy programs, while GSMF CBDs focus on family planning.

4.3 Referral system

a) Organization

The referral system in the CBD program consists of the use of referral cards an encouragement of clients to see services not available at CBD level. the results of data analysis show that referral is one of the tasks performed by all categories of CBDs and referral forms / cards are available (see chapter on CBD agents pg. 20-35). Usually, they refer to the nearest health facility. analysis of field data showed that referral points include health centers and posts, clinics, MCH centers, maternity homes and hospitals (see Table 38 on types of health facilities which CBDs refer clients to).

Table 38: Type of health facility visited as referral point

	No.	(%)
Health center	4	22.2
Health post	4	22.2
Clinic	4	22.2
MCH center	3	16.7
Maternity home	2	11.1
Hospital	1	5.6
TOTAL	18	100.0

In most cases, clients seeking other methods like IUDs, injectables, sterilization and Norplant are referred. Usually, no feedback from the referral point to CBDs is given. It is relevant to not that TBAs may also refer for conditions related to safe motherhood.

As observed previously (see CBD working conditions, page 29), a checklist is not available and not used by CBDs to screen women who should be referred for pill use conditions. Nevertheless, at the referral point, most service providers rely on client checklist history for pill supply.

b) FP service availability at referral point

The variables for service availability described in the following include contraceptive availability and availability of providers trained in FP. (Other variables are described in the working conditions paragraphs - see pg. 29). The frequency distributions of contraceptives available at referral points assessed during the study are presented in Table 39.

Table 39: Frequency distribution of contraceptive availability at referral points

	ACTUALLY AVAILABLE (%) n=18
Combined oral contraceptives (COCs)	89.5
Injectables	89.5
Condoms	89.5
IUDs	78.9
Foaming tablets	78.9
Progestative oral contraceptives (POCs)	73.7
Norplant®	11.1
Diaphragm	10.5

Most of the referral points provide COCs, POCs, injectables, barriers and IUDs. Norplant® seems to be the least available, as it has not been well-promoted yet. Vasectomy is mentioned by assessed health providers at clinics and hospitals.

The lack of service availability was mentioned as one of the factors that could negatively influence CBD performances. Nevertheless, the results from the analysis of working conditions at referral points show that only 20% of assessed health providers claimed some shortage as a supply problem. It is noted that 94.7% of health facilities are regularly supplied.

The 18 health facilities visited had a total number of 36 providers trained in FP. Among them, 30 (83%0 were providing services. The mean number of health providers trained in FP and providing services was equal to 2 per referral point (see Table 40).

Table 40: Frequency of health providers available at visited referral points and involved in providing services to referred clients

	AVAILABLE			INVOLVED		
CATEGORY	TOTAL#	TRAINED IN FP	% TRAINED	TOTAL #	TRAINED IN FP	% TRAINED
Public Health Nurse	10	10	100	9	9	100
Midwife	10	10	100	8	8	100
Community Health Nurse Midwife	10	7	70	8	5	75
Community Health Nurse	11	7	63.6	8	5	62.5
Medical Assistant	8	2	25	5	2	40
TOTAL	49	36		38	30	

c) Health service providers' level of knowledge and skills

Twenty-three health providers were observed performing FP tasks and completed a knowledge questionnaire.

* Knowledge

Areas of knowledge assessed were anatomy and physiology, contraceptive methods (pill, IUD, condom, injectable, spermicide and Norplant®) and eligibility for contraceptive methods. Overall, their knowledge level was weak (44.3% group mean score). The higher level was observed for IUD (53%) and condom (67.4%), while Norplant seemed to be unknown (see Table 41).

Table 41: Knowledge performance assessment of health providers at referral point (group mean %0 per content (n=23)

Anatomy/Physiology	38%
Method Counseling	
Eligibility Criteria	39.1%
IUD	53%
Pills	49%
Injectables	49%
Norplant®	0%
Spermicides	43.5%
Condom	67.4%

*Skills

The skills were assessed using an observation checklist that covered the following tasks related to referred conditions.

- Initial interview for IUD-referred client, method counseling, client assessment, pre-insertion counseling, insertion, post-insertion counseling, pre-removal counseling removal and post-removal tasks and counseling
- Management of referred pill conditions
- Initial supply for injectable and follow-up

Table 42: FP-related skills assessment of health providers at referral points and per selected tasks (individual and group mean %)

TASK	%
Initial interview (n=20)	72.5
Method counseling (n=20)	78.0
Client Assessment (n=18)	69.2
Pre-Insertion Counseling (n=18)	87.8
Insertion (T 380 A) (n=18)	79.1
Post-Insertion Counseling (n=18)	75.9
Counseling Removal (n=18)	84.4
Removal (n=19)	85.5
Post-Removal Tasks (n=19)	81.1
Post-Removal Counseling (n=19)	53.5
Referred Pill Conditions MGT (n=19)	76.2
Injectable (n=20 and 19)	78.9
Injectable Follow-up and Supply Visit (n=18)	84.0

The overall performance of service providers in these areas was encouraging (see Table 43). However, it is found that almost half (46.5%) do not offer post-IUD removal counseling.

Concerning injectables, some provides do not perform pelvic exams and do not provide enough information on what to do if the client is late for the next injection and on weight gain. More than 20% of providers massage the injection point.

In general, performance skills are very high because providers have been practicing the same skills continuously. The knowledge level, however, is low, due to the fact that most service providers have not attended any refresher courses to update their knowledge after their initial training.

d) Working conditions at referral points

The variables assessed to describe the working conditions at referral points include the availability of IEC materials and contraceptives, the supply frequency, the existence of a recording system and supervision.

The IEC materials commonly available at most of the points visited include posters, contraceptive samples, FP leaflets and pamphlets (see Table 43). some of the points also have pelvic models, brochures, artificial penises, flipcharts and videotapes.

Table 43: Types of IEC materials at referral points

	YES (%)	NO (%)
Posters	94.7	5.3
Contraceptive samples	68.4	31.6
FP leaflets	52.6	47.4
Pamphlets	52.6	47.4
Pelvic models	42.1	57.9
Brochures	26.3	73.7
Artificial penises	21.1	78.9
Flipchart	15.8	84.2
Videotapes	5.3	94.7

The IEC materials which need to be posted have been displayed at vantage areas (client waiting room, 83.3%; counseling areas, 77.8%; and examination area, 55.6%) to enhance information dissemination and clients' acceptance and continuation of FP method use.

Table 44: Where they are posted

	YES (%)	NO (%)
Client waiting room	83.3	16.7
Counseling area	77.8	22.2
Examination area	55.6	44.4
Curative consulting room	5.6	94.4

The content of IEC material is generally oriented to FP benefits 977.8%), STD/AIDS prevention (77.8%), FP methods available (61.1%). In several health facilities, the content also includes ORS preparation, immunization, malaria and teenage pregnancy.

Table 45: What is the content

	YES (%)	NO (%)
FP benefits	77.8	22.2
STD/AIDS	77.8	22.2
Avail. methods	61.1	38.9
ORS	38.9	61.1

Envir. hygiene	33.3	66.7
Immunization	22.2	77.8
Malaria	16.7	83.3
Teenage pregnancy	11.1	88.9
Reproductive system	5.6	94.4
Breastfeeding	5.6	94.4
Prevention of guinea worm	5.6	94.4
Infection control	5.6	94.4
Neonatal	5.6	94.4

The supplies and commodities are quite regular and various contraceptive methods are available and stored according to minimum standards at referral points. some problems were: the cost of commodities, some shortages and insufficient supply in several facilities.

All types of forms and books are available for record keeping: client checklists, family planning registers, stock forms. However, some forms such as referral forms, report forms, and daily logs, are the least available. Meanwhile, documents on policy, standards and protocols for RH/FP service delivery are not available at all the referral points visited.

Table 46: Types of recording forms available at referral points

	YES %
FP registers	100
FP client checklists	89.5
Stock report forms	68.4
Supply cards	57.9
Referral forms	36.8
Monthly/annual reports	10.5
Identification cards	15.8
Daily logs	5.3

As discussed in the service availability section, the providers are of different categories and have been trained. they are also supervised regularly, at most on a quarterly basis. Supervisors include the district supervisor, the clinic manager, and the regional manager. GRMA regional representatives are involved in supervision of private clinics owned by midwives.

5. Supply and Pricing

5.1 Contraceptive Distribution

The three major organizations directly involved in contraceptive procurement and distribution in Ghana are the Ministry of Health, PPAG and GSMF. All three organizations receive donated products from several sources. Contraceptives are deposited in a central location before distribution to target groups using commercial or institutional channels. All other organizations obtain their contraceptive supplies from any or all of these three organizations, depending on the type of product needed by target groups, the price and commission level of product and the ability of target groups to pay.

Table 47: Contraceptive Supply

	GRMA (current)	GSMF	IAE	MOH	PPAG
Source of supply	Johnson Wax	USAID	GSMF, MOH	n.i. [5]	IPPF, UNFPA
Type of products supplied	Condoms, VFTs, pills	Condoms, VFTs, injectables	Condoms, VFTs	Pills, Norplant, VFTs, condoms, Depo-Provera, IUD	Pills, IUD, injectables, diaphragm, condoms, foam/jelly/crea m
Supply mechanism	Bought by the Secretariat and distributed to regional representativ es for sale to individual midwives	USAID to GSMF, GSMF to key distributors, distributors to wholesalers in the region, wholesalers to retailers (including the NGOs)	Regional coordinators purchase from MOH or GSMF wholesalers, in the regions, coordinator to district supervisors, supervisors to CBDs	MOH to supervisors and sub-districts, supervisors to TBAs	Headquarters to regions, regions to supervisors, supervisors to CBDs

Distribution mechanisms, therefore, vary from organization to organization.

- In the case of the MOH, products move from a central medical store located in Tema to regional depots, then to district and sub-district levels before they are

[5] *n.i. = no information*

- distributed to clients by TBAs.
- PPAG regional offices receive allocations from their headquarters, which they further distribute to program officers or supervisors. Supervisors supply CBDs for distribution to clients.
- GSMF centrally stores and packages all contraceptives from GIHOC warehouse in Accra. Key national distributors (Johnson Wax, DANAFCO, Starwin) lift products to the regional wholesalers, for onward distribution to NGOs and other commercial outlets.
- Local NGOs and organization such as the Institute of Adult Education that are supported by GSMF get their contraceptives through GSMF national key distributors or the MOH regional medical stores. Regional offices receive the products from their headquarters, which they further distribute to the district supervisors. The supervisors provide products to the CBDs for distribution to clients.

Contraceptive products distributed vary depending on type of service providers being used.

Whereas GSMF CBDs distribute mainly non-clinical contraceptives such as condoms, vaginal foaming tablets (VFTs) and pills for resupply, GRMA midwives insert IUDs and some give injectables. A large range of contraceptives is currently distributed by CBDs and clinic-based health providers including pills, condoms, foaming tablets/foam/jelly/cream, injectables and IUDs. Implants and diaphragms are also available in some clinics.

Furthermore, clients theoretically have the choice between a large variety of branded or unbranded products. There are 3 different condoms, 5 different vaginal foaming tablets/foam/jelly/cream, 9 different pills, 3 different injectables. In the field, contraceptives distributed by CBDs are, however, limited to condoms and foaming tablets and pills in some cases, while other methods are available at referral points. In addition, only one to two brands of each contraceptive are generally available, depending on the source of supply.

5.2 Pricing

Pricing policy also differs from organization to organization. As shown in Table 47 below, GSMF products are generally the highest priced. MOH and PPAG have comparable prices for their different products.

Among similar products, prices vary depending on the organization and the type of product. For example, prices of condoms range from ϕ75 per unit for GSMF PROTECTOR condoms to ϕ15 per unit for MOH unbranded condoms. Regarding the foaming tablets, the price ranges from ϕ30 per tablet for GSMF KAMAL tablets to ϕ25 for PPAG or MOH tablets. For injectables, the price ranges from ϕ900 for GSM FAMPLAN injectables to ϕ120 for DEPO PROVERA provided by the MOH.

Nevertheless, PPAG and MOH contraceptives are provided free if the client cannot afford them.

Table 48: Price list of products supplied by type and brand

	GSMF	PPAG	MOH
BARRIER METHODS: CONDOMS			
Protector	(215) 6 300 7		
Panther	(28) 40		
Unbranded Condom		20/unit	15/unit
BARRIER METHODS: DIAPHRAGM			
Diaphragm		1,000	
SPERMICIDES: VAGINAL FOAMING TABLETS/CREAM/FOAM			
Kamal (pack of 10)	(200) 300		
Neo Sampoon (tube of 20)		250	25/tablet
Conceptrol			25/tablet
Koromex (tube)		300	
Delphen (tube)		300	
ORAL CONTRACEPTIVES			
Secure (pack of 2 cycles)	(220) 300		
Neogynon, Nordette, Exluton, Eugynon		50/cycle	
Lofemenal			80/cycle
Ovrette		50/cycle	80/cycle
Micro-Gynon			80/cycle
Micro-N			80/cycle
LONG-ACTING METHODS: INTRAUTERINE DEVICE (IUD)			
Copper T 380 A		250	200
LONG-ACTING METHODS: INJECTABLE			
Famplan Noristerat Depo-Provera	(62) 900	 200 200	 120
LONG-ACTING METHODS: IMPLANT			
Norplant		5,000	2,000

Project managers interviewed during the assessment stated that due to GSMF mass media campaigns for the promotion of contraceptive brands, GSMF products are better known. However, PPAG and MOH products are preferred by most clients due to their lower prices.

retail price in Cedis

[7] GSMF recommended price

6. Sustainability

One key issue in CBD programs is their long-term sustainability. Even if sustainability does not necessarily mean self-sufficiency, sustainability mechanisms are important so that the program can continue to function with increased internal resources and with resources from the community it serves [8]. This section describes how the organizations implementing CBD activities are addressing sustainability issues in their programs and to what extent the community is involved in the programs.

6.1 Financial responsibility

Program managers reported that some financial sustainability plans are included in their CBD program. They vary according to the organizational characteristics. While GSMF, IAE and the MOH intend to integrate CBD activities into other existing programs, GRMA and PPAG plan to develop sustainability schemes within their CBD programs, including cost recovery and fund raising.

Table 49: Sustainability mechanisms

GRMA (proposed)	GSMF	IAE	MOH	PPAG
• Cost recovery system • Revolving supply system	• Integration into NGO mainstream funding • Integration into district and community financing sources • Introduction of income generation activities for CBDs • Cultivation of other donor agencies	• Integration into each community project • Community initiative before project is undertaken • Integration of income generation onto programs	• Integration into the MCH/FP program	• Cost recovery through sales and services • Fund raising • Commission to CBDs • Free use of facilities belonging to other services

With the exception of cost recovery mechanisms, plans for sustainability are not formally described in the programs. In addition, most strategies to sustain the programs described in the Table above have not yet been implemented.

[8] *Community-based distribution of contraceptives - A guide for program managers. World Health Organization, 1995.*

Apart from the support received from external sources, revenues for the CBD programs are coming from contraceptive sales and service provisions. The exception is the MOH, which has already integrated its TBA program under the MCH/FP national program. As a result, the TBA program benefits from the resources made available for the overall MCH/FP program.

The most innovative approach proposed by the organizations is the integration of income-generating mechanisms for the CBDs. As motivation of the CBDs is a key issue in the programs, PPAG, GSMF and IAE plan to assist the CBDs in initiating income generation activities (trade, farming) which better compensate and motivate them. Such activities would, however, take away from their time for CBD activities.

6.2 Community involvement

Review of the CBD programs showed that community involvement is generally limited and varies according to organizational characteristics, strategy for selection of the CBDs and the type of provider:

In the case of GSMF, opinion leaders in communities where CBDs operate are involved to some extent at all stages of the program through the local NGOs (initiation and development of the program, selection of CBDs and monitoring).

In the case of PPAG and the MOH, communities participate directly in the selection of the providers and are involved in the monitoring of CBD activities in the field.

In the case of GRMA and IAE, programs are initiated and developed by the organizations. CBDs/MWAs are identified by the organization or individual providers based on their capacity to perform proposed jobs and tasks.

Table 50: Community involvement

	GRMA (proposed)	GSMF	IAE	MOH	PPA
In initiation of the program	No	NGO and GSMF	No	No	No
In development of program	No	NGO in consultation with community opinion leaders	No	No	No
In identification of selection criteria	No	NGO and GSMF in consultation with community opinion leaders	No	Yes	Yes

In selection of CBD agents	No	NGO in consultation with community opinion leaders and GSMF (for vetting)	Yes	Yes	Yes
In monitoring of providers	No	Direct	Yes	Yes	Yes
In compensation/ motivation of CBD agents	No	No	No	Yes	No

With the exception of the TBA program, communities generally do not provide any compensation for CBDs. TBAs interviewed during the assessment reported that the community is not always willing to compensate or to pay for the services they are provided. At best, the CBDs receive recognition and respect, especially from their community leaders, and appreciation from their clients.

Community perception of their own involvement in CBD programs and sustainability issues were also assessed. The focus group discussions conducted in Eastern Region [9] showed that opinion leaders and clients are well-informed about the CBDs' problems in the field and what they need to provide better services to the community. They suggested that CBDs should be provided with regular refresher courses, training in first aid, IEC materials, materials like T-shirts or uniforms, bicycles, torchlights, Wellington boots and raincoats.

Regarding the sustainability of the program, motivation was identified as the key issue. They called for the provision of incentive and motivation schemes, billboards and TV advertisements and a competitive pricing mechanism. However, opinions were divided regarding who should pay the CBDs. While some felt CBDs should be put on the State's payroll, others felt the community should pay or initiate some compensation mechanisms.

Concerns expressed by the community reflect CBDs' perception regarding their own working conditions. to date, CBDs from GSMF, IAE and PPAG are authorized to retain a commission ranging from 30% to 50% on the contraceptive sale price, depending on the organization and the type of product. However, due to the low level of demand, the level of compensation for CBDs remains very low. As a result, some CBDs are discouraged and drop out.

[9] *See Focus Group Discussion Report on CBDs, Opinion Leaders and Clients in APPENDIX*

VI. Findings

A. Findings on CBD Agents

1. The CBD agents are identified within the community in which they offer services. The MWAs are selected by the clinic owners. their profile and selection mode vary among organizations. Communities are sometimes involved in the selection process (i.e. identification, approval, presentation to the community).

2. Selection criteria are various and include ability to read and write, credibility in the community, communication capability, marital status, age, residential status, involvement in community development activities and employment.

3. Actual person characteristics show they are males and females, are or have been married and most have children. They have a mean age of 37.8 years for males and 39.5 for females and are experienced in FP use. Almost all of them have attended school and are literate. Since they live within their communities, they speak the local language and have been trained for the tasks to be performed.

4. Their jobs and tasks include IEC activities (home visits, community lectures, videotape showings, group discussion and counseling), distribution (and sale) of non-prescription contraceptives and pills and safe motherhood activities (labor management and delivery, ante- and post-natal services), referral, record-keeping and reporting.

5. The CBD agents are deployed throughout the country. Sometimes they are employed by more than one organization (PPAG and GSMF).

6. Apart from the MWAs, who receive wages, and TBAs, who are compensated by the community, all CBDs work on a volunteer basis, compensated only through 30% to 50% commission on contraceptive sales. The community is not involved in the motivation of most of the CBD agents. Some support materials and basic equipment are motivational and include bikes, IEC bags and materials, and notebooks. Generally, the CBD agents are reimbursed for their transportation costs. Most CBDs and the community view the level of compensation and motivation as insufficient.

7. The CBD agents have basic knowledge in FP and First Aid. TBAs and MW assistants knowledge levels seem to be low. Similarly, MWAs and TBAs do not perform well in the RH related tasks. Weaknesses in skills are observed in counseling and management of fever and convulsions.

8. CBD working conditions are inadequate to allow them to provide quality services. Insufficient quantities of IEC materials do not facilitate IEC and

counseling activities. The checklist for screening pill clients is not used. The technical input of the supervisor is weak. In addition, although most CBDs have some informal collaboration with other community health workers (i.e. nurses), in a few cases, there is rivalry that may negatively affect CBD work.

9. Even though the community has not been assigned the task of following up CBD activities, the community is aware of CBD activities. Clients and opinion leaders are quite satisfied with the CBD services, but suggest more support, motivation and compensation that may improve the CBS agents' work. In addition, clients expect more from the CBD agent (treatment of common diseases, drug distribution for malaria, snake bite, etc.

B. Findings on Training

1. There are institutions in the country which have had positive experiences in CBD training.

   a) PPAG provides technical assistance trainers and training materials to other institutions for the training of CBD agents and their supervisors.

   b) MOH has experience in planning, implementation and evaluation of safe motherhood training for providers with very low levels of education (TBAs).

   c) IAE received technical assistance from JHU/CCP for needs assessment and the development of training materials for CBD agents (facilitators).

2. Reference documents are available in the country for the training of providers involved in CBD programs implementation: for example, RH/FP service Policy and Standards not yet disseminated, CBD agents' training curricula, manuals for the training of TBAs.

