Follow up reproductive health needs assessment in the process of evaluating a CBD programme in Lushoto Division, Lushoto District

Tanzanian-German Programme to Support Health (TGPSH)
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I. Executive Summary

This study is a follow-up to a baseline study on CBD activities in Lushoto Division which was carried out in the year 2000. Therefore, the same study area and mainly the same information were surveyed in this study. Additionally, two villages without CBD activities were chosen for comparison with CBD villages. Information about knowledge of and demand for long-term methods was collected.

A. Fertility and Fertility regulation

- Contraceptive prevalence (modern methods) in the study area was 43.2 %, which is considerably higher than the average CPR for Lushoto District measured by the Comprehensive Council Health Plan Lushoto 2004[1] (24%) and compared to the baseline study (26.6%).

- Women's knowledge of contraceptive methods has increased significantly (from 77.1% in 2000 to 84.4% in 2004).

- It seems that CBDs can propel women who are already using a traditional FP method towards a modern method.

- Though the contraceptive prevalence in Lushoto district is made up of a considerable amount of injection users it seems that CBDs serve as referring agents in the villages and have an important function in providing a "social link" between village community and the professional health care sector. Their tasks include counseling as well as providing information about modern FP methods.

- Problems faced in obtaining contraceptives were hardly reported. The coverage of sources for obtaining contraceptives is quite good; Lushoto division is covered with CBDs.

- The most common reason given for not using contraceptives is that women are currently or do not have a partner. The number of women using contraceptives without their husband knowing increased significantly (from 15.9% in 2000 to 28.3% in 2004).

- Unmet need for family planning has decreased although it cannot be statistically proven (from 55.2% 2000 to 44.3% 2004). One figure supporting a decrease in unmet family planning need is the significant decrease of unplanned pregnancies from 58.3% in 2000 to 26.8% in 2004.

B. Long-term methods

- The knowledge of long-term methods is high. 33.6 % of all women (N=680) knew about sterilization, while 34.1 % knew about IUDs and 26.9% knew about Norplant.

[1] Comprehensive Council Health Plan for January-June 2004, Lushoto District Council, Ministry of regional administration and local government

- Nearly half of all women asked (49.2%) answered they would plan to use a long-term contraceptive method. Such a high figure is far too high to translate into actual use.

- The intention to use a long-term method in the future differs significantly between CBD villages (53.3%) and non-CBD villages (39.7%). This supports the hypothesis that CBDs intensify the demand for those services.

C. Comparison of CBD villages and villages without CBD activities

- Villages without CBD activities have nearly the same overall contraceptive prevalence as CBD villages (CBD villages: 43.2%, non-CBD villages 39.5%). However, in the non-CBD villages a statistically significantly higher percentage of women were still using traditional methods (8.3%, for CBD villages and 14.7%, for non-CBD villages).

- Knowledge of condoms is about 14% higher in CBD villages than in villages without CBD activities.

D. Maternal health and delivery indicators

- The number of unplanned pregnancies has significantly decreased from 58.3% in 2000 to 26.8% in 2004.

- Home deliveries decreased (78.9% in 2000 to 63.7% in 2004) and deliveries in hospitals, dispensaries and health facilities increased (from 21.1% in 2000 to 35.8% in 2004). Accordingly, a higher proportion of deliveries was attended by health personnel (22.0% in 2000 to 37.5% in 2004.

E. Abbreviations used

- CBD Community based distribution/distributor (of family planning services)
- CI 95% Confidence interval
- FP Family planning
- GTZ Gesellschaft fuer Technische Zusammenarbeit (German Technical Cooperation)
- IUD Intra Uterine Device
- MoH Ministry of Health
- MW Midwife
- PHC Primary Health Care
- Std Dev Standard Deviation
- TBA Traditional Birth Attendant

II. Introduction

A. Objectives

The main objective of this study was to evaluate the impact of the CBD programmeme in Lushoto division by carrying out a follow-up study and comparing the results with the baseline study from 2000. The specific objectives are listed bellow:

- To obtain current and reliable household based data in order to gain a better understanding of the impact of the CBD programme.
- To relate this data to the health system data and to the baseline study by using comparable methods.
- To assess the information women have on long-term and permanent contraception, as well as the need and demand for such methods.
- To compare villages with and without CBD activities in order to assess differences.

B. Methodology

The data was generated using a rapid assessment methodology (developed by MoH/GTZ Reproductive Health Project in Kenya) with a structured questionnaire, which was adapted to the current needs.
In this study nearly the same (with some additional) information as in the baseline study 2000 have been surveyed.
Households were randomly selected. One person per household was interviewed. Inclusion criterion was being female and aged between 15-49 years (women of child bearing age). The data was analyzed using Epi Info 2000.

C. Study area

The study area was Lushoto division in Lushoto district. The district counts about 419.970 inhabitants and has an average household size of 4.7 people per household.
Lushoto division has a total population of 63.410 (15.09 % of the total district population) and comprises 22 villages in 4 wards.[2]
Lushoto itself is a district captial and an important tourist and trading centre in the centre of Western Usambara Mountains. The Villages of Lushoto division are scattered around the town in a perimeter of 10-20 km. Some are only accessible by 4 wheel drive vehicles and are situated about 10-15 km off the main road.
Lushoto division is still a rural area and most people pursue farming activities.

[2] 2002 Population and housing census, http://www.tanzania.go.tz/census/census/districts/lushoto.htm and Sensa ya watu na makazi 2002. Wastani wa familia kwa kaya -wilayani Lushoto

8 villages were purposely selected to meet the following criteria:

- ✓ Having been included in the baseline survey 2000 (6 out of 8).
  The selection criteria of the baseline survey were:
  - Distance to Lushoto town – pastoral or urban setting;
  - Villages with high coverage of recently trained CBDs or without CBD coverage at all;
  - High unmet need for family planning methods
- ✓ Villages without any CBD activities at all (2 out of 8)

At the time of the survey the whole of Lushoto division was covered with CBDs, therefore two additional villages were selected from different divisions. Additional selection criteria were comparability with the already selected ones. This included

- Pastoral or urban setting
- Similar distance to the main road and to the capital division town
- Approximately the same household and population size
- No health facility/dispensary in the village itself

All villages have either health facilities in the neighborhood or a monthly mobile clinic. In villages without CBD programme mobile clinics provide injections and pills. In villages with CBD activities mobile clinics only provide injections as far as FP are concerned.
Table shows the population and CBD coverage of the selected villages.

Table 1: Population in the villages visited for the follow-up survey in March 2004, Lushoto District

Village	No. of households	Total population	CBD Coverage	Distance to Lushoto [2]	Ward	Division
Yoghoi [1]	882	2378	10	6 km	Lushoto	Lushoto
Irente [1]	459	2469	3	6 km	Lushoto	Lushoto
Miegeo [1]	292	1436	6	11 km	Ubiri	Lushoto
Ubiri [1]	881	3945	10	8 km	Ubiri	Lushoto
Ngulu [1]	436	2102	8	14 km	Ubiri	Lushoto
Kwemashai [1]	723	3352	9	10 km	Ubiri	Lushoto
Mgwashi	738	3601	Non-CBDs	34 km	Mgwashi	Mgwashi
Magila	526	2785	Non-CBDs	26 km	Soni	Soni

Source: Population and housing Census 2002
[1] Follow-up villages
[2] Measured by car kilometer indicator

D. Sample

680 women of childbearing age (15-49 years) from eight different villages were interviewed. The sample size of 450-500 women for the six follow-up villages was calculated on the basis of an estimated contraceptive prevalence of 27% (baseline study) and an accepted error of 5% (confidence interval 95%) to be able to measure a change in contraceptive behavior of more than five percent.
The sampling design was a one-stage cluster sampling. Since there were no lists available for all households, selection of households was done by a random starting point in the center of the village (either the village chairman's office or a central junction of the village) followed by a randomly chosen direction.
In this direction all households were interviewed till 75-80 women were interviewed. If

needed the procedure was repeated from the same starting point in the village to choose a second direction.
All women of childbearing age who slept last night in the respective house and were present at the time of interviewing were eligible.
Women coming back from the market were eligible if they could clearly been identified as a member of a household which was in the chosen direction.