3. The training of CBD agents and TBAs is conducted in the locality or districts where they live.

4. The training manual in supervision currently used by PPAG does not reflect sufficiently rich content on technical supervision (based on the quality standards of the task to be executed or services to be offered by CBD agents).

5. Job descriptions exist for CBD agents and are specific according to organizations (PPAG, IAE).

6. In addition to CBDs, the other important target groups actively involved in the implementation of CBD programs are: managers, supervisors, TBAs, and FP/MCH service providers at referral points. MWAs are also potential agents for the execution of CBD activities.

C. Findings on Supervision

1. Supervisors are generally trainers, midwives, social agents, regional project coordinators, or CBD agents. They work full-time or part-time as salaried employees or volunteers. They are based at the regional or district level.

2. Supervisors have not been updated since their basic training in supervision. (75% of supervisors interviewed were trained more than one year ago.)

3. Supervisors who were interviewed obtained high scores in the execution of certain tasks, such as demonstration of the use of condoms and ORS preparation. Their level of knowledge is relatively high in first aid, AIDS, and advantages of FP. But scores are weak in supervision, calendar preparation, and supervision reporting.

4. Supervisors help CBD agents mainly in contraceptives procurement and the keeping of contraceptive sales/distribution books. They provide little technical assistance to CBD agents for quality service delivery.

5. There exists a feedback mechanism between CBD agents and their supervisors. Feedback is essentially conducted during meetings and supervision visits. However, this mechanism does not involve the personnel of service delivery clinical system (e.g. the personnel of referral centers).

6. There are no supervision protocols for CBD agents. Standards and documentation existing in the country can serve as reference for the elaboration of supervision protocols.

7. Certain supervisors (a minority) have no means of transportation for their supervisory visits.

8. Generally, CBD agents have a positive perception of the supervisory visits they received with regard to frequency and assistance received from supervisors are concerned.

D. Findings on monitoring and evaluation

1. All organizations have indicators for monitoring CBD programs (for example, the quantity of contraceptives sold or distributed, the number of referred cases). The number and quality of these indicators sometimes differs according to the organization. It seems improbable that these indicators have the same meaning for all organizations/institutions.

2. There are data collection documents which reflect process indicators (e.g. notebooks for CBD agents, monthly/quarterly activity report sheets, referral cards). The content of these supports differs according to the organization.

3. The activity reports from CBD agents are manually compiled at the regional level and then transmitted to the central level where data are processed. Feedback is not systematic at all levels.

4. The lack of quantitative objectives for CBD programs at community, district, and regional levels makes it difficult to interpret data collected in the field.

E. Findings on service delivery and referral system

1. Type of services differ according to institutions. GRMA<MOH and PPAG provide integrated MCH/FP and First Aid services. GRMA also focuses on safe motherhood. GSMF and IAE offer non-clinic based FP and First Aid services. In general, most CBDs carry and administer First Aid drugs in addition to non-clinical contraceptives. This is an added attraction for clients.

2. All CBD service strategies are community-based and outreach-based. The MOH, PPAG and GRMA have clinic-based service delivery systems combined with outreach activities. GSMF and IAE do not provide clinic-based health services. FP services are offered at the grassroots level by CBDs and clients are referred to the closest public or private clinic.

3. While GSMF relies on mass media advertising and promotions to create brand awareness and generates demand through its commercial outlets and through the CBD program, IAE has a captive audience in literacy learners, and has trained their facilitators to serve as CBDs to provide integrated education and services.

4. Even though some CBDs use referral Cards and/or encouraging words to convince clients to seek services at the referral point, the checklist is not used to screen clients. In addition, feedback to the referring CBD agents is very weak.

5. The global level of FP knowledge of the health providers at referral points is weak. It seems that some methods are better-known (like IUDs) than others (Norplant®). The overall level of FP-related skills is encouraging but some critical tasks and procedures are not performed by health providers according to standards and protocols.

6. In general, health providers at referral points have the minimum working conditions required to provide services. However, IEC materials and equipment for IUD insertion and removal are insufficient. Reference documents such as Standards and Protocols were unavailable in any point visited. Some health providers are offering services without having attended any basic FP training.

F. Findings on supply and pricing

1. Three organizations receive donated products from several sources for supply to the public and non-profit sectors: the Ministry of Health, PPAG and GSMF.

2. Each organization has its own distribution channel. All other organizations obtain their contraceptives from any or all three organizations.

3. A large range and variety of contraceptives are available. However, access to the different products depends on the organization which supplies the CBDs.

4. Contraceptive products distributed vary, depending on the type of service provider being used.

5. GSMF products are generally the highest priced. MOH and PPAG have comparable prices for their different products.

6. Differences in prices among similar products depend on the organization and the type of product.

7. PPAG and MOH contraceptives are provided free of charge if the client cannot afford them.

8. PPAG and MOH products are preferred by most clients due to their lower prices.

G. Findings on sustainability

1. Some non-formal plans for sustainability are included in CBD programs. Most of the strategies to sustain the CBD programs have not yet been implemented.

2. Apart from the support received from external sources, revenues for the CBD programs come from contraceptive sales and service provision only.

3. The most innovative approach provided by the organizations is the integration of income-generation mechanisms for the CBDs.

4. Community involvement in program functions is generally limited and varies according to organizational characteristics, strategy for selection of CBDs and type of provider.

5. Opinion leaders and clients are well-informed about the CBDs' problems in the field and what they need to provide better service to the community.

6. With the exception of the TBA program, communities do not generally provide any compensation for the CBDs.

7. While some opinion leaders and clients feel that CBDs should be put on the State's payroll, others feel the community should pay or initiate some compensation mechanisms.

8. The community is not always willing to compensate or to pay for the services the CBDs provide. At best, the CBDs receive recognition and respect, especially from their community leaders, and appreciation from their clients.

VII. Recommendations

A. Recommendations on CBD agents

1. The CBD profile should be defined according to the tasks to be performed. The community should be prepared and involved in the entire selection process to ensure its support and even its contribution to achieving CBD objectives.

2. Selection criteria should be defined with regard to the current personal characteristics of operational CBDs. Those criteria should take into account the needs of different client groups. Providers should be mature, with some literacy, and supported by the community opinion leaders and the public. Acceptors of FP and individuals with enthusiasm and energy for FP work are important. Both males and females should be recruited. However, guidelines for selection should remain general, and flexible enough to take special target audiences into account (e.g. adolescents).

3. Minimum tasks should be defined with regard to the target group priority needs. they should include:

   - IEC and counseling on RH/FP (including postpartum and newborn care)
   - Contraceptive distribution (pill supply and resupply, condoms and foaming tablets)
   - First aid and treatment of minor ailments
   - Referral for FP methods or other conditions
   - Record-keeping and reporting
   - Follow-up of users
   - Recruitment of new users

4. CBD deployment should take into account the priority needs of underserved or hard-to-reach communities in remote rural (or even urban) areas. The distribution of CBD agents should be done under some defined coordination mechanism at different levels of program implementation to avoid duplication of efforts and ensure program efficiency. In addition, deployment of CBD agents should be based on program objectives and performance indicators as well as expected results.

   In conclusion, expansion within a geographical area should be based on the need for services. Some factors should be taken into account to determine these needs: population density, fertility, access to health facility, socio-economic status of population.

5. Motivation should be improved and based, not only on compensation, but also on either material or non-material incentives and reward, and through factors such as:

Supportive resources and basic environment
Improvement in technical supervision
Training and refresher activities
Minimum working conditions (visual aids, job aids, contraceptives)
Community support (follow-up, recognition of services, material or financial contribution, respect, income-generating activities)
Special incentives, such as free-of-charge care, official invitations

6. Minimum working conditions should be provided to the CBD agents. These include IEC materials, regular supply of contraceptives, checklists and other necessary forms.

   the IEC material should be simple, clear and acceptable to the community, and produced and developed based on needs and requirements of the community. They should be available for interpersonal communication with individuals and small groups, and for distribution, More general materials should be available for public gatherings (posters, etc.)

7. The community should be involved in the follow-up of CBD activities and in promoting CBD activities and in coordinating all community health workers' activities.

   Mechanisms for collaboration among CBD agents and other health community workers should be defined to ensure collaboration rather than rivalry.

B. Recommendations for CBD agent training

1. For an effective use of positive experiences and existing local resources in CBD agent training, it is necessary to define standards as well as program planning and coordination mechanisms among organizations for the training activities.

2. CBD agents' job descriptions should be standardized and account for real needs (demand for services) and expectations of the Ministry of Health as expressed in the national reproductive health service policy and standards. The CBD training curricula and materials should correspond to the national policy and standards and the job description of CBD agents.

3. The CBD agents' knowledge and skills should be improved through training and refresher training, particularly in FP method characteristics, counseling, pill supply and resupply, foaming tablet demonstration, fever and convulsion management.

   For TBAs and MW Assistants, RH/FP basic and performance-based training should be organized with regard to the specific tasks to be performed. Supervisors and health providers at respective referral points should be involved

in the organization of some continuous practical training for CBDs, TBAs and MW Assistants at the local level with the support of the regional and national levels.

4. Training of CBD agents in their locality or at district level should be encouraged. This could help to accomplish practical objectives and reduce training costs.

5. Managers, FP/MCH service providers at referral points, TBAs, and MWA supervisors should be trained in the context of CBD activities.

6. The country's capacity and competence in planning, conducting, evaluating and following up CBD training should be assessed.

C. Recommendations on supervision

1. Supervisor's job description should be harmonized and supervision protocols should be developed and disseminated. These protocols would, for example, include supervision instruments (tasks, working conditions, results), analysis sheets, etc.

   The supervisor's profile should be defined in reference to the supervisory tasks to be carried out and mainly the technical assistance to be provided to CBDs for quality service delivery. So, a supervisor whose profile it is to be a trainer, a midwife, a social assistant… is very challenging.

2. Supervision protocols should be developed in reference to local standards. the use of supervision protocols should be included in the objectives of supervision training or retraining.

3. Develop a retraining program in supervision for CBD agents' supervisors. This program would aim at reinforcing technical supervision skills (based on the quality of tasks executed and services delivered by CBD agents).

4. The training curriculum in supervision of CBD agents should be adapted from the PPAG manual on supervision training. The adapted curriculum should emphasize quality of services.

   Update CBD agents' supervisors using the elaborated program. Retraining sessions should be organized after supervision protocols are developed.

5. The weak feedback from referral point should be addressed through an integrated advocacy program with MOH (for example, involve supervision teams from MOH at the level of districts/sub-districts and service providers from referral centers in the supervision and training of CBD agents).

6. Minimum working conditions (means) for effective supervisory activities should be defined in reference to supervisory jobs and tasks. Each supervisor should be provided with these means so as to be able to execute his tasks effectively.

7. The current regularity of supervision visits is encouraging and should be maintained. The potential for on-the-job training, re-training and CBD support during supervision visits should be exploited.

8. CBD agents' supervisors should also be supervised by managers at the regional or central level and ways to improve working relationships identified and implemented.

D. Recommendations for monitoring and evaluation

1. Develop a national management information system. This system would be developed according to CBD programs objectives and defined for each level of information management. Responsibilities in information management should also be clearly defined.

2. Identify a service in the present national structures which will centralize, analyze and disseminate information collected in the field.

3. Systematically conduct basic studies (before starting the programs) in order to have reliable data for defining objectives and evaluate CBD programs at all levels of service delivery.

4. Reinforce data collection and processing systems in order to make them more effective and efficient at all operational levels. Feedback mechanisms should be defined at all levels for effective planning.

E. Recommendations for service delivery and referral system

1. Selection of the types of services provided to the community by CBD workers and the strategies and approaches for service delivery should be based on the target group priority needs and the organization's policy and objectives. Efficiency in terms of easy supervision, supply and management should be taken into account when considering possible strategies and approaches.

2. Mechanisms for feedback should be clearly defined between the CBD and the referral point. The use of checklists and referral forms should be standardized. The checklist should undergo regular review to ensure its appropriateness.

3. In-service training should be organized for service providers to update and strengthen their knowledge and skills in the areas where performance is low. training should focus on competencies needed to address referred conditions.

Local health facilities should be involved in identifying needs to be met in CBD supervision, follow up and training, since they are receiving referred cases.

4. Services provided at referral points require related IEC material and technical equipment. All of these should be provided in sufficient quantities to ensure satisfaction of (referred) clients and credibility of CBD work. Reference materials, including standards and protocols, should be made available throughout the country to be used in the training of health providers and for quality service delivery.

F. Recommendations for supply and pricing

1. As much as possible, organizations receiving donated products should ensure continuity in the types and brands of contraceptives distributed.

2. The Ministry of Health should monitor and coordinate the introduction of the new brands of contraceptives in the country to avoid uncontrolled proliferation of brands in the field.

3. Organizations should harmonize their pricing policies to limit/reduce differences in price for similar products as much as possible, in order to allow clients to make a choice based on their preference, rather than on financial considerations.

G. Recommendations for sustainability

1. Organizations involved in CBD activities should develop formal sustainability plans as part of their programs. Plans should include both financial sustainability, such as cost reduction and income generation mechanisms, and technical sustainability.

2. Forms of community support other than funding should be explored, including labor, materials, in-kind contributions and services.

3. Innovative incentives for CBDs, other than commissions, should be tested in order to improve CBDs' level of motivation. Communities and CBDs should be involved in the identification of these incentives.

4. Communities should be involved at early stages of program planning and implementation as a way to better determine community needs and to gain the community's support. For example, key individuals, women's groups and traditional leaders are possible channels to reach the community.

5. Strengthening of technical skills through CBD and supervisor training, follow-up and support; improved linkages between CBDs/communities and referral points; and improved evaluation, monitoring and dissemination systems, as discussed in

previous recommendations, should be pursued to promote the technical sustainability of the CBD program and the quality of services provided to clients.

APPENDICES

APPENDIX 1

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ACNM	American College of Nurse Midwives
AMA	Amasachina
ANC	Ante Natal Care
AVSC	Association for Voluntary Surgical Contraception
CBD	Community Based Distribution
CCG	Christian Council of Ghana
CIDA	Canadian International Development Association
COC	Combined Oral Contraceptives
CODE	Canadian Organization for Development and Education
CYP	Community Year of Protection
DDHS	District Director of Health Services
DWM	December Women's Movement
FP	Family Planning
GRMA	Ghana Registered Midwives Association
GSMF	Ghana Social Marketing Foundation
GTZ	German Agency for Technical Cooperation
HIV	Human Immunodeficiency Virus
IAE	Institute of Adult Education
ICPD	International Conference on Population and Development
ID	Identification
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
IUD	Intra Uterine Device
JHU/CCP	Johns Hopkins University/Communication Programs
JOICFP	Japanese Organization for International Cooperation in Family Planning
MCH	Maternal and Child Health
MMR	Maternal Mortality Rate
MOH	Ministry of Health
MWA	Midwife Assistant

NGO	Non-Governmental Organization
NPC	National Population Council
ORS	Oral Rehydration Salt
PHC	Primary Health Care
POC	Progestin Only Contraceptive
POSIVA	Postal Savings for International Voluntary Aid
PPAG	Planned Parenthood Association of Ghana
RH	Reproductive Health
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant (trained)
TOT	Training of Trainers
UNFPA	United Nations for Population Activities
USAID	United States Agency for International Development
UNICEF	United Nations for International Children's Emergency Fund
VFT	Vaginal Foaming Tablet

APPENDIX 2

List of Key Persons Met

USAID/Ghana

Dr. Pamela Wolf, Chief HPN Officer
Dr. Benedicta Ababio, Deputy Chief HPNO
Mr. Donald Dickerson, Technical Advisor

Ministry of Health

Dr. Henrietta Odoi-Agyarko, Head of MCH/FP Unit
Mrs. Docia O. A. Saka, Deputy Chief of MCH/FP Unit

National Population Council

Dr. Richard B. Turkson, Executive Director
Mr. Emmanuel Tofoatsi

Planned Parenthood Association of Ghana

Mrs. Joana Nerquaye-Tetteh, Executive Director
Dr. Nii Adote Addo, Director of Program
Mr. Francis Yankey, Regional Program Manager
Mr. Georges Ampa, Director of Administration and Finance

Ghana Registered Midwives Association

Mrs. Florence Quarcoopome, Director

Ghana Social Marketing Foundation

Mr. Alex Banful, Executive Director

Institute of Adult Education

Mr. J. O. Barnor, Executive Director

APPENDIX 3

Assessment Team Members

Full-time team members:

Mr. Koffi Glover, PPAG
Mr. Emmanuel Obeng, PPAG
Mrs. Augustina Abbey, PPAG
Mr. Jacob Larbu, IAE
Mrs. Alice Lamptey, GSMF
Mrs. Patricia Odoï, MCH/FP Unit

Part-time team members and resource persons

Mrs. Mary Dampson, Public Health Nurses' School
Mrs. Victoria Davis, MOH
Mrs. Perfect Pearl Blebo, Moh
Mr. Matthew Atinyo, MOH
Mrs. Jessie Ramaswamy, PPAG
Mr. V. D. Kunkpeh, PPAG
Mr. Issahaku Al Hassan, Amasachina
Mrs. Lydia Eleblu, CCG

APPENDIX 4

PPAG CBD Supervisors Training Manual

Tasks of Community-Based Distribution Agents

1. To conduct house to house visits, educating people on family planning.
2. To sell non-prescription contraceptives.
3. To meet with Project Assistant to organize lectures, group discussions and film shows in her communities/villages.
4. To keep accurate records on all sales and IEC activities.
5. To submit monthly records on sale of contraceptives, drugs and other activities, including acceptors.
6. To store drugs and contraceptives well.
7. To provide First Aid in communities.
8. To treat and/or refer minor ailments like malaria, diarrhea, etc.
9. To act as a liaison between the community and PPAG staff (other medical staff).
10. Give health talks to small groups in the local dialects.
11. Organize community members to clean their environment.
12. Organize other activities to improve the health of people in the community/village.
13. Know the services available in the health centers, other primary health care workers and health facilities in the community or area.

APPENDIX 5

Ghana Basic Training for Community-Based Distribution
Institute for Adult Education

The Tasks of (a Literacy Group Facilitator as) a CBD Agent

A CBD agent is to undertake the following tasks:

1. Educate and motivate clients to accept family planning.

2. To counsel clients about reproductive methods to enable them to make free and informed decisions and choices.

3. Distribute non-clinical contraceptives to clients and refer those who would like other methods to the nearest family planning clinic.

4. Keep adequate records and use them for reporting.

5. Occasionally conduct follow-up home visits to new clients, continuing clients, and dropouts.

6. Organize lectures, group discussions, durbars and film shows in his or her community.

7. Provide First Aid and treat some minor ailments and refer difficult cases beyond him/her to the nearest hospital or clinic.

8. Know the health facilities in his or her area and to serve as a link between the community and other health workers.

9. Educate and motivate community members to practice good health care.

10. Collaborate with other extension workers in the community to work as a team in order to minimize the use of available resources.

APPENDIX 6

PPAG CBD Supervisors Training Manual

Tasks for CBD Supervisors/Post Training Functions

1. Will ensure that agents under her get all their inputs (quarterly or monthly).
2. Will coordinate the activities of all agents under her (10-15 agents).
3. Will keep an activity chart quarterly on all agents/villages under her for effective supervision.
4. Will ensure that all records are kept well and are up-to-date (monthly).
5. Will organize monthly area CBD review meetings to discuss problems, successes, challenges and achievements.
6. Will collate area records/reports for onward submission to the Senior Project Assistant at the regional level, who will collate into a regional report under the guidance of the Assistant Project Officer.
7. Will submit an area requisition of contraceptives, drugs, etc. to be compiled for a regional supply and ensure that agents get them in good time.
8. Pay supervisory visits to agents especially during their IEC activities.
9. Prepare monthly supervisory plans.
10. Will keep up-to-date basic information on his/her catchment [???] area.
11. Will work in her own community as a CBD agent.

APPENDIX 7

Key Organizational Characteristics of Institutions Involved in CBD Activities in Ghana

	GRMA	GSMF	IAE	MOH	PPAG
Type	NGO	NGO	Public sector semi-autonomous	Public sector	NGO (IPPF Affiliate)
Sources of Funding	USAID, UNICEF	USAID	GOG [1], CIDA, CODE, UNFPA	GOG, USAID, UNICEF, UNFPA	IPPF, USAID, POSIVA, World Bank, JOICFP, GTZ, AVSC, local sources, GOG
Geographic coverage	All regions	All regions	All regions	All regions	7 regions
Organizational structure	Decentralized clinic based	Decentralized local NGOs based	Decentralized bureaucracy	Centralized bureaucracy	Centralized bureaucracy
Organizing strategy	Top-down	Bottom-up	Top-down	Top-down	Top-down
Affiliation at periphery	Clinic outreach	18 local NGOs	None	Clinic outreach	Clinic outreach
Strategic focus	MCH/FP	• Brands demand creation • Contraceptive distribution	Adult literacy program with FP integration	MCH/FP	FP
Organizational focus	National (urban and rural clinics)	National (urban and rural)	National (urban and rural)	National (urban and rural)	National (urban and rural)

[1] *GOG = government of Ghana*

APPENDIX 8

Focus Group Discussion Report on
CBDs, Opinion Leaders and Clients in East Akim and Upper Manya Krobo

by

Mark Asare
Osea K. G.

Accra, April 1995

Executive Summary

The research team conducted focus group discussion (FGD) sessions in Koforidua and Oyoko in the New Juaben District and Asasewa and Asaasehene in the Upper Manya Krobo District, all in the Eastern Region. The purpose of the FGDs was:

1) to learn the clients and community leaders' perception of the service provided by the Community Based Distributors of family planning contraceptives and related materials.

2) to assess the level of involvement of community opinion leaders in the role being played by CBD.

3) to identify factors that influence the quality of service provided by the CBDs.

4) and to ascertain the level of integration of the CBDs in their communities and also the quality of supervision of CBDs. In all, 46 participants were involved in the four (4) FGD sessions. The session was composed of 21 male CBDs, 7 female clients, 9 male clients and 9 community/opinion leaders.

From our FGD sessions, we learn that the CBDs are an important community resource insofar as they provide available contraceptives to an increasing number of community members demanding family planning methods. They enjoy a great deal of support from their clients and members of their communities. They are perceived in a positive light due to their character, integrity, knowledge of family planning concept and materials, and commitment to their CBD health programs.

Main Findings

The principal concerns of the CBDs were the lack of regular refresher courses to update their knowledge and skills and the lack of a permanent mechanism for providing supervision, especially in the Upper Manya Krobo District. It came out clearly that what caused the low level of supervision was the problem of finances - the non-payment of travel and transport expenses and the absence of an incentive and motivation scheme. the use of information, education and communication materials was either minimal or lacking.

The CBDs are working in an environment where a lot is expected of them from both the community and official circles, but are, sadly, being frustrated by official silence on promises made to them. The promised or expected monthly Wellington boots, raincoats, torchlights or bicycles, First Aid equipment and drugs to enhance services rendered to all communities are not forthcoming.

Conclusion and Recommendations

The role of the CBD is a very important link in the provision of family planning contraceptives, particularly in communities where clinic-based family planning services are not available. The introduction of the CBD approach has therefore been of immense benefit to many communities.

To sustain the CBD approach, therefore, requires the total commitment of agencies like the PPAG, Plan International and others. With the high level of support/patronage enjoyed by the CBD, the agencies concerned should play their part in sustaining the CBD health program by addressing:

1. the incentive and motivation schemes for the CBD: e.g., financial support, materials for mobility and personal convenience, e.g., bicycles, Wellington boots, raincoats, bags, T-shirts, uniforms, torchlights, etc.

2. the establishment of a permanent and reliable supervisory structure.

3. the integration of refresher courses in the CBD health program.

4. and the need to establish a collaborative network with health workers including FP nurses and traditional birth attendants.

This, it is hoped, will go a long way towards promoting the CBD health programs and thereby sustain them.

CBDs Focus Group Discussion

Background Information and Methodology:

From the verbal brief given by INTRAH, for a Focus Group Discussion to be done in rural Ghana where CBDs operate; we were assigned to draw our sample from Eastern Region of Ghana.

The team (Research Team) therefore chose 2 districts in Eastern Region, which has little or no influence from the urban center. The districts were between 20-40 km from the regional capital of Koforidua. The two districts were East Akim, where the PPAG CBD operates, and upper Manya Krobo, where PLAN CBDs also operate. The selection of CBDs was therefore based on availability and proximity of the CBDs at the time when the team visited their centers. In all, the team tried to contact 18 PPAG CBDs and 20 "Plan" CBDs, of which 10 and 11 respectively were available for the FGD.

Three CBDs were asked to select about 20 clients each for the team.

From these clients, 7 female and 9 male clients were selected for the FGD.

The opinion leaders were all selected from Oyoko, where they have 2 CBDs, because it was difficult getting Opinion Leaders from the other location to join. The 10 opinion leaders used in the FGD ranged from traditional rulers to a youth organizer.

Moderation of FGD and data analysis

Each of the FGD sessions were conducted by a trained moderator and assisted by a note taker.

All of the sessions were tape recorded and later transcribed by the moderator.

The research team was made up of two research consultants, two moderators, two note takers and one mobilizer.

The reports (attached) were generated from field notes and transcribed materials. All the materials were compared and differences were highlighted. Otherwise, all of the findings were summarized.

FGD - Clients

To ensure that culture and tradition do not negatively affect the results, the team selected the FGD participants from an exclusively female group in the East Akim District in the Eastern Region. The FGD for the female-only group was conducted at Oyoko, about 15 km from Koforidua. Inhabitants are mostly farmers, with a few traders and artisans. This community is served by a male CBD agent who has been trained by the Planned Parenthood Association of Ghana. The team chose this female-only group because it was felt something interesting would come out of discussions regarding their relationship with a male CBD. The mean age of the participants was 24. The group's educational background ranged from middle school to secondary education. The group members had an average of one child.

In the Upper Manya Krobo District, the team spoke with an exclusively male group, including a deaf and dumb client. The participants were 9 in number, all farmers, from a village called Asaasehene, about 25 km from Odumase, the district capital. The mean age of this group was 39.5 years. These clients are served by a female CBD trained by GSMF through Plan International.

Perception of CBDs by Clients

One of the areas examined was the level of interaction between clients and community-based distributors. It came out that the CBDs were seen by their clients as confidential and caring. "He keeps our secrets and so we can always confide in him and because he is friendly we always feel free to talk to him." Others saw the CBDs as people who are "open and prepared to receive you at any time of the day." It was also evident that the CBDs in the eyes of the clients "are patient, knowledgeable and are able to explain everything clearly to us, especially how to use the contraceptives." Regarding the character of the CBDs, participants were unanimous. "Before she even went for the training, she was a very good person and no one had anything bad to say about her. In fact, that is the reason why she was well-accepted when she finished her training. Some of us go to her because of her good character."

Availability/Accessibility

The issue of the CBDs as always available and accessible to clients brought to the fore the positive points underlying the concept of CBDs. Participants came out to say clearly that the fact that the CBDs lived amongst them made them easily accessible. "He is always available and at no time of the day will you look for him with difficulty. Even when he has to travel he will tell his wife to tell clients when he will be coming." The other very interesting thing is that CBDs do not wait for the clients all the time: "When she does not see you for about two weeks, she will come to visit you and find out if you have any problems."

Degree of Satisfaction of Services

Participants expressed satisfaction with the role of the CBD in the community. Some were of the view that the CBD has come to provide them with good services which they hitherto had to travel to get or deal with service providers they were not so familiar with. "Formerly, my husband did not want to hear about family planning, but the CBD has been able to convince him, so this time my husband has been in for the Sampoon and I am happy about that." Another important observation was that the clients were satisfied with the prices of the products to the extent that a satisfied client said, "since I started using her products I have my peace, and she will always supply me; in fact, she has given me supplies on credit on two occasions."

One drawback which was evident was the availability and use of IEC materials by CBDs. None of the participants has ever been given a leaflet or brochure on any of the methods sold to them. Asked whether the CBDs used materials like cue cards or flash cards or flip charts, one participant who said she had seen a poster said she had seen it in the CBD's house. Another client who claimed to have an IEC material ran to his house, which was close by, and brought an IUCD Direction For Use material meant for trained service providers. Asked where he got it from, he said, "My wife went weighing and said she picked it up off the floor of the clinic."

Involvement

Most of the clients had started promoting the activities of the local CBDs. Some informed their friends and people about the work of the CBD, others took questions from friends to the CBD, and some others actually sold some FP drugs for the CBD. Clients made comments like, "Since I'm here, I collect the questions of those who feel shy for Bro. Kwame [the CBD]" and "I tell others about the importance of FP and Bro. Kwame." They also think that in order to sustain the CBD health program, the CBD should be given more training about other diseases and be paid well; supply drugs regularly and be supported by other government agencies like the Ministry of Health, Information Service; and also be "recognized or respected" by the chiefs and community members.

"She should be paid well…"

"I think regular supply of drugs…" [???]

Expectations

Participants were of the opinion that the workload of a single CBD in a community was too much. "If there are two CBDs in our community, that will be fine." It was also suggested that if the authorities saw the need to train another CBD, then in a community where the present CBD is male, a female CBD should be trained, and vice versa. This, participants felt, was important, because "Sometimes, as a woman, I am not able to ask him all the questions because some of the issues are too intimate, but I will feel comfortable talking to a female CBD." Apart from the CBD selling family planning products, the expectation of all participants was that they should be given extra training in order to be able to diagnose and treat small ailments. "They should also be supplied with drugs like codeine, plaster, snakebite drugs, chloroquine and drugs for stomach pains." Besides this, it was suggested that CBDs be given enough IEC materials so that "we, the clients, can have some on our walls and also read them, so that we can help him do his job better." Participants were unanimous that CBDs should be given periodic training in family planning so that they will be up to date. This, they felt, was important because "now we hear there are colored condoms, which we haven't seen before, and I don't think our CBD has either." Another remarked, "At first we only knew of EMKO (a foam); now there are different things and our CBDs may not know about them."

Future/Sustainability

Participants suggested that for the CBDs to be motivated enough, they need to be provided with a kiosk or stall where they can sell their stock. Apart from this, it was their opinion that CBDs should be provided with materials like T-shirts or uniforms, so that they will not only be motivated but could "be easily identified by community members or even by strangers."

With regard to remuneration for CBDs, there was division among group members. Whilst they all agreed that the CBDs should be given some incentive in the form of a salary, the issue of who should pay them could not be resolved. Whilst some felt they should be put on the state's payroll, others felt the community should pay them, whilst others supported the idea that the community members should help the CBDs on their farms. Other participants came up with the idea that instead of paying them, the community members should contribute some money for the CBD so that they can buy more drugs, sell them and keep the profits.

FGD - Community Leaders in Oyoko

Background of FGD Discussion Participants

In the focus group discussion held for community leaders (or opinion leaders) of Oyoko near Koforidua in the Eastern Region, there were nine participants, including teachers, an assemblyman, a traditional leader (i.e. Okyeame) and youth association members. Their average age was about 42 years, with the youngest aged 30 and the eldest aged 63 years. The lone female was a teacher serving as the Deputy Headmistress of the local Junior Secondary school.

Community Leaders' Perception of CBDs

The participants were aware that there were other health workers in their community. They were equally aware of the presence of the CBD and of his work in Oyoko and its surrounding villages. With regard to the CBD's image, they expressed satisfaction with his work, because they always saw him "doing his work afternoon, evening and night, making contact with a cross-section of the people," but particularly with his peers, i.e. the youth and the seamstresses and head-dressers of the community.

The participants know the CBD as an executive member of the local youth association. They said they were aware that he took advantage of his position as an executive member to educate people, especially during soccer and other games, which he officiates as a referee. The CBD is also reported to be discussing family planning while he sits in his lotto kiosk.

In short, they have a positive opinion of him, in that "he is respectful and has patience in discussing family planning and is not quick to anger."

Community Leaders' Expectations About the CBD

The CBD's positive and likable personality are what have won him the admiration and respect of the opinion leaders. They think that he is knowledgeable about his work and that he is interested in his work. As a youth leader he is well known in the community and that "there is nothing distasteful about him."

CBD's Needs:

The community leaders are well-informed about the CBD's problems and what he needs to provide better service to his community. These are resources dealing with:

a) Mobility - bicycle to reach villages, mobile van with PAS.

b) Incentives and motivation - allowance, torchlight, Wellington boots, salary, raincoat.

c) Office accommodation - desk and furnishings

d) Technical competence - refresher courses/workshops to update his knowledge

e) Colleagues/staff - a female counterpart to provide female contraceptives

Community Involvement/Participation in Health Programs

According to the assemblyman and other participants, Oyoko was the venue for the launching of two health programs (events) in 1995. These are Eastern Regional Family Planning Program and the Malaria Awareness month celebration. The drama displays the Non-formal Education Division both occasions went down well with the community members as they were useful for most community members.

Most Important Health Program

From the perspective of the community leaders, malaria control programs were perceived to be their most important health activity programs, because malaria causes many deaths. Others mentioned included cholera, TB, jaundice and measles. They remember the outbreak of cholera in Oyoko in 1983.

Community Leaders' Participation in Health Programs

The community leaders see the youth of Oyoko and teachers' role in educating pupils on health problems and disease as the community's principal participation in health programs.

The assemblyman reported on his mobilization of community members "to provide a latrine and to keep the environment clean of weeds, bushes and refuse." Through his mobilization, "pools of water have been drained, and empty cans or containers buried." A place for the disposal of waste has also been provided.

CBDs' Participation

The participants credit the CBD with active involvement and participation in community health programs or activities because of his mobilization of community members and resources for communal and development projects.

They also see the CBD as someone with good anticipation because of how he takes the opportunity in gatherings and games to also begin a discussion of or educate people on family planning contraceptives. According to one of the panelists, he has approached the CBD several times for contraceptives and he had also referred people to the CBD. In sum, the participants were of the opinion that Nyame (the CBD) was simply interested in his CBD work.

Sustainability of CBD Health Programs

Some of the community leaders remarked upon the impact of the work of the CBD in lowering teenage pregnancy and abortion in Oyoko. "For the past two years or so since the CBD program was introduced, teenage pregnancies in this area have been reduced drastically…" They therefore called for the "provision of incentive and motivation

schemes for the CBDs so that the CBD program can continue, so that it does not become a nine day wonder." Other things participants suggested as tools to sustain the CBD health program were billboards and TV adverts, a competitive pricing mechanism, giveaway contraceptives, a professional uniform, regular refresher courses, and training in First Aid.

FGD - CBDs

Background Information

The Focus Group Discussions (FGD) for the CBDs were conducted in the Eastern Region of Ghana.

The 21 participants for the 2 FGDs were: 10 PPAG CBDs (4 men and 6 women) and 11 Plan International (PI) CBDs (PI and GSMF trained the CBDs) who were all women.

PPAG CBDs are all located in the East Akim district, while the PI CBDs were from the Manyo Krobo district.

All of the CBDs were over 30 years of age. Four of the PPAG CBDs were teachers; the rest were mostly traders and farmers.

All of the CBDs had 2 weeks training conducted by PPAG at Koforidua; however, 3 PPAG CBDs were trained as far back as 1991. The rest were trained in 1994. All the PI CBDs were trained in March 1995 (in other words, they have been CBDs for just one year).

Services

All the CBDs were selected by their agencies, PPAG and Plan International, in conjunction with the local people, i.e. the chief or assemblyman or woman. However, their educational qualifications were considered before they were recruited and trained. Many of the CBDs said they saw the need for someone like them to be trained to help people in their communities, especially healthwise. The CBD participants in the two FGDs made comments like:

"I didn't know anything about the CBD concept. It was one Mr. Osei who, while he was attending a funeral at Anyinam, introduced me to it…"

"There was a need to make Family Planning services available to help the people… you will realize, if you consider the catchment area, that people give birth a lot… the way nurses talk to the women… the message does not get out well to the women and others in town… so I agreed to be trained."

"In the first place, Plan was going to give our community a corn-mill and they needed someone to be trained… so I was selected by community members for the training…"

All the CBDs were given two weeks training, conducted by PPAG at Koforidua. According to the participants, they received tuition in Family Planning and First Aid. In their training they were given instruction on how to refer clients to nurses or clinics, and to refer difficult questions and demands for drugs or contraceptives they are not supposed

to administer to clinics. They were also taught AIDS and STD education, First Aid and personal hygiene education.

"How to use contraceptive pills… and condoms properly without breaking them; how to identify an expired pill or condom."

"We were taught that if it is beyond our competence, we should refer our client to the MOH nurses who have been specifically trained to handle problems."

During discussion it came up that while the PPAG CBDs work solely in Family Planning services, the Plan CBDs work in both Family Planning and First Aid. According to the PPAG CBDs, they haven't got the opportunity to practice what they were taught in First Aid. However, they are doing very well in Family Planning and AIDS education and the selling of contraceptives.

However, Plan CBDs are doing both - they sell and educate on Family Planning contraceptives, and treat small cuts and sponge children with high temperatures.

The difference may be where the two agencies' CBD operate. While the PPAG CBDs are residing in medium-size towns (pop. 5000+), the Plan CBDs are operating in far smaller settlements (pop. < 1000), where there are no clinics. The nearest clinic is at Asesewa, in the case of the PLAN CBDs, while there are clinics in all the PPAG CBDs' stations.

A PLAN CBD had this to say:

"We also sponge the children, show mothers how to do it… if it is serious we ask the person to send the child to the Asesewa clinic."

The general complaint from the PPAG CBD was:

"We were taught First Aid, but up until now we haven't been given the materials…"

However, when it comes to Family Planning and environmental hygiene, they are able to educate or provide service.

"I go around to sell or teach people about Family Planning. Sometimes I talk to them in groups; sometimes I go to their homes and have discussions with them." (PLAN CBD)

"Yes, I talk about how to prevent pregnancy and how to use 'rubbers,' about AIDS and how to avoid diseases." (PLAN CBD)

"We were taught about personal hygiene, environmental hygiene, the breeding of houseflies, AIDS and STDs, etc., for when we go to the clients." (PPAG CBD)

Most of the CBDs were introduced to the community members during a public forum. Mostly, the chief and his elders and the Assemblymen introduce the CBD at the gathering. The introductions were done just after training; the CBDs began their work in the community shortly afterward. The few who were not introduced had to introduce themselves to the community by going from house to house.

One PPAG CBD who is also a youth association executive said,

"As for me, I didn't need an introduction; I am known by everybody."

Since the CBDs do a lot of home visits, they are easily seen by the community members. Previous clients also contribute in providing information about the CBD.

When participants were asked what they thought they should do in order to provide better service to the community, they all started mentioning their needs. However, when they were prompted, the all claimed they were doing their best.

"We're promised Wellington boots, raincoats and even bicycles to reach villages and bags for protection of contraceptives and other materials from being soaked by rain, but up until now these have not been provided. We were also promised a monthly allowance of about ¢5,000 as an incentive, but this too has not been forthcoming." (PPAG CBD)

Other things mentioned were IEC materials - posters, leaflets, models, ID cards, etc.

Supervision

PPAG CBDs have had some supervision. Those who have been CBDs for the past 5 years have had different supervisors over that period. The supervisors mentioned were Messrs Amaniampong and Yirenkyi and Mesdame Paulina and Cecilia (deceased) among others.

PLAN CBDs have had little or no supervision since they became CBDs about a year ago. Only two (2) have been visited once by their supervisor. Since the PLAN CBDs too were trained by PPAG, initially they were paid visits by PPAG and a nurse was asked to do supervision, but she also stopped for a reason not known to the respondents.

So far the supervisory structure for the PLAN CBDs has yet to be established. In the meantime, some of the CBDs have been selected to supervise their colleagues' work.

Most PPAG CBDs have efficient supervision, but others don't. The latter group claimed that the last time they saw their supervisor was in June 1995. Many see their supervisor fortnightly.

Those who received poor supervision had this to say:

"Mr. Yirenkyi (supervisor) has not come since auntie Cecilia passed away, so I have to come to Koforidua for supplies and to submit the sales I've made at the end of the month… so I've had a problem with mine."

"At times, I even think that the community-based distribution program has fallen into pieces, so I should relax."

According to participants, the PPAG CBD supervisors mostly inspect stock, check sales and progress of work, and help them to answer difficult questions posed by clients:

"When Sister Paulina comes to me to work, she collects my returns, inspects my remaining stock, and adds some more contraceptives."

"In the days of Auntie Cecilia her work was done in a similar way… Many a time she would help me answer those difficult questions my clients posed!"

Conclusions made from the discussions are that some of the supervisors' T & T and other expenses they incurred during their supervisory visits were not paid, and that was the main reason why they dropped out.

It was also concluded that most of the CBDs share all their problems with their supervisors.

The CBDs claimed that since the supervisors help them with their work, everything should be done to give them (the supervisors) incentives to motivate them to do their work. They said their supervisors provide information from the regional headquarters as well as from other CBDs and this encourages them a lot.

The CBDs had no problem communicating with their supervisors when they came to visit.

Community Members/Leaders

There has been some involvement of community members and opinion leaders in the activities of the CBDs.

In the first place, almost all CBDs were selected with the help of some opinion leaders like the Chiefs, Town/Village Development Committee members, Assemblymen, etc.

All of them claimed most community members and opinion leaders are supportive and had shown much interest in their work. This is because they think the CBDs are offering a useful service to the community.

However, most opinion leaders' involvement ends at the introduction of the CBDs to the community after their training. Some chiefs and elders, though, allow CBDs to talk about work at any gatherings.

People who have been very instrumental in helping CBDs are their relatives: sisters, parents, children or even neighbors in their household. Their involvement had mainly been sales of contraceptives and promoting the CBD's work.