The interviewers were given a target of 10-12 interviews per day to get a total of 75-80 interviews in one day. Revisiting 15 respondents validated the interviews. More than half of the interviews have been inspected for internal plausibility during the time in the field. If necessary, questions about internal plausibility were discussed in the evenings.

E. Data collection instrument

The questionnaire was field-tested several times in the respective baseline surveys 1999 and 2000 and with changes in the respective follow-up survey 2001.
Parts of the questionnaire were modified to adapt to special areas of interest.
Questions about demography, knowledge and use of contraceptives, fertility, fertility regulation and maternal health remained the same. All questions about sexually transmitted diseases were replaced by questions about knowledge and use of long-term and permanent contraception, some questions about the need and demand for such methods were added.

The questionnaire used covered the following topic areas (see annex):
- Knowledge and use of Contraception
- Knowledge and use of long-term and permanent contraception
- Need and demand for long-term and permanent contraception
- Future intention for long-term and permanent contraception
- Reasons for non-use
- Accessibility
- Antenatal Care
- Stillbirths
- Current pregnancy
- Abortions
- Awareness about Maternal Deaths and Aids

The following demographic indicators were used:
- Age
- Religion
- Occupation
- Marital status
- Education
- Residence

The questionnaire was translated into Kiswahili and tested during the interviewer training. Seven interviewers were chosen from Muheza School of Nursing and Midwifery and trained in one and a half day. The data collection was completed within 8 days.
Data were entered and analysed using Epi-Info 2000 software.

III. Basic characteristics of women interviewed

Table 2: Basic characteristics of 680 women interviewed

Characteristics	Follow-up Villages		No-CBD Villages		Total	
	N	%	N	%	N	%
Mean age	**27.28**		**26.33**		**27.00**	
Age groups						
15-19 years	46	9.7	24	11.8	70	10,3
20-24 years	128	26.9	63	30.9	191	28,1
25-29 years	137	28.8	59	28.8	196	28,9
30-34 years	93	19.6	29	14.2	122	18,0
35-39 years	46	9.7	20	9.8	66	9,7
40-44 years	15	3.2	6	2.9	21	3,1
44-49 years	10	2.1	3	1.5	13	1,9
Total	**475**	**100**	**204**	**100**	**679**	**100**
Current marital status						
Not yet married	39	8.2	17	8.3	56	8.2
Living with husband	320	67.4	146	71.6	466	68.6
Divorced	15	3.2	1	0.5	16	2.4
Separated	10	2.1	2	1.0	12	1.8
Husband living far away	48	10.1	19	9.3	67	9.9
Widowed	5	1.1	3	1.5	8	1.2
Consensual union	38	8.0	16	7.8	54	8.0
Total	**475**	**100**	**204**	**100**	**679**	**100**
Religion						
Christian	157	33.1	101	49.3	258	37.9
Muslim	316	66.5	102	49.8	418	61.5
No answer	2	0.4	2	1.0	4	0.6
Total	**475**	**100**	**205**	**100**	**680**	**100**
Ever been to school						
Yes	419	88.2	187	91.2	606	89.1
No	56	11.8	18	8.8	74	10.9
Total	**475**	**100**	**205**	**100**	**680**	**100**
Years of schooling						
7 years or less	402	96.2	186	99.5	588	97.2
8-10 years	3	0.7	1	0.5	4	0.7
more than 10 years	13	3.1	0	0	13	2.1
Total	**418**	**100**	**187**	**100**	**605**	**100**
Ability of reading and writing						
Yes	399	84.0	183	90.6	582	86.0
No	76	16.0	19	9.4	95	14.0
Total	**475**	**100**	**202**	**100**	**677**	**100**
Occupation						
Farmer	341	71.8	176	85.9	517	76.0
Housewife	102	21.5	21	10.2	123	18.1
Something else	32	6.7	8	3.9	40	5.9
Total	**475**	**100**	**205**	**100**	**680**	**100**

The majority of women from the follow-up villages (55.7 %) are aged between 20 and 30 years. Nine percent are teenage women (15-19 years). The mean age is 27.2 years. The majority of women are Muslim (66.5%).