Satisfied clients also talked to their friends about the work the CBDs were doing.

The CBDs believe that if community leaders speak positively about Family Planning and CBDs and warn others about the dangers of AIDS at every gathering, or allow the CBDs to speak, it will go a long way to help them.

CBDs think community leaders must do more to encourage the whole community to adopt healthier lifestyles by setting examples.

Problems and Difficulties

The participants also mentioned a catalog of problems ranging from incomplete training to young people, especially boys, who sometimes make jokes out of their efforts at AIDS education.

According to the PPAG CBDs, during their initial training as CBDs some years back, they were promised ¢5,000/month allowance, Wellington boots, bags, raincoats, etc. for their work, but they never received any of these items, which they actually need for their work. According to them, they met 2 years ago about the same issues, but nothing came of it. They felt the issue of incentives for CBDs should be addressed immediately because it was a great source of frustration.

Mention was also made of ID cards, so that CBDs can be easily identified in new communities if questioned about their identities.

Some CBDs (PLAN) complain about young boys making fun of their efforts at AIDS education. They believe that if more IEC materials were given to the CBDs and an information van went around to the villages to reinforce their message, it would help them a lot. This, they claimed, would also combat if not stop completely the opposition to family planning by some of the Christian and Muslim community members.

Failure and/or misuse of contraceptives was also mentioned as another problem that often damages the credibility of CBDs. Often, clients claimed that CBDs sold expired or false drugs to them, which led to rumors being spread.

Participants mentioned refresher training as a possible solution, in order to upgrade Family Planning knowledge as new FP developments keep arriving.

Upgrading training in Primary Health Care should be considered, as the CBDs said people came to see them about all sorts of diseases which they were not trained to diagnose, leading them to refer clients to local clinics.

Partnerships with health workers also need to be strengthened so that each can involve the other in their work, since they share the common goal of promoting good health.

Health workers should recognize CBDs as partners, not rivals, in Family Planning services.

ID cards, uniforms, T-shirts, torchlights, educational materials and many others were mentioned as needs.

Motivation

None of the CBDs receive pay as a motivation. However, they have been promised a monthly allowance which they have never received.

What is keeping most CBDs at their jobs seems to be their interest in serving their own communities. For some, it is a fear of backing out after they have put up with so much already. Few of them seem to be frustrated by these developments or the non-payment of their allowance.

All the CBDs want to be paid or given money to help them start something (trade, farming, etc.) on their own.

Apart from money, CBDs want materials for health education, tools for their work and support from the community and their leaders in order to serve their communities better.

The community support should come in the form of CBD promotion, respect, preferential treatment and the like.

Integration

Most CBDs have had some collaboration with health workers in their localities, especially the nurses. In most cases, the nurses had planned and executed many health talks in the communities with the CBDs. Some of the CBDs arrange for the nurses or other health workers to talk to the groups. This, according to the participants, helps promote the image of the CBD.

In the few cases where there was rivalry, the CBD's reputation had suffered some damage. The CBD was portrayed as someone who was not knowledgeable or competent in Family Planning services, sold cheap, low quality contraceptives and so forth.

Aside from these few problems, however, CBDs claimed that most community members see them as very useful. According to them, CBDs save them time and money, since their services are cheap and clients don't have to travel to get them.

APPENDIX 9

Data Collection Instruments

1. Interview guide for key program managers at headquarters and NGO levels

2. Knowledge questionnaire for

    2a. CBD workers
    2b. Supervisors of CBD agents
    2c. Service providers at referral points

3. Skills assessment checklist for:

    3a. CBD workers
    3b. Supervisors
    3c. Service providers at referral points

4. Working conditions instruments for:

    4a. CBD workers
    4b. Supervisors
    4c. Service providers

5. Work environmental factors interview guide for CBDs

6. Focus Groups guide for:

    6a. Female and male clients of CBD agent's services
    6b. Community leaders
    6c. CBD agents

APPENDIX 10

List of CBD Agents by Organization

Location of CBD Agents

Region	Name	Sub-district	Community
Greater Accra			
	1. Aisha Yahaya	Kpeshie	Burma Camp
	2. M.S. Bawa	Ayawaso	Nima East
	3. Ibrahim A. Akim	Tema	Madina
	4. Mohammed A. Ayub	Ayawaso	Nima West
	5. Jamilatu Abdullah	-do-	Accra Newtown (west)
	6. Mariama Bawa	-do-	Accra Newtown (East)
	7. Ahmed Akoutey	-do-	Nima - 441
	8. Fati Alhassan	-do-	Kanda/Ruga
	9. Abdul Rahman	Ablekuma	Sukura
Eastern			
	10. Hamdiya Tahir	Koforidua	Koforidua-Zongo
	11. Fati Awudu	-do-	-do-
	12. Mohammed Ali Kiari	Akuse	Akuse-Zongo
	13. Rukaya Mumuni	-do-	-do-
	14. Abdul-Razak Garba	Nsawam	Adoagyiri
Central			
	15. Ishmael McQuil	Buduburam	Refugee Camp
	16. Clement Yamson	Winneba	Winneba-Zongo
Ashanti			
	17. Sharif Ali	Kumasi	Asawasi
	18. Omar Farouk Bin Sallah	-do-	Bantama
	19. Hajara Suleiman	-do-	Sepe Timpom
	20. Ramatu Mohammed-Sani	-do-	Akwatia Line
	21. Shuaib Nasirudeen	-do-	Suame
	22. Umar Ibrahim	-do-	Yati Yati
	23. Abdulai Ishaq	Obuasi	Obuasi-Adansi
	24. Mohammed Awal	Kumasi	Aboabo
	25. Aremeyawo Ali	-do-	Suame
	26. Zelihatu Alhassan	Konongo	Konongo-Zongo
	27. Mohammed Saeed	Kumasi	Kwadaso
	28. Musah Shanum	-do-	Old Tafo
	29. Salamatu Ibrahim	-do-	Moshie Zongo
	30. Amina Ibrahim	-do-	Asawasi
	31. Rakia Salifu	-do-	Dichemso

Region	Name	Sub-district	Community
Ashanti			
	32. Amina Iddris	Kumasi	Suame
	33. Jamila Alhaji Ibrahim	-do-	Aboabo No. 2
	34. Habib Mohammed Shareef	-do-	Aboabo No. 2
	35. Yusif Huseein Sharif	-do-	Yati Yati
	36. Ayeshatu Abdulai	-do-	Asawasi
	37. Issah Ahmed	-do-	Sawaba
	38. Omar Adams	-do-	Anloga
	39. Mohammed K. Mohammed	-do-	Aboabo No. 1
	40. Ibrahim Ahmed	-do-	Aboabo Ext.
	41. Anwar Sadat Rashid	-do-	Akurom
	42. Suleiman Mohammed	-do-	Suame
	43. Amina Musah	-do-	Asawasi
	44. Aminu Ibrahim	-do-	Akurom
	45. Salmatu Sumaila	-do-	
Brong Ahafo			
	46. Adams Mohammed	Techimantia	Zongo
	47. Fatima Abdulai	Sunyani	Sunyani-Zongo
	48. Hadiza Yunusa	Techiman	Techiman-Zongo
	49. Hawa Seidu	Bechem	Bechem-Zongo
	50. Habiba Osman	Wenchi	Wenchi-Zongo

P O Box 798
Tamale, N/R

GHANA
WEST AFRICA

Our Ref . ...

Your Ref ....

21st March, 96.
....19 ..

NGO PROGRAMME MANAGER,
G. S. M. F.,
ACCRA.

Dear Sir/Madam,

INFORMATION ON CBD PROGRAMME

With Reference to your letter dated 29th February, 1996 on the above issue, below is the information needed. (List of CBDs location in the District/ Communities attached)

1. Trained GSMF CBDs - 105
2. Location of our CBDs are spread throughout twelve (12) districts of the Northern Region as follows:-

	DISTRICT		NO. OF CBDs
1.	Tamale Municipal	-	16
2.	Tolon/ Kumbung. District	-	17
3.	Savelugu/Nanto "	-	11
4.	Yendi "	-	10
5.	Gushegu/Karaga "	-	19
6.	Zambaga "	-	9
7.	Zabzugu/Tatale "	-	7
8.	Bimbilla "	-	7
9.	Salaga "	-	6
10.	Walewale "	-	6
11.	Damongo "	-	3
12.	Bole "	-	3
	Total	=	105 CBDs

We have one supervisor/Trainer each of the twelve Districts and Six in the Amasachina Secretariat, bringing the total number of Supervisors/Trainers to Sixteen (16).

SUPERVISION

Supervision is carried almost every week by Supervisors/Trainers in the Districts and every month by the Secretariat.

PROCUREMENT OF CONTRACEPTIVE

Currently, all drugs are available and our main agent is DANAFCO. However, we sometimes buy our condom from Ministry of Health because of the cost of DANAFCO drugs. It is not even easy getting the quantity of condom we want.

OTHER SUPPLIES

Flip charts, IEC material etc., are sometimes obtained from Ministry of Health (IEC Material) and PPAG (Flip charts)

CBDs PERFORMANCE:

So far as Amasaciima is concerned, the CBDs are performing well. We look at the Volunterism attached to the job. no incentives, no means of transport (cycles) for most of them and other things that will motivate them (Reference Previous reports).

PROBLEMS/CONSTRAINT

- Incentives
- Bicycles
- Rain Coats
- Wellington Boots
- Refresher Courses
- Cost of Drugs.

RECOMMENDATION

We believe if the problems stated above are looked into seriously and tackled, CBDs will be able to perform better than what they are doing now.

DROPPED OUT OF CBDs

One Supervisor/Trainer was dropped due to a divorce between her and husband and subsequent marriage to another husband who will not allow her to do the job. However, efforts are being made and it is likely the lady will continue her job. Amasaciima has however, trained some one to take her place.

One CBD from Tamale Municipal (Jisonayili Community) has also gone to School, but some one has taken her place also.

Yours faithfully,

(ISSAH SALIFU)
CO-ORDINATOR

cob

ADRA CBDs

No.	NAME	CONTACT
1.	Amos Allotey	Akramaman
2.	James Abloh	Ashamoah
3.	Samuel Amponsah	Krokoshew
4.	Peter Sackey	Ofuaplem
5.	Simon Awuku Kloslah	Ofanko
6.	Marittama K. Lamptey	Zongo-Ayikudoblo
7.	Rosena O. Wentum	Manhea
8.	Vinolia Gamadeku	Ayighe Town-Ayikai
9.	J. B. Aryee	Mayera-Osofoama
10.	Mary Adjiman	Obokwash
11.	Edward Quaye	Amasaman
12.	Sarah Quartey	Amasaman

GSMF Rural Help Integrated (RHI) CBD List

Name of Volunteer	Village
Patrick Anabah	DATOKO
Samuel Sampana	KOLPELIGA
Veronica Gbandan	KOLPELIGA
Theresa Gang	DUUSI
Simon Sampana	DUUSI
Bernard Ayasko	SIRIGU
Rose Akilma	SIRIGU
Patrick Ayamga Akagura	SUMBRINGU
Robert Bogbon	ZANLERIGU
Elizabeth Miba Sampanbil	ZANLERIGU
Assibi Abane	YOROGO/MADINA
Joseph Aganda	YOROGO/MADINA
Gilbert Agansabga Anaba	YOROGO/MADINA
Dominic Anafo	WINKOGO
Dominic Kumdah	NANGODI
Victoria Kumdah	NANGODI
Victoria Boabil	SHEEGA
Francis Yamah	SHEEGA

CBD Agent Information

	Name	District	Village
1.	Juliana Eva Cann	Adansi West	Obuasi
2.	Susana A. Boateng	Afigya Sekyerea	Towne
3.	Mama Theresa Aful	Ahafo Ano South	Barniekrom
4.	Philomena Agyepong	Amansie West	Manso Nkwanta
5.	Rhoda Opoku	Ashanti	New Eduabiase
6.	Mary Badu	Ashanti	Abirem
7.	Mary Opoku Antwiwaali	Ashanti	Akomadan
8.*	Hadjo Abdul Wahaab	Ashanti	Kokode
9.*	Hanna Osei Frimpong	Ashanti	Agona
10.*	Miss Memuna Issakah	Ashanti	Ejisu
11.	Victoria Kyei	Ashanti	Effiduasi
12.	Elizabeth Anokye	Ashanti	Kokode
13.*	Comfort Adu Nyarko	Ashanti	Kokofu
14.	Tanko Salamatu	Ashanti	Ejura
15.*	Faustina Nimako	Ashanti	Juaso

YWAC CBDs for Eastern and Volta Regions

No.	Name	Community	District	Region
1.	Adelaide Yirenkyi Manu	Obosomase	Aburi	E/R
2.	Agnes Nanor	Apeguso	Asuogyaman	E/R
3.	Confort Tawiah	Kunahia, Betease, Suhum Niew Town, Ayekotse, Akorabo, Suhum Community	Coaltar	E/R
4.	Dora Dzata	Sokode-Bagble, Sokode-Gbogame, Sokode-Etoe, Tsawoanu	Sokode	NO
5.	Esther Asamoah	Akwadum*, Oboutumpan, Mpayiem, Adimensa	New Juaben	E/R
6.	Florence Daley	Kpandu	Kpandu	V/R
7.	Frienda R. Agbo	Kpeve	Kpeve	V/R
8.	Gladys Amankwa	Soviefe Ayorkpo*, Savifie Deme, Saviefie Gbgame, Anfoeta Tsebi, Nyagbo Soroe	Dzolokpuita	HO
9.	Grace Kwakudgie	Somanya*, Okpepiemi, Salosi, Adjikpo, Zongo, Labout	Yilo Brobo	E/R
10.	Hilda Hodo	Hohoe*, Sandrokofi, Aziave, Koloedu, Klefe, Akrofu	Hohoe	
11.	Joyce Ofei Baagiwa	Kye*, Aboaba, Apoputiam, Amanfo, Osaebrom, Daakye	Akuapem North	E/R
12.	Juliana Mamle Tetteh	Odumase Krobo	Krobo	E/R
13.	Janet Norghey	Transferred		V/R
14.	Lilian Mary Anof-Ntow	K'dua Old Estate*, Kwabenya Densuadja, Asaman	New Juaben	E/R
15.	Margaret A. Bruku	Akrade*, Juapong, Aboatia, Kagagi, Ahimansu, Old Akrade, Senchie (new), Old Senchie	North Tongu	REPLACED
16.	Nancy Mensah	Nsukwao*, Koforidua*, Ejisu Estate, Pkgkuge, Nkwanta, Sarkodee JSS, Presby Church	New Juaben	E/R
17.	Regina Amoako	Suhum*, Garba Zongo, Maamehueso, Namanku Larteh, Otwebedidua	Coaltar	E/R
18.	Regina Afaribea	Atimpoku*, Asumpaneye, Anyensu, Mpakadam	Asuogyaman	E/R
19.	Salomey Adobor	Bankoe*, Dome, Akofe, Polke Depot	Ho	V/R
20.	Victoria Ayesu	Akuatio - GCD Camp, Akwatech, Adofo Hotel	Kwaebibirem	E/R

No.	Name	Community	District	Region
21.	Lydia Nyarko	Somanya	Krobo	E/R
22.	Vicentia Shika	Anloga	Keta	V/R
23.	Salome Anane	Akweteman, Ofankor	Amasaman	G/R
24.	Sherifatu Ibrahim	Achimota - Kopevi	Okaikwei North	G/R
25.	Joseph B. Owusu-Ansah	Osu	Accra-District	G/R
26.	Adwoa Anima	Otojor	Accra	G/R
27.	Charity A.M. Tetteh	Kwasieman	Accra	G/R
28.	Elizabeth Sasu	Mamprobi	Accra	G/R
29.	Stella Lavordite	Fadama, Abeka-Lapaz, Nii Boi-Man, Olengle Gonno, Jarse	Accra	G/R
30.	Pamela C. Amoo	Malam, Awoshie	Ga Rural	G/R
31.	Mrs. J. Adu-Gyamfi	Frafrahu, Adenta	Amasaman	G/R
32.	Ellen A. Ohene	Legion Village, Mobil Force, Licensing Office	Ayawaso	C/R
33.	Lucy Adams	Abeka Lapzas	Gbemono	G/R
34.	Elizabeth Letsa	Mamprobi	Accra	G/R
35.	Dede Teiko	Mobole	Dangbme West	G/R
36.	Betty A.B. During	Aboso, Homokorpe, Bronikrom, Kobinanoikrom, Demekorpe	Shama-Ahanta East	W/R
37.	Philomela Quargrainie	Effia Kumah, Fijia, Effia, Kasaworadu, Debenokrom	Ahanta Shama	W/R
38.	Doris Eboyie	Esiama	Axim	W/R
39.	Roselrene Mansah Atsuvia	Adakope	Shama Ahanta East	W/R
40.	Francis Azagbo	Beposo	Sekondi	W/R
41.	Robert A. Sowah	Takoradi, Kwesimintsim, Apremo, Asakae, Anaji	Shama Ahanta East	W/R

Participants in Family Planning Community Based Distributor (CBD) Course

No.	Name	Address/House No.	Occupation	Office Designation	Station
1.	Moses Moisob	c/o Tambing Primary Sch.	Facilitator/Farmer	CBD	Tambing
2.	Jadaan Konlaan	c/o Bianbik Primary Sch.	VHW/Farmer	"	Bianbik
3.	James Mamoya	c/o Benkura Primary Sch.	Facilitator/Farmer	"	Benkura
4.	David Konlaan	c/o Naauk Primary Sch.	VHW/Farmer	"	Nasuk
5.	James Laarbik	Najong JSS	VHW/Teacher	"	Najong North
6.	Labik J. Binakin	c/o Gbadauk JSS	VHW/Farmer	"	Gbadauk
7.	Fibne Binakin M.	c/o Kambatiak JSS	"	"	Kambatiak
8.	Timothy Bayaakaa	c/o Guangbiang Primary Sch.	"	"	Guangbiang
9.	Konlaan Barabu Jacob	c/o Gbankoni JSS	"	"	Gbankoni
10.	Duut David Kanaatin	c/o Kambagu Prim. Sch.	"	"	Kambagu
11.	Konlanbik Jabou	c/o Japsak Prim Sch.	"	"	Japsak
12.	Konyaan Konlan	c/o Bimbagu JSS	"	"	Bimbagu
13.	Adams Konlaan	c/o Nasniik Prim Sch.	"	"	Nasniik
14.	Solomon Suuk	c/o Jagander Prim Sch.	"	"	Jagander
15.	Gazare Moses	c/o Bendi JSS	"	"	Bendi
16.	Simon Muulee	c/o Timpaant Prim Sch.	"	"	Timpaant
17.	Moses Monkas	c/o Kinkangu JSS	"	"	Kinkangu
18.	J.D. Sulemana	c/o Yunyoo JSS	"	"	Yunyoo
19.	Ali Lambon	Jimbale Primary Sch.	VHW/Teacher	"	Jimbale
20.	Peter Kamari	c/o Mozio Prim Sch.	VHW/Farmer	"	Mozio
21.	Gariba Muniru	c/o Gbankurugu Prim Sch.	"	"	Gbankurugu
22.	Kombat Philip	c/o Jiirik No.2 Prim Sch.	"	"	Jiirik No. 2
23.	Damfei Jabon	Mangor Primary Sch.	VHW/Teacher	"	Mangor
24.	Damaan Lambon	Waawa Primary Sch.	"	"	Waawa

No.	Name	Address/House No.	Occupation	Office Designation	Station
25.	Badabuk	c/o Gbenkoni Prim. Sch.	VHW/Farmer	CBD	Gbenkoni
26.	Richard	Poolot Prim. Sch.	VHW/Teacher	“	Poolot
27.	Laar	c/o Naayiar Prim. Sch.	VHW/Farmer	“	Naayiar
28.	Nuniyent	c/o Bunbuna Prim. Sch.	“	“	Bunbuna
29.	Jakper	c/o Poolot Prim. Sch.	“	“	Tatara
30.	Yaayoo	c/o Naayiar Prim. Sch.	“	“	Naayiapaak
31.	Isaac Naanlan	c/o Paknaatiik JSS	Facilitator/Farmer	“	Paknaatiik
32.	Laar	c/o Namujoak Prim. Sch.	“	“	Namujoak
33.	Malakar	c/o Gbingbani Health Post	“	“	Gbingbani
34.	Laar	c/o Gbankurugu Prim. Sch.	“	“	
35.	Kombian	c/o Kambagu Prim. Sch.	VHW/Farmer	“	Kambagu
36.	Kombat	c/o Naakoruk Prim. Sch.	“	“	Naakoruk
37.	Miikaa	c/o Tambing Prim. Sch.	“	“	Tambing
38.	Momomm	c/o Jiirik Prim. Sch.	“	“	Naakpeuk
39.	Samar	c/o Paknaatiik JSS	Facilitator/Farmer	“	Gbetmung
40.	Yambor	c/o Naaniik Prim. Sch.	“	“	Naaniik
41.	Kantamm	Jagoouk Prim. Sch.	“	“	Jagoouk
42.	Laar	c/o AG Church, Kaauk	“	“	Kaauk
43.	Kombat	c/o Bimbagu JSS	“	“	K’Gberuk
44.	Laar	c/o Zongo JSS, Bunkpurugu	Housewife	“	Bunkpurugu
45.	Tampuri	Zongo Prim. Sch, Bunkpurugu	VHW/Teacher	“	“
46.	Jamajo	c/o Gbankurugu Prim. Sch.	Facilitator/VHW	“	Tooboung
47.	Konlaan	c/o Naaburik JSS	Facilitator/Farmer	“	Naaburik
48.	Wumbila	c/o Bendi JSS		“	Bendi
49.	Gbantong	c/o Jagander Prim. Sch.		“	Jagander

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No.	Name	Address/ House No.	Occupation	Office Designation	Station
50.	Biigoor Laar	c/o Naaburik JSS	Facilitator/Farmer	CBD	
51.	Emmanuel Yenaunam	c/o Tampuut Prim. Sch.	“	“	
52.	Bawanin E. Konlaan	c/o A.G. Church, Tinkpang	“	“	
53.	Peter Saaru	c/o Jiirik Prim. Sch.	“	“	
54.	Joseph Laar	-do-	“	“	
55.	Duut Lambon	c/o A.G. Church, Bufoak	Facilitator/Teacher	“	
56.	Biisoat Daauk	c/o Bamong Prim. Sch.	Facilitator/Farmer	“	
57.	Tinuru Moisomin	c/o A.G. Church, Jiirik	VHW/Farmer	“	
58.	Seidu Lambon	c/o St. Andrews Church, Toojing	Facilitator/Farmer	“	
59.	Jangbiok K. Nelson	c/o Kinkangu JSS	VHW/Farmer	“	
60.	Peter Jabong	c/o Kambatiak JSS	Facilitator/Farmer	“	
61.	Wabik Konlanbik	c/o Tanbona Primary	“	“	
62.	Amos Kwame	c/o Bimbagu JSS	VHW/Farmer	“	
63.	Jakper Konlaan	c/o Kpentaaung Primary	“	“	
64.	Maama Duut	c/oNaaburik Primary	VHW/Facilitator	“	
65.	Yoanu Lanbon	c/o Gbingbaranchet Primary	VHW/Teacher	“	
66.	Yennu Konlaan Damyen	c/o A.G. Church, Kparsouk	“	“	
67.	Kangben Gingaung	c/o Paknaatiik JSS	“	“	
68.	Bimbom David Laar	c/o A.G. Church, Saagbann	VHW/Farmer	“	
69.	Bilugib Gam	c/o Gbingbani Health Post	“	“	
70.	Bigui Suuk	-do-	“	“	

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No.	Name	Address/House No.	Occupation	Office Designation	Station
71.	Soaka	c/o Bunbuna-Boouk Primary	Facilitator/VHW	CBD	Bunbuna
72.	Nangyabit	c/o Bimbagu Prim. Sch.	Facilitator/Teacher	“	Bimbagu
73.	Kombat	c/o Tambing Primary	Facilitator/Farmer	“	Tatara-Nanbont
74.	Yennu	Gbankoni Prim. Sch.	“	“	Sinsabjina
75.	Konlaan	c/o Bunkpurugu JSS	“	“	Toomoni
76.	Malam	c/o Zongo JSS, Bunkpurugu	Facilitator/Teacher	“	Bunkpurugu
77.	Siat	-do-	Housewife	“	“
78.	Acker	Jimbale JSS	VHW/Teacher	“	Jimbale
79.	Jatuat	c/o Kinkangu Primary	Facilitator/Farmer	“	Basarik
80.	Lambon	c/o Paknaatiik JSS	“	“	Sakbauk

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Amasachina CBDs Trained by GSMF in the Northern Region

No.	Name of CBD	District	Community
1.	Memuna Alhassan	Tamale	Tishigu
2.	Sirina Alhassan	"	Jisonayili
3.	Adam Iddrisu	"	Sagnarogi
4.	Alhassan A. Sadic	"	M'Manayili
5.	Saibu Abukari	"	Kukuo
6.	Abukari Y. Z. Chocho	"	Sakasaka
7.	Abdulai Sayibu	"	Taha
8.	Nudu Iddrisu	"	Gimbihini
9.	Sulemana Alidu	"	Kogni
10.	Abubakari W. Alhassan	"	Kanville
11.	Dalchisu Abdulai	"	Tamale
12.	Alhassan Issah	"	Nakpan-Zoo
13.	Amama Sadiq	"	Tamale
14.	Ayishetu Sumani	"	Poloyafung
15.	Rabi Adam	"	Tamale
16.	Zakaria A. Awudu	"	Warizeki
17.	Mahama Azumi	Tolon/Kumbungu	Voggu
18.	Mahama Abiba	"	Tali
19.	Alhassan Abukari	"	Gingani
20.	Iddrisu Z. Iddi	"	Gbullung
21.	Alhassan Issifu	"	Garizegu
22.	Paul Alhassan Issahaku	"	Nwodua
23.	Muazu Abukari	"	Kumbungu
24.	Abdulai Yapalsi	"	Tuunayili
25.	Tahidu Alabira	"	Kumbungu
26.	Abdulai Zakaria	"	Zugu
27.	Abubakari Zakaria	"	Zugu
28.	Osuman Baba	"	Jekpahi
29.	A. A. Seidu	"	Gbrumani
30.	Alhassan Fozia	Tolon/Kumbungu	Tali
31.	Mahama Sanata	"	Dalun
32.	Sumani Asia	"	Kumbungu
33.	Abukari Abiba	"	Nyankpala
34.	Samatu Zakari	Gushegu/Karaga	Gushegu
35.	Yakubu G. Botin-Naa	"	Gushegu
36.	Mahammed D. Sanatu	"	Karaga
37.	Abdulai Adam	"	Pishigu
38.	Abdulai Zakari	"	Kpatinga
39.	Bawa Abdulai	"	Bagli
40.	Alhassan Abubakari	"	Galwei

No.	Name of CBD	District	Community
41.	Halid M. Kooshe	Guakogu/Karaga	Karaga
42.	Abukari Yakubu	“	Taloli
43.	S. Sayibu Ziblun	“	Wawuu
44.	Ayishetu Ibrahim	Yendi	Zugu
45.	Abdulai Sahara	“	Yondi
46.	Muhammed Ayishetu	“	Choo
47.	Abukari Sumani	“	Demen
48.	Yakubu A. Choo	“	Yondi
49.	Abubakari I. Ziblin	“	Adiboo
50.	Abukari Rufai	“	Sunseng
51.	Zakaria Kadiri	“	Ngani
52.	Abdul-Samed Adam	“	Malisari
53.	Mohammed Adams	“	Sambu
54.	Ibrahim Mahama	Savalugu/Nanton	Ziong
55.	Abdulai Osman	“	Savelugu
56.	Abubakari Huseini	“	Nanton
57.	Zaid Ise-Hak	“	Diare
58.	Osman Habeed	“	Gbungbum
59.	Baako Michael Dokurugu	“	Nantonkurigu
60.	Alhassan Dokurugu	“	Charisere
61.	Issah Asara	“	Fazikini
62.	Seidu Abiba	“	Savalugu
63.	Opoku Efia	“	Savalugu
64.	Yakubu Meimunatu	“	Tampion
65.	Musah Gumah	Gambaga	Boaterigu
66.	Muniratu Mahama	“	Gambaga
67.	Baba Sadia	“	Sakogu
68.	Kolugu Mahama	“	Gambaga
69.	Mohammed Issah	“	Gambaga
70.	Karim Mansaligia	“	Gambaga
71.	Alhassan Zakari	“	Gambaga
72.	Muhtaru Mohammed	“	Nyingari
73.	Iddrisu Ali	“	Gambaga
74.	Mohammed Mariama	Bimbilla	Jilo
75.	Salifu Sawaratu	“	Bimbilla
76.	Abdul-Rahimani Awulatu	“	Kpatiki
77.	Jibril Mashud	“	Bakpabi Sugani
78.	Hamsa Braimah Damba	“	Wulensi
79-80.	cut off		

No.	Name of CBD	District	Community
81.	Ibrahim Ramatu	Zabzugu/Tatale	Zabzugu
82.	Sefah A. Leticia	“	Tatale
83.	Alhassan Fulera	“	Sabali
84.	Mahamadu Adam	“	Sheini
85.	Mutaru Issahak	“	Korle
86.	Sulemana Mohammed	“	Zabzugu
87.	Mahama Issah	“	Tatindoo
88.	Meinuna Alidu	Salaga	Kpemba
89.	Iddisah M. Seidu	“	Sisipe
90.	Seidu Moses	“	Kalande
91.	Shahadu Yussif Baba	“	Salaga
92.	Mamdu Muntankilu	“	Salaga
93.	Mumuni Seidu	“	Masaka
94.	Jackson T. Yamdow	Walewale	Wungu
95.	Bugzua Majida	“	Tinguri
96.	Musah Sugri	“	Kpasinkpe
97.	Adam Iddirisu	“	Kubori
98.	Samata Saaka	“	Sanga
99.	Sumani Ayishetu	“	Walewale
100.	Asani Mary	Damongo	Damongo
101.	Mary Iddi	“	Yapei
102.	Amama Aub	“	Daboya
103.	Albert Iddisah	Bole	Sawla
104.	Isaac Adams	“	Sanyeri
105.	Abudu Soale	“	Sawla

List of Recruited CBDs for Training - 1994

Zone	Name	Sex	Age	Qualification	Community
1	Emelia Ayorkor	F	43	MSLC	Danfa
1	Robert Kwame Oclo	M	36	MSLC	Ayimensah
1	Jonas Otutey	M	31	MSLC	Pantang
2	Alfred Abbey	M	40	MSLC	Amamorley
2	Felicia Quartey	F	24	MSLC	Pokuase
2	Eugenia Dwamena	F	42	MSLC	Agric Qts.
3	Veronica Gaglo	F	22	MSLC	Kotoku
3	Moses Wodopey	M	24	MSLC	Agortikope
3	Matthew K. Ahorli	M	24	MSLC	Akotoshie
4	Daniel Allotey	M	33	Teacher	Akweiman
4	Sarah Oblie	F	25	JSS (3)	Kojo Ashong
4	Grace Tetteh	F	24	JSS (3)	Onobie
5	Sarah Sackey	F	32	MSLC	Domiabra
5	Rose Gblonyeru	F	30	MSLC	Hobor
5	Philip Nii Amatey	M	44	Teacher	Danchira
6	Evans Adom	M	34	Teacher	Oblogo
6	Beatrice Odoi	F	37	MSLC	Anyaah
6	Florence Gbeyo	F	31	MSLC	Tettegu New Town
7	Faustina Addo	F	27	MSLC	Dome
7	Margaret Ankrah	F	45	MSLC	Achimota
7	Samuel Anie-Amoah	M	36	Teacher	Taifa
9	Nancy nettey	F	32	MSLC	Mayera
9	Doris Amaah	F	32	MSLC	Korleman
9	Benjamin A. Okai	M	32	MSLC	Odumase
10	Malwine A. Dzekoe	F	34	MSLC	Abehenease
10	Grace Clottey	F	41	Nurse	Amasaman
10	Harrison Addo	M	43	MSLC	Pobiman
11	Emanuel Otchere	M	37	MSLC	Kwashiekuma
11	Nancy Adegbey	F	32	MSLC	Ayikaidoblo
11	Mary Aryee Arku	F	26	MSLC	Manhean
5	Agnes Boamah	F	45	MSLC	Odupong-Ofankor
5	Philomina P. Solomon	F	27	TBA	Odupong-Ofankor

IAE CBDs
Upper East Region
Bolgatanga, Kasana-Nankane, Bongo District

No.	Name	Community	Sex	District
1.	Peter B. Nagaalah	Sabovo/Chiana	M	Kasena - Nankane
2.	Faustina A. Ayomah	Iankuma/Bundun	F	"
3.	Victoria Abobiya	Janania/Yunania Gaani	F	"
4.	Jackson Amoah	Nayina/Kologu	M	"
5.	Patrick Lugunia	Paga/Nakolo	M	"
6.	Alfred Yoroyire	Sakunia/Manyor	M	"
7.	Vincent A. Nyaaba	Naaga	M	"
8.	Mustapha Mohammed	Paga-Kakungu/Niwia	M	"
9.	Bridget Atongo	Sirigu Basengo Amena	F	"
10.	Raphael Adeyija	Paga-Zehgu	M	"
11.	David Atanga	Wingoko/Apesokobiisi	M	Bolgatanga
12.	George Alebeinaba	Sumbrumgu - Kulbia	M	"
13.	Daniel B. Yimbila	Yameriga	M	"
14.	Atanga Bismark	Zaare Arutobie	M	"
15.	Joseph A. Anabila	Dulugu	M	"
16.	Adongo Siddik	Yorogo/Atiabis	M	"
17.	John K. Anaffo	Pelungu	M	"
18.	Georgina Ayamga	Zuarungu/Azemabisi	F	Bongo
19.	Lydia Damolubon	Sekoti/Namoranteng	F	Bolgatanga
20.	Leticia Ayeo	Zaare Avonbiss	F	"
21.	Margaret Wane	Kazuli/Navio	F	Kasena - Nankane
22.	Baaba Agatone	Bongo	F	Bongo
23.	Rudolf Akolgo	Bongo	M	"
24.	Rudolf Akolgo	Bongo	M	"
25.	Matthew Atenga	Bongo Soe	M	"
26.	Cecilia Mba	Dua	F	"
27.	Grace Abileo	Gowrie	F	"
28.	Sabastian Ayaviga	Namon	M	"
29.	Roger Awine	Balungu	M	"
30.	Andrew Asingu	Zarko/Vea	M	"
31.	Ben Akuina	Beo	F	"
32.	Paulina Zahaga	Basre	F	"

IAE CBDs
Upper East Region
Bolgatanga, Kasana-Nankane, Bongo District

No.	Name	Community	District	Sex
1.	Juana Alfred		Wa	M
2.	Galmah Mary	Nadowli	Nadowli	F
3.	Dabuo Martin	Ullo	Jirapa	M
4.	Dand-Meh Mary-Grace			F
5.	Edward Nikpe			M
6.	Cecilia Yuoni	Jirapa	Jirapa	F
7.	Mary M. Kangpi	Jirapa	Jirapa	F
8.	Uloo Damino K.	Hain-Chepuri	Jirapa	F
9.	Emmanuel Saadie		Jirapa	M
10.	Mrs. Monica Naah	Wa	Wa	F
11.	James Ngimenbon	Lasia Tuolu	Wa	M
12.	Philip Daara Nabile	Takpo		M
13.	Sulley Tagali			
14.	Dapilah James Nortah	Nanvilli	Wa	M
15.	Charles Nyekore	Sombo	Nadowli	M
16.	Thomas Gbare	Sabuli	Jirapa	M
17.	Hans K. Ballans		Nadowli	M
18.	Ajara Kawuribi	Wa	Wa	F
19.	Gerald Kanso	Jeffiri	Jirapa	M
20.	Mengu Suman		Wa	M
21.	Kwabena Torcher	Nadowli	Nadowli	M
22.	Emmanuel Tiher	Charie	Wa	M
23.	Peter K. Sumabe	Kparisaga	Wa	M
24.	Gabriella Tabie	Kaleo	Nadowli	F
25.	Fidelis Tengan			M
26.	Clarissa Galyvon	Jirapa	Jirapa	F
27.	Mahama Darimani	Wa	Wa	M
28.	Daniel Dumah		Wa	M
29.	Lucianus Mavayiri	Charikpong	Nadowli	M
30.	Tandow Abuduki		Wa	M
31.	Ignatus Badong	Kunchene	Jirapa	M
32.	Mary Assunta Dakora	Wkpong	Jirapa	M
33.	Gregory Yelsory	Daffiama	Nadowli	M

IAE CBDs
Volta Region

No.	Name	Community	Sex	District
1.	Dekpor K. Gilbert	Devego	M	Keta
2.	Avissey A. Victoria	Agbogbome	F	“
3.	Gbafa Seth	Agornesah	M	“
4.	Kwetey Michael	Agbozume	M	“
5.	Ahiabli A. Alice	Adina	F	“
6.	Mary Dorgbettor	Ehi	F	“
7.	Shiki D. K. Martin	Korfeyia	M	“
8.	Victoria Lewu	Vakpo-dunyo	F	Kpando
9.	Gbadagba Janet	Botoku	F	“
10.	Ellen Appiah	Pei-Dzozbati	F	“
11.	Ruth Ntsutse	Avema-Dzeme	F	“
12.	Gerhard Dikyi K.	Gbefi Tornu	M	“
13.	Augustine Ametefe	Kpando Dzizbe	F	“
14.	Fosua Rosina	Dzemni	F	“
15.	Emmanuel O. Nyarko	Kaira	M	“
16.	Samuel Okota	Toh Kpalime	M	“
17.	Nene Woamku-Woaku	Kpetoe	M	Ho
18.	Boateng A. Sitsofe	Abutia-Kloe	F	“
19.	Tefe Elesie	Abutia Tefi	F	“
20.	Akpaloo F. K. Thomas	Ho New Zongo	M	“
21.	Agbleeze V. K. Henry	Anfoeta Gbogame	M	Ho
22.	Dzradowosi Forson	Avenvi	M	“
23.	Agbeko Steven	Matse	M	“
24.	Foli Kumah Godwin	Anyirawase	M	“
25.	Togbe Kpodedzi	Adajky-Waya	M	“
26.	Geophery Kleh	Adaklu-Tsrefe	M	“
27.	Irene Awude	Klefe	F	“
28.	Benjamin Afakozi	Tanyigbe	M	“
29.	Ben Kumah	Taviefe Aviefe	M	“
30.	Juliana Abiwei	Sokode Bagble	F	“
31.	Mathias Kumah	Adaklu-Ahunta	M	“
32.	Ayim Emmanuel	Wegbedzi	M	“

List of CBD Agents
Brong-Ahafo
Wenchi District

Name of Agent	Sex	Year of Training	Community	Remarks
Addai	F	1991	Tromeso	Active
Drobo	M	"	Drobo	Active
Kfena	M	"	Aveasu	Active
Kru?	M	"	Awisa	Active
Joseph	M	"	Buoku	Active
Patrick	M	"	Subinia	Active
Okrah?	M	"	Kokoago	Inactive
K. Opoku	M	"	Mframaso	Active
Eliia Osei	M	"	Akrobi	Inactive
Bour	M	"	Akete	Active
Boadu	F	1992	Nchiraa	Active
Meyaw?	M	"	Subinso (II)	Active
Boasiako?	M	"	Offuman	Active
Peter Kwasi	M	"	Branam	Active
Nsiah	M	"	Mansie	Active
Badu Yaw	M	1995	Amponsakrom	Active
Seidu		1995	Taiso	Active
Agyen		"	Gensoso	Active
Techiman District				
Achiaa	F	1991	Tuobodom	Active
Boahene	M	"	Akrofrom	Active
Ameyaa	F	1992	Buoyem	Active
Obeng	F	"	Bamire	Active
Stephen	M	"	Nkwaeso	Active
Danquah	F	"	Nsuta	Active
Kumi		"	Mangoase	Active
Kwaku Collins	M	"	Techiman	Active
Simon	M	"	Bonkwae	Active
Opoku Boahene	M	"	Aworowa	Active
Adu Kusi	M	"	Forikrom	Active
Appiah	M	"	Techiman	Active
Sunyani District				
Baffour Awuah	M	1992	Susuanso	Active
Boakye	F	"	Afrisipakrom	Active

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List of CBD Agents
Brong-Ahafo
Wenchi District

Name of Agent	Sex	Year of Training	Community	Remarks
Alfred	M	"	Yamfo	Active
Boateng	M	"	Techire	Active
Asamoah	M	"	Adrobaa	Active
Asantewaa	F	"	Fiapre	Active
Sarmoah	M	"	Nsoatre	Active
Maxwell	M	"	Odumasi	Active
Abubakari	M	1995	Zongo	Inactive
Mohammed	F	"	Zongo	Active
Abdulai	F	"	Zongo	Inactive
Farouk	M	"	Ahyiamu	Active
Kyeremeh?	F	"	Abesim	Active
Gordon	M	"	Chiraa	Active
Elija	M	"	Kobedi	Active
Amoah?	F	"	Kwatire	Active
Kwaa	F	"	Mantukwa	Active
Mensah	M	"	Domasua	Active
Kwame Adu	M	"	Yawhima	Active
Afi?	M	"	Kotokrom	Active
Boah?	M	"	Adantia	Active
Baffour	M	"	Atronie	Active
Tano				
Iddrisu	M	1995	Boaso	Active
Owusu	F	"	Mansin	Active
Adubea	F	"	D/Nkwanta	Active
Asante	F	"	D/Nkwanta	Active
Agyemang		"	Dwomo	Active
Appiah A.	M	"	Susuanho	Active
Awiah?	F	"	Subinso	Active
Agyemang A.	F	"	Bourkrukruwa	Active
Kwasi Darkwa	M	"	Adum (Bechem)	Active
Kwarteng	F	"	Community Centre (Bechem)	Active
Nkoranza				
Clovis	M	1995	Krumu Dromankese	Active
Issifu	M	"	Zongo/Dromankese	Active
Mponsa?	F	"	Dromankese	Active
Asante Mensah	M	"	Betoda	Active