Most prevalent occupation reported was farming (71.8%) followed by housewife (21.5%). Other occupations mentioned were teacher (n=9), tailor (n=9), running a small-scale domestic business (n=8), clerk and hotel waiter (both n=1). Three were pupils and two students.
Formal education rate (88.2% CI 84.9% - 90.9%) is relatively high and compared to the baseline study there is a statistically significant increase of about 10% (78.9% in 2000; CI 74.9% - 82.4%).
3.8% entered secondary or higher education, slightly more than four years ago (1.5% in 2000) but still a very small proportion.
Illiteracy rate is 16% (CI: 12.9% - 19.7%) which is statistically significant different from the year 2000 with 23.7% (CI: 20.0% - 27.9%). This goes along with the higher formal education rate.

A. Comparability between baseline and follow-up

In order to compare the baseline survey with the follow-up survey the basic characteristics should not be too different. The main characteristics like the distribution of age and marital status are quite similar. In the follow-up survey there are slightly less women aged between 40-44 years and 45-49 years. For further follow-up surveys a quota design instead of a random sample could be the method of choice to ensure comparability.
Only the share of religious denomination differs between the follow-up villages with CBDs and the villages without CBDs. Nevertheless, the two groups still seem to be quite comparable since religious reasons don't have a big influence (was only mentioned 3 times as a reason for non-use of FP).

Table 3: Basic characteristics baseline survey and follow-up survey

Characteristics	**Baseline survey 2000**		**Follow-up survey 2004**	
	N	**%**	**N**	**%**
Mean age	**29.1**		**27.3**	
Age groups				
15-19 years	35	7.3	46	9.7
20-24 years	121	25.3	128	26.9
25-29 years	115	24.1	137	28.8
30-34 years	84	17.6	93	19.6
35-39 years	57	11.9	46	9.7
40-44 years	33	6.9	15	3.2
45-49 years	33	6.9	10	2.1
Total	**478**	**100**	**475**	**100**
Current marital status				
Not yet married	-	-	39	8.2
Living with husband	355	80.9	320	67.4
Divorced	15	3.4	15	3.2
Separated	10	2.3	10	2.1
Husband living far away	28	6.4	48	10.1
Widowed	21	4.8	5	1.1
Consensual union	10	2.3	38	8.0
Total	**439**	**100**	**475**	**100**

* Not an option in 2000

IV. Fertility and Fertility Regulation

A. Age of initiation of living with a male partner

Marriage or any other consensual union between men and women is a proxy of regular sexual activity and triggers the onset of women's exposure to the risk of pregnancy and childbearing as well as the risk of sexually transmitted diseases.

Table 4 shows that 48.8% have started living with a male partner between 16-18 years of age, while 43.6% of the women have started between 19 to 25 years.

Table 4: Age of initiation of living with a male partner (N=475)

Age	Frequency	Percent	Confidence Intervals
15 years and less	7	1.5%	0.6% - 3.1%
16-18 years	223	48.4%	42.4% - 51.5%
19-25 years	207	43.6%	39.1% - 48.2%
25 years and more	13	2.7%	1.5% - 4.8%
Don't know	25	5.3%	3.5% - 7.8%
Total	475	100%	

B. Women's knowledge of contraceptive methods

Overall 84.4% (401/475) women knew at least one modern contraceptive method. This percentage differs significantly from the percentage of the baseline study 2000 (77.1%). The villages without CBD programme don't differ from those with CBD programme regarding knowledge of FP methods (see table 5).