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Planned Parenthood Association of Ghana
Western Region Branch
Profile of CBD Agents by District and Locations
Nzema District

No.	Name	Year of Training	District	Community	Age	Sex	Education Background	Occupation
1.	Alex Donkeh	1991	Nzema	Esiama	41	M	MSLC	Chemical Seller
2.	Pauline Mensah	1988	"	Nuba	45	F	"	Farmer
3.	Albertina Kaiyeng	1988	"	Abura	45	F	"	Nurse
4.	Wilson Cobbinah	1992	"	Asanta	35	M	"	Farmer
5.	Joana Abore	1994	"	Awiebo	43	F	"	"
6.	Veronica Esi Davies	"	"	Alabokaso	29	F	"	"
7.	Elisabeth Assafuah	"	"	Berewire	38	F	"	Fishmonger
8.	Shaibu Abdulai	"	"	Kamabunli	32	M	"	Drug Seller
9.	Mary Dickson	"	"	Kikam	42	F	"	Teacher
10.	Morkeh Menlaba	"	"	New Nzulezo	37	M	"	Farmer
11.	Mary Solomon	"	"	WTI (AXIM)	41	F	"	Teacher
12.	Sarpong Williams	"	"	Menzezor	36	M	BA degree	Tutor/Chemical Seller
13.	Ismaila Hagan	"	"	Nyame Bekyere	45	M	MSLC	Farmer
Wassa West District								
14.	Peter K. Minnah	1994	Wassa West	Essamang/Nsuaem	38	M	"O" Level	Teacher
15.	Samuel K. Hayford	"	"	Tamso	39	M	"	Technical ?
16.	Agnes Kwesie	"	"	Atwereboanda	35	F	MSLC	Farmer
17.	Mary N. Asafuah	"	"	Samanadze/Ekutuase	34	F	"	Trader
18.	Theresah Kwofie	"	"	Nsemafokrom	35	F	"	"
19.	Jemima N. Quaidco	"	"	Fanti Mines	32	F	"	"

20.	Daniel Tulashie	"	"	Rogoso	40	M	"O" Level	Clerk
21.	Allan N. Gyimah	"	"	Sankyem	29	M	MSLC	Farmer

Planned Parenthood Association of Ghana
Western Region Branch
Profile of CBD Agents by District and Locations
Wassa West District

No.	Name	Year of Training	District	Community	Age	Sex	Education Background	Occupation
22.	Anthony Nyamson	"	"	Simpa Pepesa	45	M	"	"
23.	Anthony K. Asare	"	"	Teberebe	41	M	"O" Level	Teacher
24.	Alex Oboh	"	"	Huni-Valley	41	M	"	Clerk
25.	Stephen M. Djan	"	"	Damang/Mahuntam	28	M	MSLC	Trader
26.	John Ashon	1992	"	Nsuta	32	M	City & Guilds	Technical ?
27.	Frank Amo	"	"	Samahu	21	M	MSLC	Farmer
28.	F.W. Atakora	"	"	Bonsaso	43	M	"	"
29.	J.R. Essien	"	"	Agona Wassa	38	M	"	"
30.	John Amoako	"	"	Bompieso	38	M	"	"
31.	Lydia Norman	1994	"	Kadawen	28	F	"	"
32.	George Lee Mensah	1984	"	Prestea	46	M	"O" Level	Educator ?
33.	K. Afrifa	1984	"	Aba Tarkwa	46	M	"	Pharmacist ?
34.	Samson Carrie	1994	Wassa East	Domenase	38	M	"O" Level	Teacher
35.	Ignatius K. Andoh	"	"	Obra Ye Bona	29	M	"	Farmer
36.	John Bessman	"	"	Edum Trebuom	39	M	MSLC	"
37.	Sarah Mensah	1992	"	Edum Banso	25	F	"	"
38.	Robert Afanyi	1992	"	Aboaboso	34	M	"	"

Wassa East District

No.	Name	Year of Training	District	Community	Age	Sex	Education Background	Occupation
39.	Alex Darfour	"	"	Adansi	33	M	"	"
40.	Peter Nkrumah	"	"	Domama	29	M	"	"
41.	Cecilia Doe	"	"	Anyinabirim	45	F	"	Teacher
42.	Comfort Mensah	"	"	Sekyere Hemang	29	F	"	Farmer
43.	Peggy Amoah	"	"	Akutuase	33	F	"	"
44.	Sherry Adjai	"	"	Kwabaa	28	F	"	"
45.	Mary Edukorang	"	"	Sekyere Krobo	28	F	"	"
46.	Margaret Amponsah	"	"	Sekyere Wsuta	31	F	"	"
47.	Veronica Darko	"	"	Atooiase	28	F	"	"
48.	Rita Essoun	"	"	Adiembra	29	F	"	"
49.	E.G. Assan	"	"	Aboradzewuram	33	M	"	"
50.	Bernard Tawiah	"	"	Essamang	32	M	"	"
51.	Christopher Aidoo	"	"	Senchem	42	M	"	"
52.	Emmanuel Gigabah	"	"	Jerusalem	40	M	"	Native Doctor ?
53.	Thomas F. Asante	1992	Wassa East	Daboase Town	31	M	"A" Level	Liaison
54.	Janet Azalu	"	"	Nkapiem	35	F	MSLC	Farmer
55.	Daniel Gezele	1988	"	Daboase Water Works	38	M	City & Guilds	Technic ?
56.	J.K. Ankomah	"	"	Mpohor	35	M	MSLC	Field ?
57.	I.K. Mensah	1984	"	Pretsea	50	M	"O" Level	Police Inspector

Ahanta East District

No.	Name	Year of Training	District	Community	Age	Sex	Education Background	Occupation
58.	Yamoah Pieterson	"	Ahanta East	Esikafoambantem	45	M	"O" Level	Chemical ?
59.	S.K. Sarponz	"	"	Naval Base	50	M	"	Naval Personnel ?
60.	W.O. Incoom	"	"	Air Force	50	M	"	Army Personnel ?
61.	Paul Yankey	"	"	Esikado	30	M	MSLC	Chemical Seller ?
62.	J.K. Addo	"	"	Cocoa Products	46	M	City & Guilds/"O" Level	Technical ?
63.	S.A. Hayzel	"	"	Rlv Tr. School	42	M	"	Clerical
64.	Charles Thompson	"	"	Adiembra	40	M	City & Guilds	Mechanic
65.	Moses Dzokoto	"	"	Railway Station	42	M	"O" Level	Administrator ?
66.	M.K. Eshun	1988	"	Effia - Kuma New State	45	M	"	Chemical Seller ?
67.	J.A. Bosomtui	"	"	Kojokrom	50	M	MSLC	Artisan
68.	Osei Boakye	1988	Ahanta East	Nkotompo Lower	44	M	"O" Level	Chemical Seller
69.	E.K. Annan	"	"	Nkotompo Lower	48	M	MSLC	Tradiitonal Healer
70.	Mary Johnfiah	"	"	PCC	40	F	"	Production Assist.
71.	Christina Payne	"	"	Esikafoambantem No. 2	50	F	"	Businesswoman
72.	Peter Obeng	"	"	Ngyriresia	37	M	"	Chemical Seller

Ahanta East District

No.	Name	Year of Training	District	Community	Age	Sex	Education Background	Occupation
73.	Florence Twinto	1991	"	Komfoeku	26	F	"	Seamstress
74.	Mark Arthur	"	"	Assorku-Essamang	37	M	"	Clerk
75.	Regina Payinyena	"	"	Bakado	33	F	"	Chemical Seller
76.	Charity Bwool	"	"	Abuesi	40	F	"	Ward Assistant
77.	Susuana Salvo	"	"	Apremdu	35	F	"	Trader
78.	John Eshun	"	"	Anaji Village	37	M	"	Technician
79.	Paul Kumah	"	"	Kansaworadu	34	M	"	Fish Farmer
80.	Martin Daatse	"	"	Inchaban	35	M	"	Technician
81.	John Quayson	"	"	Ketan	39	M	"	"
82.	Emelia Parker*	"	"	Apowa		F	"	Trader
83.	Elizabeth Dadzie	1992	"	Effia	30	F	"	"
84.	Cecilia Donkoh	"	"	Tanokrom	42	F	"	Field Assistant
85.	Dorcia Acheamborg	"	"	Anto	33	F	"	Farmer
86.	Kate Arthur	1992	Ahanta East	Botodwena	38	F	MSLC	TBA
87.	Cecilia Essel	"	"	Dompim No. 1	35	F	"	Farmer
88.	Howard Ansah	"	"	European Town	45	M	"O" Level	Clerical Officer
89.	Cecilia Tabiri	"	"	Manso	36	F	MSLC	Ward ?
90.	Doris Eshun	"	"	Mpintsin	30	F	"O" Level	Farmer
91.	D.K. Sropenyo	1994	"	Adakope	38	M	MSLC	Army ?
92.	Isaac N. Entsie	"	"	Fijai	29	M	"	Salesman
93.	Grace Anumel	"	"	New Takoradi	31	F	"	Trader

* Deceased

Ahanta East District

No.	Name	Year of Training	District	Community	Age	Sex	Education Background	Occupation
94.	Robert Ackon	"	"	Atwereboanda/ Beposo	30	M	"	Farmer
95.	Paul Arthur	"	"	Dunkwa/Beposo	36	M	"	"
96.	Paul Enimil	"	"	Nkwantakese	30	M	"	"
97.	Frank J. Andoh	"	"	Sofokrom	38	M	"O" Level	Teacher
98.	John Dadzie	"	"	Dwomo	38	M	MSLC	Farmer
99.	Isaac Eshun	"	"	Asakai	44	M	"	Chemical Seller ?
100.	Elizabeth Mensah	"	"	Lagos Town	46	F	"	Trader
101.	Janet Cobbina	"	"	Ntankoful	26	F	"	Chemical Seller ?
102.	Elizabeth Agbodzi	"	"	Kwabena Anokrom	38	F	"	Farmer
103.	Anna Cudjoe	"	"	Butumajebu	40	F	"	Housewife ?
104.	R.E. Fynn	"	"	Beposo	38	M	"	Chemical Seller ?
105.	Agatha Quayson	"	"	Abaesi?	33	F	"	Fishmonger ?
106.	Collins E. Osei	1984	Ahanta East	Esikafoambantem No. 3	32	M	"O" Level	Execut ?
107.	Sophia Quarcoe	"	"	Nyamkrom	41	F	MSLC	Housewife
108.	Lucy Adzizbli	"	"	Old Hospital	46	F	"O" Level	Nurse
109.	Phyllis I. Leeward	"	"	Anaji Estate	25	F	MSLC	Trader
110.	Rv. Fr. C.H. Holdbrooke	"	"	Liberation Road	40	M	"O" Level	Priest

Ahanta West District

No.	Name	Year of Training	District	Community	Age	Sex	Education Background	Occupation
111.	Kaizer	1984	Ahanta West	Sankor	36	M	MSLC	Farmer
112.	John Quayson	1991	"	Akatankyi	38	M	"	"
113.	Moses koomson	"	"	Eyyam	32	M	"	Ward ?
114.	Pieterson Quayson	"	"	Bunsokrom	35	M	"	Farmer
115.	Sarah Andoh	"	"	Beahu	50	F	"	"
116.	Jospeh Bordoh	1992	"	Kanfokrom	35	M	"	"
117.	James Wallace	"	"	Whindo	38	M	"	"
118.	Kingsford B. Cudjoe	"	"	Nsueam	39	M	"	"
119.	Johnson K. Torwodzo	1994	"	Awonakrom	39	M	"	Teacher
120.	Philip Ansah	"	"	Dixcove	35	M	"	Chemical Seller ?
121.	Stephen Quarm	"	"	Hotopo	30	M	"	Farmer
122.	Lucy Bunyan	"	"	Busua	33	F	"	Trader
123.	Hafsatu Yakuba	"	"	Funkoe	38	M	"	"
124.	Sophia Benyah	"	"	Ewusayo	35	M	"	Farmer
125.	Margaret Aso	1984	Juabeso Bia	Sefwi Bonzain	42	F	MSLC	?
126.	Susuana Saben	"	"	"	45	"	"	?

Parenthood
FEDERATION

P O Box 5756, Accra-Ghana
Tel 021-224101

FROM Zonal Manager

TO Executive Director

SUBJECT . PROFILE OF GREATER ACCRA/IP POSIVA AREAS CBD AGENTS

DATE 18th March, 1996

I submit the profile of CBD Agents within the Greater Accra/IP and Posiva areas for your perusal

Thank you.

Ayawaso (Sub-district) Apenkwa
Emma Adamafio

Name	Year of Training	Age	Sex	Educational Background	Occupation	Community	Remarks
Patience Holloman	1991	45	F	MSLC	Trader	Apenkwa	
Christiana Affanyi	1994	32	F	"	"	Alajo	
Comfort Botwe	"	45	F	"	"	"	
Peggy Nortey	"	47	F	"	"	"	
? Gyamfi	"	30	M	"	"	"	
Janet Doku	"	29	F	"	"	"	
Sarah Tetteh	"	30	F	"	"	"	
Vincent Artiso	"	47	M	"O" Level	Poultry Farmer	Alogloshie	
Martha Azu	1992	41	F	MSLC	Trader	Dome	
Andalatu Sanni	1994	29	F	Commercial	"	"	
David Teiko Coleman	"	30	M	Technical	Auto Technician	"	
Lord Nii Otoo	"	41	M	RSA	Adm. Assist.	Tesano	
Charity Dorning	"	29	F	MSLC	Trader	Achimota	
Maxwell Diaba	"	30	M	"O" Level	Artisan	Achimota	
Mustapha Quarshie	"	31	M	"O" Level	Trader	Nima	
Isaac Tackie	1991	47	M	MSLC	Farmer	Bortianor	
Nathaniel Amui	1991	41	M	MSLC	Farmer	Bortianor	
George Agbeyaku	?	31	F	"O" Level Cert. A	Teacher	Oblogo	
Esther Sackey	1991	31	F	MSLC	Nursery Attendant	Weija	
Margaret Quartey	1992	37	F	"	Trader	Gbawe	
Gibiren Amadu	1994	28	M	Technical	Auto Mech.	Mallam	
Massaudu Abdul Salsu	1994	37	M	"O" Level	Painter	Mallam	
Gladys Quartey	1992	41	F	MSLC	Trader	Gbawi	

Name	Year of Training	Age	Sex	Educational Background	Occupation	Community	Remarks
Osman Moro Fukuyama	1991	37	M	RSA II	Accounts Officer	Darkuman/Fadama	
Joseph Allotey	1991	36	M	MSLC	Technician	Odorkor	
Rexford E. Quayefio	1992	46	M	MSLC	Boot Collector	Darkuman	
Kenneth Armah	1992	40	M	GCE "O" & "A"	Agriculturalist	Ashifla (Ga)	
Sarah Nortey	1994	48	F	Polytechnic	Caterer	Anyan	
George Akakposu	1992	36	M	MSLC	National M. Prog.	Kasunya	
Thomas Boduah	"	36	M	"A" Level	Teacher/ Insurance Counselor	Avakpo	
Daniel Fuafo	"	45	M	MSLC	Farmer	Kortorkor	
Esther Osei	1994	33	F	MSLC	"	Duffor	
Francisca Ahoto	1992	28	F	MSLC	Nursery Attendant	Tokpo	
Angela Ahoto	1994	32	F	Secondary F. 2	Trader	Dzorkpo	
Theophilus Daliku	1992	32	M	MSLC	Farmer	Dormelian	
Joseph Agbeko	1994	37	M	"O" Level	"	Abgekotsekpo	
Roger N. Nartey	1994	35	M			Afienya	
Solomon Tetteh Amahortey	"	3629	M	MSLC	Farmer	Lorlorvor	
Benedicta Nartey	"	29	F	"	Seamstress	Kpane	
Janet Kwablah	"	30	F	"O" Level	Trader	Ayikumah	
Faustina Anim	"	26	F	"	Trader	Kordiabe	
Joyce Agawu	"	28	F	"	Nursery Teacher	Doryumu	
William Kwesi Tetteh	"	26	M	"	Farmer	Dodowa New Town	
Edith Ablah Dodebo	"	47	F	"	Trader	Dodwa Upper Town	
Emmanuel Mensah-Bio	"	33	M	"	Farmer	Dodowa Lower Town	
Elizabeth K. Ekudo	"	35	F	MSLC	Trader	Luom	

Dangbe East
Grace Mensah

Name	Year of Training	Age	Sex	Educational Background	Occupation	Community	Remarks
Olivia Aku Fofoe	1994	35	F	Post Sec.	Teaching	Ada Foah	
Felicia Kudayo	"	52	F	MSLC	Trader	Big Ada	
Emmanuel Kweitsu	"	27	M	"	Health Worker	Dawa	
Humphrey Anim Amarnor	"	29	M	"	Trader	Kolwedor ?	
Martha Anumabley	"	26	F	"	Seamstress	Sege	

Dangbe West
Grace Mensah

Name	Year of Training	Age	Sex	Educational Background	Occupation	Community	Remarks
J.B. Buenor	1994	40	M	MSLC	Farmer	Osuwem	
Mary Ametordzi	"	41	F	"	Farmer	Congo	
Stephen Lomotey	"	33	M	"	Farmer	Jerusalem	
Rebecca Dzikunu	1991	36	F	"	Seamstress	Astuare	
Victoria Teye	1992	25	F	MSLC/RSA I	Storekeeper	Osuwem	
Nelson Nartey	1994	41	M	"O" Level	Farmer	Teikwam	
Gabriel Tetteh	"	42	M	MSLC	Farmer	Nafaku	

Ga (Mashina)
Mrs. Fredrica Ouarshie

Name	Year of Training	Age	Sex	Educational Background	Occupation	Community	Remarks
Veronica Ashoe	1994	24	F	MSLC	Ward Assistant	Madina	
Yaw Nelson Nutekpor	"	37	M	Sec. Form 4	Driver	"	
Rebecca Adams	"	31	F	MSLC	Trader	Oyarifa	
Gloria Tsakley	"	29	F	"	"	"	
Mabel Twumasi	"	25	F	"	"	Accra New Town	

? Municipal (Ashaima)
Emma Adamafio

Name	Year of Training	Age	Sex	Educational Background	Occupation	Community	Remarks
Grace Lily Amanor	1994	36	F	MSLC	Teacher	New Ningo	
Francis Martey	"	30	M	"	Health Worker	Dahwenya	
Felicia Nyavor	"	36	F	"	Trader/TRA	"	
Vida Tsah	1992	39	F	"	Enrolled Nurse	Ashaiman	
Peace Saka	"	29	F	"	Lotto Receiver	"	
Matthew Shine K. Aglago	"	41	M	"	Admin. Assist.	"	
Isaac Anthony Doe	"	27	M	"O" Level	Kente Weaver	"	
Dorcas Amartey	1994	24	F	MSLC	Factory Hand	Kpong	
Grace Odoi	"	40	F	"	Trader	"	
Daniel Awer	"	33	M	Technical Sch.	Elec. Technician	Tema Sanyo	
Carolina Gorkah	1992	28	F	Dip. Journalism	Journalist	Tema - Gratis	
Ggrace Laryea Okoe	"	43	F	MSLC	Nursery Attendant	Tema Manhean	

AMA (Ablekuma Sub-district & Ashiedu Keteke)
Fredrica Quarshie

Name	Year of Training	Age	Sex	Educational Background	Occupation	Community	Remarks
Agnes Frances	1991	43	F	MSLC	Trader	Chorkor	
Marian Donkor	"	3039	F	Post Sec	Teacher	Chorkor	
Mary Mensah	"	33	F	MSLC	Hairdresser	Chorkor	
Paulina Adjei	1992	39	F	Sec. From 4 Vocational	"	Chorkor Alomo Junction	
Sarah Amoo	"	33	F	MSLC	Trader	Chorkor	
Gladys Mintah	"	48	F	"	"	Chorkor (Chemuna)	
Doris Annan	"	33	F	"	"	Sukula/Russia	
Eva Allotey	"	45	F	Primary Level	"	"	
Solomon Neequaye	1991	27	M	MSLC	Carpenter	Bukom	
Henry Amarteifio	"	29	M	"	Tailor	Bukom - Gbese	
Michael Amihere	1992	33	M	"	"	Sempe	

Kpeshie (Sub-District) Teshie
Fredrica Quarshie

Name	Year of Training	Age	Sex	Educational Background	Occupation	Community	Remarks
Mary Ablorb	1994	38	F	MSLC	Trader	Teshie	
Edward Adjei Okoe	“	40	FM	“	Carpenter	“	
Joseph L.A. Quaye	“	30	M	“	Artisan	“	
Mary Anyetei	“	45	F	“	Trader	“	
Seth Odenteh	“	36	M	“	Artisan	Nungua	
Emma Bortequaye	“	32	F	Primary Level	Trader	“	

Ga
Fredrica Quarshie

Name	Year of Training	Age	Sex	Educational Background	Occupation	Community	Remarks
Gladys Anamoah	1991	40	F	Commer. Sch.	Chemical Seller	Pokuase	
Amponsah Dodoo	1992	43	M	MSLC	Trader	“	
Emmanuel Armah Ofori	“	43	MM	“	Clinic Attendant	Mayera	
William Mfaafo	“	46	M	“	Farmer	Adusa	
Felix Darkey	“	33	M	“	Farmer	Demeiman	
Simon Tetteh	1991	27	M	“	Nursery Teacher	Katapor	
Daniel Sabbah	“	30	M	“	Nursery Teacher	“	
Victoria Djanor	1994	47	F	“	Housewife	Ofankor	
Edward Quaye	“	39	M	“	Poultry Farmer	Amasaman	

Community Based Distributing Agents' Profile - Greater Accra
District: Awutu - Effutu - Senya and Gomoa
Supervisor: Juliana Vanderpuye

No.	Name	Year of Training	Age	Sex	Educational Background	Occupation	Community	Remarks
1.	Vera Quaye	1989	36	F	MSLC	Trader	Ahintia	
2.	Rebecca Gyan	"	36	F	"	Farmer/Trader	Kwame Etteh	
3.	Samual Lakonam	1993	34	M	"	Farmer	Looye	
4.	Kwame Haruna	1995	32	M	"	Farmer	Kemur	
5.	Albert Mensah Odoom	1994	37	M	"	Driver/Trader	Fetteh Kakrebah	
6.	Agnes Otchere	"	38	F	"	Trader	Bududuram	
7.	Daniel Osseku Botchway	1995	31	M	"	Electrician	Awutu	
8.	Raymond Parbie	"	29	M	"	Mason	"	
9.	Christiana Mills	"	43	F	"	Nursery Teacher/Trader	"	
10.	Cecilia Aidoo	1993	42	F	"	Farmer/Trader	"	
11.	Matthew Sankofie	"	44	F	"	Farmer	"	

District: Awutu - Effutu - Senya
Supervisor: Agnes Gyekye Aboagye

No.	Name	Year of Training	Age	Sex	Educational Background	Occupation	Community	Remarks
12.	Richard Amoah	1995	36	M	MSLC	Farmer	Kwesi Budu	
13.	John Edu	"	48	M	"	Farmer	Kojo Ashong	
14.	Christiana Mensah	"	41	F	"	Trader/Farmer	Mfafo	
15.	Robert Artin	"	46	M	"	Farmer	"	
16.	Paul Okine	"	37	M	"	"	Ahintia No. 1	
17.	John Okai	"	34	M	"	"	Asubo	
18.	Charles Teih	"	39	M	"	Farmer/Teacher	Akuauku	
19.	Kofi Awudor	"	31	M	"	Farmer	Nkwadum	
20.	Mallam Anto Seidu	"	54	M	"	Farmer/Teacher	Bontrase	
21.	Joseph Anderson	"	39	M	"	Farmer	Akroma	
22.	Stephen Adawu		38	M	"	"	Kwame Quaye	replaced the Agent who died 1995
23.	Augustiana Abbey	1994	32	M	"	"	Akubrifa	
24.	Paul Dedzie	"	42	M	"	"	Olotom	
25.	Joseph Tettey	"	43	M	"	"	Kwei	
26.	Hannah Abbe-quaye	1989	60	F	"	Day N. Teacher	Bontrase	
27.	Agnes Sarfo	1992/3	40	F	"	"	"	
28.	Esther Sam	1993	43	F	"	"	"	

P O Box 500, Koforidua, Eastern Region
Tel 081-2362

FROM PROGRAMME CO-ORDINATOR | MEMO No.

TO EXECUTIVE DIRECTOR | COMMENTS

SUBJECT CBD AGENTS PROFILE DATE 19/3/96

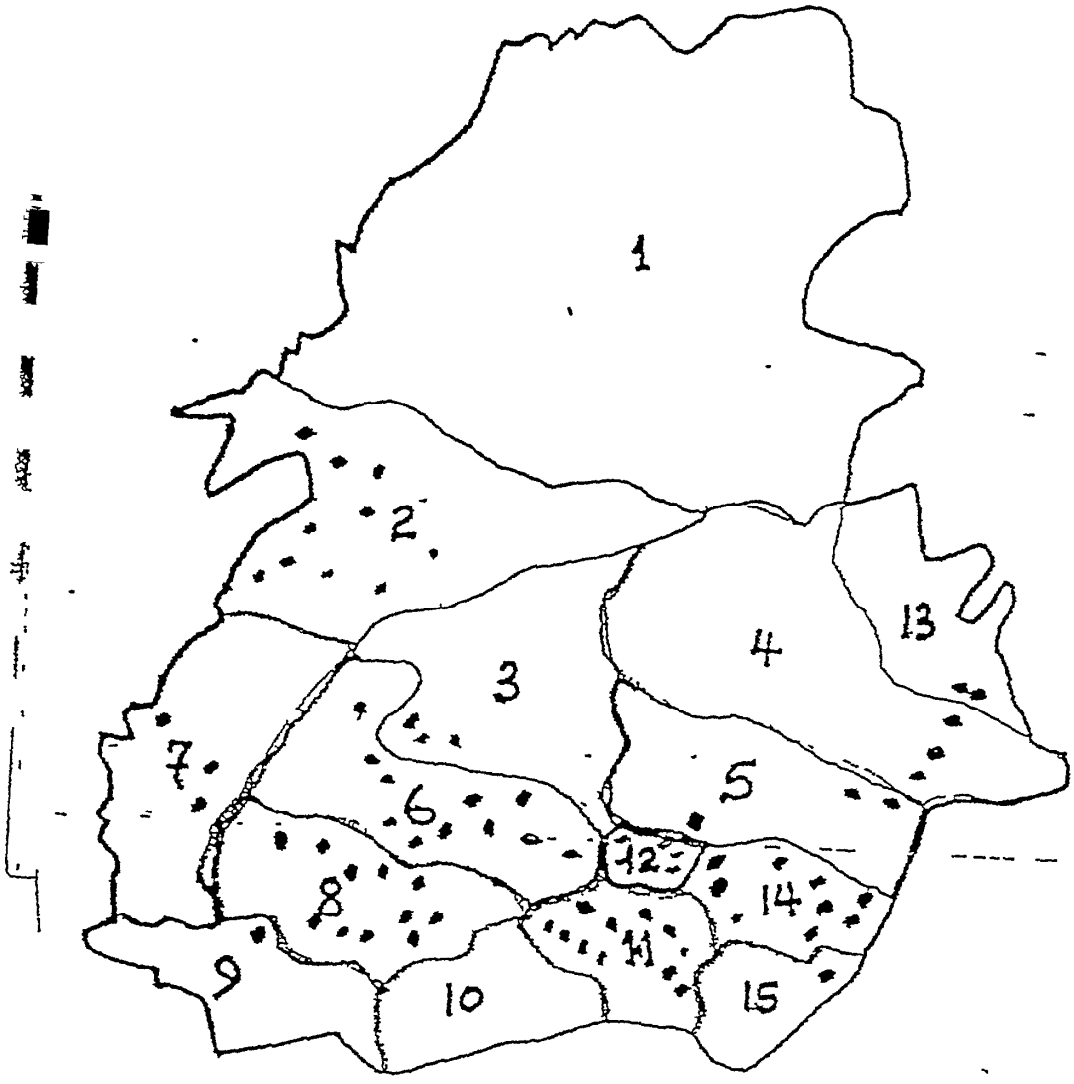
Please find enclosed Profile of CBD Agents in the Eastern Region

List of Local Agents are people who have chemical shops and were not part of the World Bank Traing for CBD Agents.

Thanks you

FRIENDHOOD ASSOCIATION OF GHANA- EASTERN REGION

MAP SHOWING CBD COMMUNITIES



REFERENCE

● CBD AGENT COMMUNITIES

1 AFRAM PLAINS DIST.
2 KWAHU SOUTH DIST
6 EAST AKIM DIST
7 BIRIM NORTH DIST
8 KWAEBIBREM DIST
11 SUHUM KRABOA COALTAR DIST
12 NEW JUABEN DIST
13 ASUOGYAMAN DIST

Profile of CBD Agents by District and Location - Eastern Region
Akwapin North District

No.	Name	Year of Training	District	Community	Age	Sex	Education Background	Occupation
1.	Margaret Yirenkyi	1994	Akuapem North	Dawu	43	F	MSLC	Trader
2.	Emma Oponwa	"	"	Apiredi	34	F	Teacher's Cert. "A"	Teacher
3.	Joyce Adu Denso	"	"	Aburi	29	F	MSLC	Toll Collector
4.	R.S. Amponsah	"	"	Adukrom	39	M	Commercial School	Stationery Supplier
5.	Alex Amoyaw Addo Jr.	"	"	Aseseeso	35	M	Post Sec.	Teacher
6.	Mavis Okain	"	"	Akropong	31	F	MSLC	Trader
7.	Samuel Awua	"	"	Larteh	32	M	Tech. School Cert.	Storekeeper
8.	Florence Ofei	"	"	Aseseeso	36	F	MSLC	Trader
9.	Gloria Apea	"	"	Hamfe	40	F	Cert. "A"	Teacher
10.	Gabriel Ayete	"	"	Larteh	37	M	Cert. "A"	Teacher

Manya/Yilo Krobo District

No.	Name	Year of Training	District	Community	Age	Sex	Education Background	Occupation
1.	Joseph N. Ademan	1991	Manya	Kpongunor, Nuaso, Maem	40	M	MSLC	Farmer
2.	Praymond A. Peter	"	"	Azitey, Odumase, Kodjona, Atua	30	M	RSA	Toll Collector
3.	Mary Kabutey	"	"	Kpong, Zongo, Quarters	28	F	MSLC	Trader
4.	Ernestina Sonu	"	"	Kpong, Lorbornya, Ahodjo	29	F	"	Clinic Asst.
5.	Elizabeth Nartey	"	Yilo	Somanya, Okwanya, Adjikpo	32	F	"	Social Worker
6.	Seth Kweku	"	"	Somanya, Agaveny	28	M	"	Toll Collector
7.	John Mahama	1994	"	Somanya	35	M	"	Clerk, Fire Service
8.	Frederick Djaba	"	Manya	Odumase	28	M	"O" Level	Clerk
9.	Daniel Hartey	"	"	Odumase	30	M	"O" Level	Clerk

Profile of CBD Agents by District and Location - Eastern Region
New Juaben District

No.	Name	Year of Training	District	Community	Age	Sex	Education Background	Occupation
1.	Cephas Wiafe-Nimako	1991	New Juaben	Ada, New Zongo	31	M	GCE "O" Level	Trader/Shopkeeper
2.	Comfort Oforiwa	"	"	Effiduase, Ghanass	36	F	MSLC	Toll Collector
3.	Robert Twum Ampofo	"	"	Asokore, SDA	32	M	"	Chain Saw Operator
4.	Osei Amaniampong	"	"	Oyoko, Mpaemu	39	M	Cert. "A"	Teacher
5.	Esther Bekoe	"	"	Jumapo, Bepoase	37	F	"	"
6.	Mary Ofosua	"	"	Suhyen, Sokoda, Beposo	43	F	MSLC	Trader
7.	Emanuel Mac Duah	1992	"	Nsukwao, Old Estate, Densu Agya	39	M	GCE "A" Level	Teacher
8.	Kwadwo Henaku	"	Akuapem North	Okorase, Tei Nkwanta, Asuoya	48	M	MSLC	Clinic Attendant
9.	Doris Sadia	1994	New Juaben	Nkurakan	26	F	GCE "A" Level	Teacher
10.	Victoria Ofori	"	"	Adawso	35	F	MSLC	Stone Quarrier
11.	Alecs Agobo	"	Akuapem North	Oyoko, Mpaemo	48	M	Cert. A	Teacher
12.	Isaac Owusu Kwarteng	"	"	Amanfrom	42	M	MSLC	Trader
13.	Richard Larbi	"	"		42	M	"	"

Profile of CBD Agents by District and Location - Eastern Region
Kwahu South District

No.	Name	Year of Training	District	Community	Age	Sex	Education Background	Occupation
1.	Armstrong Adu	1994	Kwahu	Jejeti Station, Aeoase, Abetinso	27	M	MSLC	Farmer/Trader
2.	Emmanuel Owusu Agyei	"	"	Mraeso, Amanfrom, Oframase, Atibie	29	F	"	Trader
3.	Sarah Akwaa	"	"	Akwasiho, Suwuro	32	F	"	Trader
4.	Florence Konadu	"	"	Kofi Dede, Banka, Asona	30	F	"	Teacher
5.	A.P. Yeboah	"	"	Nkawanda Nos. 1 & 2, New Jejeti	37	M	"	Shopkeeper
6.	E.K. Dankwa	"	"	Kwahu Praso Nos. 1 & 2, Besease, Fodoa, Adensua, Hwediem	40	M	Commercial School Leaver	Trader
7.	Stephen K. Amankwa	"	"	Apradan	42	M	MSLC	Farmer/Trader
8.	Samuel Adjei Frempong	"	"	Suminakese	44	M	GCE "O" Level	Farmer
9.	Jonas Owusu	"	"	Atuobikrom, Sukwa Nos. 1 & 2	38	M	Cert. "A"	Shopkeeper
10.	Rockson Ofosu	"	"	Asubone (3), Ekoso, Awurensue, Akutuase	28	M	MSLC	Farmer
11.	Felicia Asuama	"	"	Adihyema	28	F	MSLC	Trader
12.	Evelyn L. Ofori Nsaful	"	"	Nkawkaw	42	F	Post Sec.	Teacher
13.	Anim Mensah	"	"	Awuronsua	42	M	MSLC	Trader

Profile of CBD Agents by District and Location - Eastern Region
Kwaebibirim District

No.	Name	Year of Training	District	Community	Age	Sex	Education Background	Occupation
1.	Samuel Gyima-Afoakwa	1991	Kwaebibirim	Apinamang, Dwenase, Koriso	40	M	GCE "O" Level	Dispensant Assistant
2.	Comfort Ansah	"	"	Takyiman, Dokyi, Akropong	39	F	MSLC	Seamstress
3.	Grace Fobi	"	"	Abenaso, Kwamang, Krobo	28	F	"	Clinic Attendant
4.	Evelyn Korang	"	"	Nkwantanang, Subikese, Subi	28	F	"	Trader
5.	Betty Morgan	"	"	Abompe, Damang	26	F	"	Farmer
6.	Matilda Tawiah	"	"	Akwatia, Amanfrom, Camp	39	F	"	Clinic Assistant
7.	Edward Agyei Opei	"	"	Akwatia	36	M	GCE "O" Level	Dispensary Assistant
8.	Charles Twum Atta	1992	"	Topreman, Cayco, Sakyikrom	31	M	"	Farmer
9.	Emmanuel Obeng	"	"	Okumanin, Camp, Aboabo, Dwenase	36	M	"	Trader
10.	Felix Annor	"	"	Pramkesa, Abodom, Abaam	31	M	MSLC	Farmer
11.	Comfort Asarebea	"	"	Okyinao, Meposo, Amanfrom	25	F	"	"
12.	Susuana Boakye	1994	"	Wenchi	29	F	"	Clinic Assistant
13.	Mary Nketia	"	"	Buadua	27	F	"	Seamstress
14.	Faustina Ofosu	"	"	Akwatia	37	F	"	Sanitary Inspector
15.	Joyce Agyapoma	"	"	Kwae	36	F	"	Seamstress

Profile of CBD Agents by District and Location - Eastern Region
East Akim District

No.	Name	Year of Training	District	Community	Age	Sex	Education Background	Occupation
1.	Felicia Ghartey	1992	East Akim	Kukurantumi	33	F	MSLC	Trader
2.	Elizabeth Aboagyewa	"	"	Old Tafo	39	F	Teacher's Cert "A"	Teacher
3.	A.B. Yeboah	1994	"	Apedwa	41	M	MSLC	Toll Collector
4.	Stephen Abrokwah	"	"	Asafo	28	M	MSLC	Clerk
5.	Esther Obeng	"	"	Osino	40	F	Cert "A"	Teacher
6.	Faustina Boapiah	"	"	Asiakwa	36	F	Cert "A"	Teacher
7.	Grace Nkansah	"	"	Ati-Tafo	38	F	MSLC	Trader
8.	Ernest Osei	"	"	New-Tafo (CRIG)	41	M	MSLC	Clerk
9.	Edmund K. Boateng	"	"	Anyinam	42	M	Cert "A"	Teacher
10.	Dinoria Assor	"	"	Nsutam	40	F	MSLC	Teacher
11.	Hayford Adjeya	"	"	Apedwa	55	M	"	Leter Writer
12.	Nana Adu-Ofori	"	"	Kibi	44	M	"	Clerk
13.	Alimatu Amadu	"	"	New Tafo-Zongo	42	F	"	Teacher

Profile of CBD Agents by District and Location - Eastern Region
East Akim District

No.	Name	Year of Training	District	Community	Age	Sex	Education Background	Occupation
14.	Mercy Asiedu	1992	East Akim	Asamanma, Asunafo, Akoko	41	F	MSLC	Trader
15.	Veronica Wiredu	"	"	Kwabeng, Bomaa Moseaso	34	F	MSLC	Trader
16.	Ellen Boateng	"	"	Banso, Apepatia, Awenare	33	F	MSLC	Seamstress
17.	Florence Owusu	"	"	Paneng, Asikam	37	F	MSLC	Farmer

Profile of CBD Agents by District and Location - Eastern Region
Birim North District

No.	Name	Year of Training	District	Community	Age	Sex	Education Background	Occupation
1.	Charles Tuffour Ampem	1992	Birim North	Ntronang, Adasena, Hwaakoze	31	M	GCE	Farmer
2.	Dora Nyarko	"	"	Old Abirem	32	F	Post Sec.	Trader

Profile of CBD Agents by District and Location - Eastern Region
Suhum North District

No.	Name	Year of Training	District	Community	Age	Sex	Education Background	Occupation
1.	Joseph O. Badu	1992	Suhum	Okorame, Ali, Nomeso, Boko	28	M	MSLC	Health Assistant
2.	Regina Korkor	"	"	Aponoapono	30	F	"	Trader
3.	Daniel Chartey	"	"	Sowatey, Okanta, Kuano, Mfranta	23	M	"	"
4.	Jonathan Asara	"	"	Adarkwa, Ntinkum, Haame Hyeso	35	M	Cert. "A"	Teacher
5.	Faustina Twum	"	"	Akorabo, Kukua, Simatade	34	F	MSLC	Health Assistant
6.	Bismark Bekoe	"	"	Teacher Mante, yaw Korkor	30	M	"	Trader
7.	S.H. Okyara	"	"	Amanase, Ayeko, Kokooso, Abensby, Apeatu	51	M	"	Trader/Farmer
8.	Doris Nartey	1994	"	Kwaboanta	29	F	Cert. "A"	Teacher
9.	Joshua K. Opoku	"	"		39	M	GCE "O" Level	Party Organizer
10.	Lydia Offei	"	"	Kwafokrom, Teacher Mante	28	F	MSLC	Women's Organizer
11.	Partick K. Ofori	"	"	Okanta, Kwafokrom	38	M	Cert. "A"	Teacher
12.	Maxwel K. Nanso	"	"	Dokrochiwa, Abema, Wurudurudu	30	M	MSLC	Druggist
13.	Doris Bampo	"	"	Suhum	31	F	MSLC	Trader
14.	Alex Mankata	"	"	Suhum	38	M	Diploma Educ.	Teacher
15.	Comfort Opoku	"	"	Wawase	37	F	MSLC	Trader
16.	Alex Opoku-Budu	"	"	Oworam	34	M	Post Sec.	Teacher
17.	Michael Asiedu	"	"	Kofi Pare	29	M	MSLC	Trader
18.	Benjamin Adu Kwasi	"	"	Coaltar	28	M	MSLC	Trader
19.	Isaac Yaw Mireku	"	"	Suhum, Apietu	37	M	GCE "O" Level	Civil Servant

List of Local Agents - Eastern Region

No.	Name	Year of Training	District	Community	Age	Sex	Education Background	Occupation
1.	Amoako N. Asiama		New Juaben	Koforidua Central	33	M	MSLC	Chemical Seller
2.	P.A. Adomako		"	"	42	M	"	"
3.	Emmanuel Larbi Anim		East Akim	New Tafo	44	M	"	"
4.	Joris Mardoh		Yilo Krobo	Somanya	48	M	"	"
5.	Anthony King Opata		"	"	42	M	"	"
6.	Samuel Gyampoh		New Juaben	Adweso, Koforidua	39	M	"	"
7.	W.K. Kyere		East Akim	New Tafo	46	M	Pharmacy	Pharmacist
8.	David Abrokwa		Kwahu South	Kwahu Nsaba	43	M	MSLC	Chemical Seller

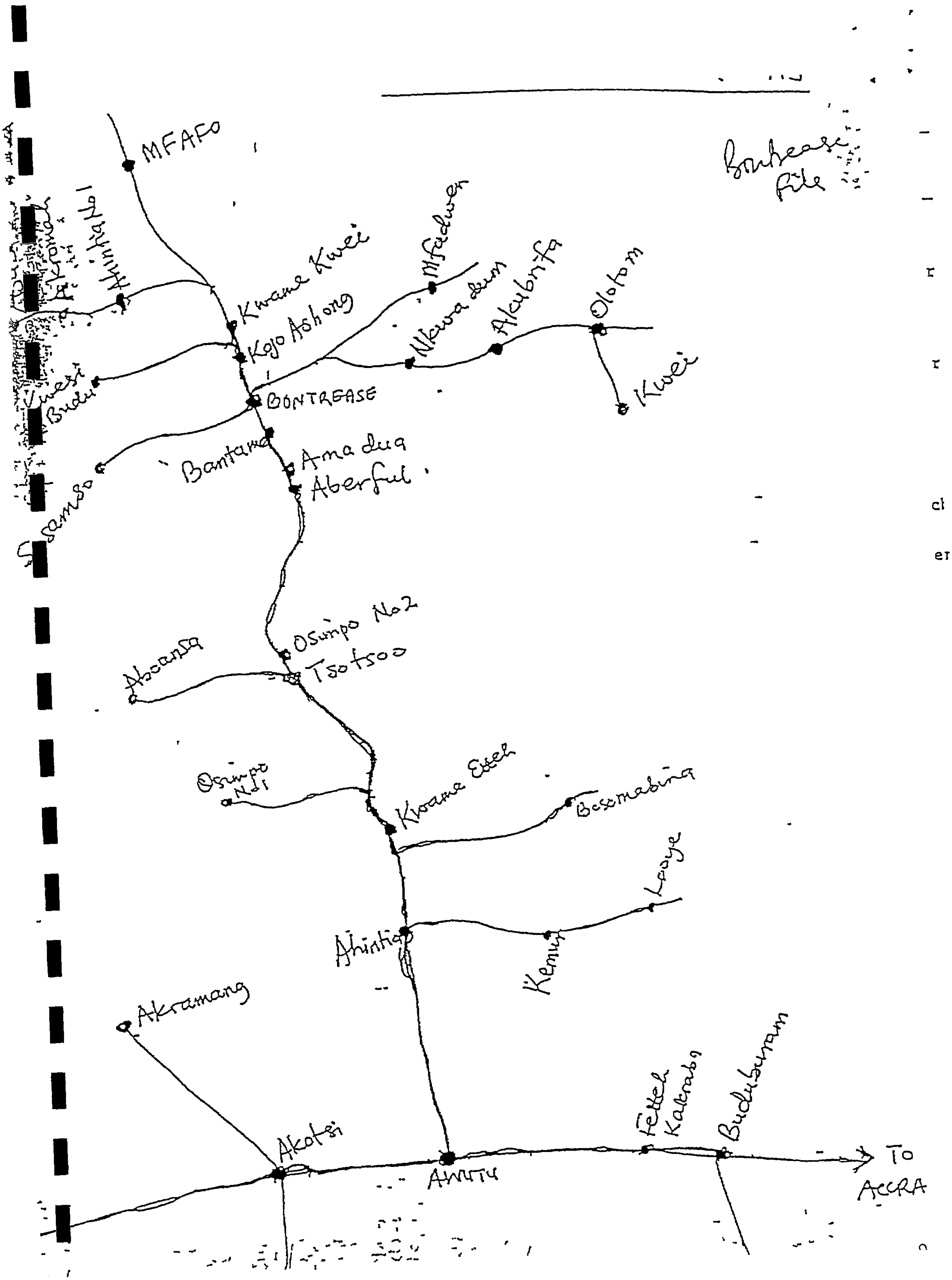
District: District-Awutu-Effutu-Senya and Gomoa
Supervisor: Theresa Aryee

No.	Name	Year of Training	Age	Sex	Educational Background	Occupation
1.	Victoria Abbeyquaye	1989	46	F	MSLC	Farmer
2.	Christian Asamani	"	36	F	"	"
3.	Alice Larbie	1993	48	F	"	"
4.	Robert Afadu	"	26	M	"	"
5.	Robert Danful	"	42	M	"	"
6.	Amos Awuah	"	52	M	"	"
7.	John Hagan	"	56	M	"	"
8.	Michael Arhin	1994	34	M	"	"
9.	Beatrice Quansah	"	44	F	Middle Form 2	Trader
10.	Theresa Essuman Saah	"	44	F	MSLC	"
11.	Margaret Kumi Odoom	"	39	F	"	"
12.	Kodjoe Attah	"	26	M	Middle Form 2	Farmer
13.	Mercy Arthur	"	35	M	Secondary Form 2	Trader
14.	Joshua Odoom		34	M	MSLC	Farmer
15.	Jacob Mensah		35	M	"	"

1) Jacob Mensah replaced the trained CBD agent, trained in 1994, who has left the community. He attended the 2 day refresher course organized for the IP in 1995.

2) Joshua Odoom replaced the trained CBD agent, trained in 1994, who has left the community. He did not attend the refresher course.

3) Mercy Arthur is no longer residing in Ojobi. She is living in Kasoa, but has agreed to come to Ojobi on Sundays to serve her clients. The community has been informed about the need for a replacement.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Aberful
Osimpo No2
Tsotsoo
Aboansa
Kwame Esseh
Bosomabina
Ahintia
Akramang
Akotsi
AWUTU
Fetteh Kakraba
Buduburam
TO ACCRA

Planned Parenthood Association of Ghana
Ashanti Region Branch

List of CBD Active Agents

No.	Name	Community	Year Trained
1.	Assenso Agyeman	Jahasi	1986
2.	John Evans Mensah	Bantama	"
3.	Alice Adade	Adum	"
4.	Mensah C.A.	Ahenkro	1991
5.	Seth Martin Opoku	Abono	"
6.	Asem Kuffour	Nnuaso	"
7.	Janet Afriyie	Esreso	"
8.	Mark Boadu	Adako-Jachie	"
9.	Frimpong Samuel	Adomfe	"
10.	R.K. Moore	Obogu	"
11.	Peter C. Owusu	Tweapease	"
12.	Edward Peprah	Asuboa	"
13.	Emelia Kyerewaa	Kwapia	"
14.	Obuor Agyeman	Kwanwomah	1992
15.	George Kutin	Nyankamasu	"
16.	Akwasi Addai	Senfi	"
17.	Agatha Cudjoe	Nyamebekyere	"
18.	Richard Boakye	Afrancho	"
19.	Grace Conduah	Pomposo	"
20.	Monica D. Ampong	Kasaem	"
21.	Kaakyire Mensah	Ntonso	"
22.	Maxwell Acheampong	Wonoo	"
23.	Elvis Okrah	Adanwomase	"
24.	James O. Asiedu	Aboaso	"
25.	Elizabeth Asante	Bipoa	"
26.	Johnson K. Yeboah	Canaan	"
27.	Yaw Owusu Amofah	Agona	"
28.	Habiba Yahaya	Aboabo No. 1	"
29.	Emmanuel Kyei	Yawkwei	"
30.	Collins Addo	New Koforidua	"
31.	Isaac N. Dapaah	Obenimase	"
32.	Agyenim Boateng	Bankame	"
33.	Kojo Tieku	Banso-Asuboe	"
34.	Gyasi Nimako	Dawereso	"
35.	Hanna Anima	Abease	1994
36.	Margaret Osei	Wiamoase Clinic	"
37.	Rose Anokyewaa	Kofiase	"
38.	Kwarteng B.B.	Tano-Odumase	"
39.	Agnes Kwakye	Ofoase-Kokoben	"
40.	Theresah Pokuaa	Behenase	"
41.	Joseph Afriyie	Ahenema-Kokoben	"
42.	Opoku Esmond	Brofoyedru	"
43.	Kwadwo Owusu	Anwiankwanta	"

No.	Name	Community	Year Trained
44.	Anthony Mensah	Atafua	1986
45.	George Amankwah	Kwadaso	“
46.	Osei Sarpong	Kona	“
47.	Agnes Afriyie Siaw	Asonomaso	“
48.	Charles Oduro	Ahensan	“
49.	Siaw M.A.	Kaase	“
50.	Abena Nyarko	Atasomanso	“
51.	Juliana Asante	Akrofonso	“
52.	Esther Awuah	Bokankye	“
53.	Rosemond Frimpong	Ntensere	“
54.	Theresa Kyidom	Esaaso	“
55.	Christiana Annin	Barekese	“
56.	Helena Dufie	Apagya	“
57.	Aboagye Da Costa	Aduman	“
58.	Gariba Seeba	Kodie	“
59.	Kwame A. Manu	Afrancho	“
60.	Togbui Nyamasadzi	Anloga	“
61.	Agyala Adamu	Moshie-Zongo	“
62.	Rugby Agyeman	Aboabo No. 2	“
63.	Serwah Bonsu	Obenimase	“
64.	Afrifa Yamoah	Obima	“
65.	Comfort O. Owusu	New Koforidua	“
66.	Agyei B. Samuel	Domeabra	“
67.	Comfort Kyerewaa	Nsuta	“
68.	Charles Baafi	Nsutaem	“
69.	Mary Forkud	Potrikrom	“
70.	Mark Wiafe	Ahwerewam	“
71.	Cecilia Sraha	Sabronum	“
72.	Jennifer Azumah	Ayigya-Zongo	“
73.	Grace Agyepong	Bankame	“
74.	Gladys Gyekye	Banso-Asuboe	“
75.	Felicia Bothway	Dampong	“
76.	John Atta Adomako	Juaso	“
77.	Doris Boakye	Dwease	“
78.	Thomas Frimpong	Onwe	“
79.	Emmanuel P. Asiase	Homase No. 2	“
80.	Falilatu Yunusah	Gausu	“
81.	Adwoa Nyako	Asikasu	“
82.	Ampadu Okyere	Obuasi-Dadwen	“
83.	Paulina Agyapong	Anyankiram	“

Dropouts

No.	Name	Community	Year Trained
1.	Comfort Boahene	Kuntenase	1986
2.	Alex O.A. Ntori	Tetrefu	“
3.	Donkor S.	Boamadumase	“
4.	Samuel Osei Asante	Ust	“
5.	Thomas Boakye	Kyerekrom	“
6.	Helena Asaah	Pankrono	1991
7.	Joseph Aborokwaa	Kwabrakwakrom	“
8.	Albert Darko	Mpobi	“
9.	Andrew Opoku	Krapa No. 1	“
10.	Veronica Dufie	Kotei	“
11.	Veronica Boahenaa	Emena	“
12.	Margaret O. Achiaa	Ahwiaa	1992
13.	Thomas Osei	Akrokeri	“
14.	Rockson Owusu	Fawdade	“
15.	Mary Awuah	Safo	“
16.	Anthony Mensah	Hemang	“
17.	Kate Domfour	Afamanso	“
18.	Agnes Nyame	Asokore Mampong	“
19.	Richard Boateng	Dampong	“
20.	Ama Tiwaa	Bonwire	“
21.	Hanna Kakari	Poano	1994
22.	Stephen Appaih	Mampongteng	“
23.	Martha Bonsu	Maase	“
24.	Paul Amoako	Adankwame	“
25.	Stephen Boakye	Kwamo	“

Inactive Agents

No.	Name	Community	Year Trained
1.	Akrofi Darko	Ejisu	1986
2.	Agnes Ampomah	Nkwanta	1991
3.	Joseph Boakye-Yiadom	Swedru	1992
4.	Owusu Acheampong	Sewua-Aboaso	“
5.	Nana Kojo Ntoah	Aburaso	“
6.	Walacas Antwi	Abira	“
7.	Agnes M. Sarpong	Kwaso	“
8.	Fosu Appiah A.K.	Apitiso	“
9.	James Y. Asante	Bedomase	“
10.	Vida Sarpong	Suhyenso	“
11.	Amankwah	Wiamoase Town	1994
12.	Agnes Badu	Bipoase	“
13.	Ohene K. Boachie	Asamang	“
14.	Comfort Owusu-Ansah	Dominase	“
15.	Gladys Fosuaa	Pakyi No. 2	“
16.	Susan Odei	Onwe Clinic	“
17.	Faustina Akoto	Akropong	“
18.	Abena Konadu	Mfensi	“
19.	Janet Asokwa	Achiase	“
20.	Alfred Frimpong	Asuofua	“
21.	Cecilia Forkuo	Breman	“
22.	Edward Amponsah	Tutuka	“

Summary

Total Agents	=	130
Active Agents	=	83
Inactive Agents	=	22
Dropouts	=	25

Community Based Distribution of Family Planning Services
Association: Planned Parenthood Association of Ghana (Northern Region Branch)

Year Trained	Village	District	Name of Agent	Personal Data			Remarks
				Age	Education	Marital Status	
1989	Fuu	Salaga	Abudulai Fusein	35	P. 6	Married	Active
"	Mbanaayili	Tamale	I. Andani	33	MSLC	"	Inactive
"	Tarkpaa	Savelugu	John Alidu	36	"	"	"
"	Vogu	Tolon	I. Mumuni	30	Sch. Cert.	"	"
"	Kusugu	Damongo	M. Damba	32	MSLC	"	Active
"	Gbambaya	Tolon	Andrew Haruna	30	"	"	Inactive
"	Kanville	Tamale	Baba Nniriba	33	"	"	"
"	Chagni	Tamale	Billa Kombian	36	SRN	"	"
"	Sakasaka	Tamale	Nixon	30	"	"	"
"	Vetrico Spot	Tamale	Baba	28	MSLC	"	"
"	Market Sq.	Wa	Haruna Zakaria	50	"	"	"
"	Market Sq.	Tamale	Issah Zakaria	30	Sch. Cert.	"	"
"	Bawku	Bawku	Ahmed Wuni	50		"	Active
"	Hill-top	Tamale	Baba	35	MSLC	"	"
"	Bawku	Bawku	Santana Imoro	40	Sch. Cert.	"	"

Community Based Distribution of Family Planning Services
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Year Trained	Village	District	Name of Agent	Personal Data			Remarks
				Age	Education	Marital Status	
1991	Moglaa	Savelugu	Adam Mumuni	34	MSLC	Married	Active
"	Nabogu	"	Y. Mohammed	39	Sch. Cert.	"	Inactive
"	Sang	Yendi	Abdul Mumuni	37	MSLC	"	Yet to Settle Down
"	Sambu	"	Issah Samata	18	"	"	Displaced & Inactive
"	Zakpalsi	"	Abukari Sule	26	"O" Level	"	Active
"	Gbumgbung	Savelugu	Tahidu Alhassan	27	MSLC	"	"
"	Kakpande	Salaga	Abudulai Mumuni	36	"	"	"
"	Kpalbe	"	Abukari Haruna	25	"	"	"
"	Duuyin	Tamale	M. Neindow	36	"	"	"
"	Chirifoyili	Tolon	J.F. Yabdow	28	"	"	"
"	Wantugu	"	Issah Abudulai	26	"O" Level	"	"
"	Tali	"	Madinatu Yamusah	26	MSLC	"	"
"	Piggu	Gushegu	I. Issahaku	25	"	"	Displaced & Inactive
"	Kpatinga	"	Alhassan Adam	32	"	"	Yet to re-settle
"	Tampion	"	Abudulai	25	"O" Level	"	Active

Community Based Distribution of Family Planning Services
Association: Planned Parenthood Association of Ghana (Northern Region Branch)

Year Trained	Village	District	Name of Agent	Personal Data			Remarks
				Age	Education	Marital Status	
1992	Zoggu	Savelugu	Awal Abukari	35	MSLC	Married	Active
"	Kuldanayili	"	Beatrice Adeti	42	"	"	"
"	Nyogloo	"	Yakubu Issaku	31	P. 2	"	"
"	Nasia	W. Mampurisi	Y.E. Mahami	30	"A" P/Sec	"	Deceased
"	Kparigu	"	S. Sulemana	29	"A" 3 yrs	"	Active
"	Kpatoribogu	Gushegu	M.M. Dawuni	30	MSLC	"	"
"	Pishegu	"	Abudulai Abu	27	P. 6	"	"
"	Bagurugu	"	Mohammed Ziblim	37	MSLC	"	"
"	Sung	"	A. Iddrisu	30	"	"	"
"	Kotingli	Tamale	Sayibu Awudu	42	P. 6	"	Died during conflict
"	Kakpaguyili	"	Tolhatu A.	40	MSLC	"	Active
"	Manguli K.	"	Adam Ziblim	34	"	"	"
"	Baliga	"	Adam Alhassan	35	P. 6	"	"
"	Kpanvo	"	Abudulai Zak.	24	MSLC	"	"
"	Kpalbusi	Salga	Jewu Hamidu	29	Sch. Cert.	"	"

Community Based Distribution of Family Planning Services
Association: Planned Parenthood Association of Ghana (Northern Region Branch)

Year Trained	Village	District	Name of Agent	Personal Data			Remarks
				Age	Education	Marital Status	
1992	Jimli	Savelugu	Adam Hamidu	22	MSLC	Married	Active
"	Kulinkpagu	Yendi	Salifu Alhassan	35	"	"	
"	Tugu	Tamale	Inusah Seidu	28	"	"	Active
"	Gbabshie	"	Iddrisu Mumuni	35	"	"	"
"	Jebriyili	Yendi	Kusimi Taane	25	"	"	Displaced & Inactive
"	Kpalsogneyili	"	Susu Tali	43	"	"	"
"	Nyankpala	Tolon/K.	Mohamadu Husein	19	"	"	Active
"	Lingbing	"	Abdul-Razak I.	24	Sch. Cert.	"	"
"	Gbirimani	"	Amadu Dawuni	29	Cert. A	"	"
"	Tolon	"	Adbul-Aziz S.	32	"	"	"
"	Tibagnaayili	"	Alhassan Imoro	24	MSLC	"	"
"	Kpanyili	"	Amadu Mahama	29	"	"	"
"	Zion	Savelugu	Alhassan I.	30	"	"	"
"	Larigu	"	Alhassan	35	"	"	"
"	Zinindo	"	Abdul-Rahaman	28	"	"	"

APPENDIX 11

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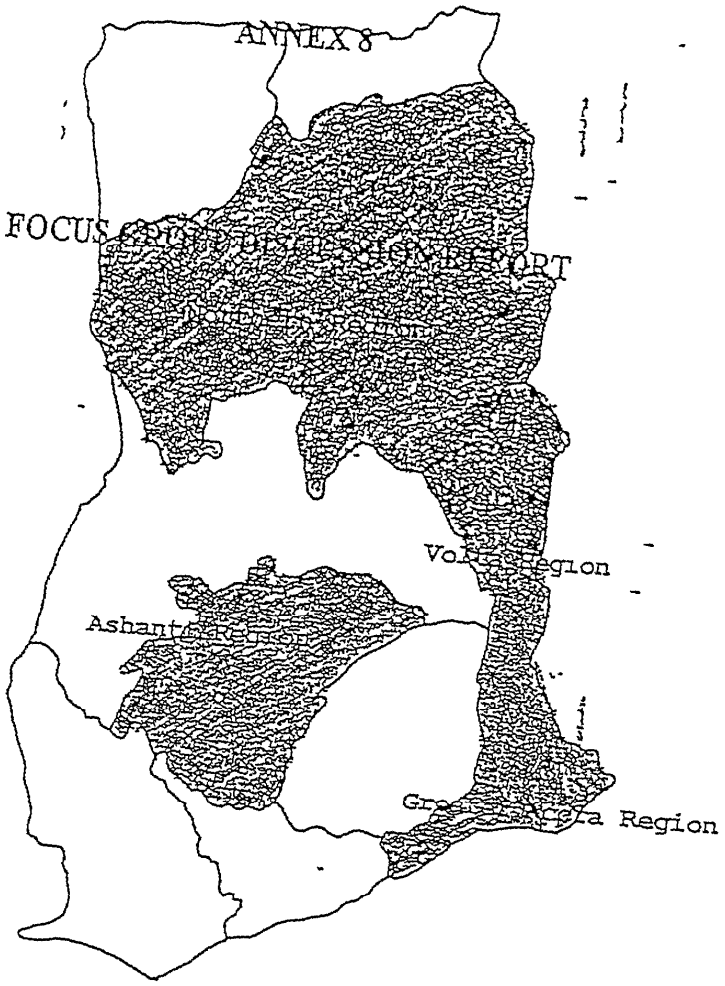
Ashanti
Region