Table 5: Knowledge of at least one modern family planning method

Year and study area	Frequency	Percent	CI
CBD Villages 2000	366/475	77.1%	73.0% - 80.7%
CBD Villages 2004	401/475	84.4%	80.8% - 87.5%
Non-CBD Villages 2004	172/33	83.9%	78.1% - 88.7%

The demographic distribution of knowledge of at least one FP method does not differ between the year 2000 and 2004. Also the non-CBD villages have the same demographic distribution of knowledge about FP as the CBD villages in both surveys. This can be seen in table 6 where schooling and current marital status are cross-tabled with knowledge of at least one FP method.

Table 6: Women's knowledge of contraception with respect to schooling and marital status

Characteristics	**Knowledge of at least one family planning method in percentage**					
Schooling	**Year: 2000 N=366**		**Year: 2004 N=401**		**Non-CBD villages 2004 N=172**	
	N	**%**	**N**	**%**	**N**	**%**
Yes	307	82.1%	366	87.4%	160	85.6%
No	59	58.4%	35	62.5%	12	66.7%
Current marital status	**Year: 2000 N=351**		**Year: 2004 N=401**		**Non-CBD villages 2004 N=172**	
	N	**%**	**N**	**%**	**N**	**%**
Not yet married	-	-	23	59.0%	8	47.1%
Living with husband	288	81.8%	281	87.8%	130	89.0%
Divorced	12	80.0%	13	86.7%	1	100%
Separated	10	100%	9	90.0%	2	100%
Husband living far away	23	85.2%	43	89.6%	15	78.9%
Widowed	11	55.0%	2	40.0%	2	66.7%
Consensual union	7	70.0%	30	78.9%	13	81.3%

Generally, age distribution of knowledge between the different groups is pretty comparable. The only difference in age groups regarding knowledge of one FP method can be found in the group of the 15-19 years old women. In this age group knowledge of one FP increased about 38%. However, this is a trend that cannot be statistically proven because of small numbers (see table 7).

Table 7: Women's knowledge of contraception with respect to age group;

Characteristics	**Knowledge of at least one family planning method in percentage**					
Age groups	**Year: 2000 N=478**		**Year: 2004 N=401**		**Non-CBD villages N=171**	
	N	**%**	**N**	**%**	**N**	**%**
15-19 years	9	26.5%	30	65.2%	12	50.0%
20-24 years	90	74.4%	111	86.7%	54	85.7%
25-29 years	103	89.6%	128	93.4%	54	91.5%
30-34 years	72	86.7%	78	83.9%	26	89.7%
35-39 years	47	83.9%	38	82.6%	18	90.0%
40-44 years	25	75.8%	9	60.0%	6	100.0%
45-49 years	20	60.6%	7	70.0%	1	33.3%

Knowledge of condoms in CBD villages is about 14% higher compared to non-CBD villages (see table 8 for detailed results). The figures for long-term methods are relatively high. The best-known long-term method was IUD (28% in CBD villages and 33% in non-CBD villages) followed by Norplant and sterilization.

Table 8: Knowledge of different contraceptive methods CBD villages and non-CBD villages 2004

Characteristics	Knowledge of different contraceptive methods (Q16)			
Contraceptives	**Year: 2004 N=475**		**Non-CBD villages 2004 N=205**	
	%	**confidence interval**	**%**	**confidence interval**
Oral pill	79.8%	75.8% - 83.3%	82.0%	76.0% - 87.0%
Injection	81.1%	77.2% - 84.4%	82.9%	77.1% - 87.8%
Condom	43.6%	39.1% - 48.2%	29.3%	23.1% - 36.0%
Sterilization	18.1%	14.8% - 21.9%	19.0%	13.9% - 25.1%
Norplant	23.4%	19.7% - 27.5%	25.9%	20.0% - 32.4%
IUD	27.6%	23.7% - 31.9%	32.7%	26.3% - 39.6%

C. Current use of contraceptive methods

The contraceptive prevalence (modern methods) has increased considerably from 2000 to 2004 (from 26.6% to 43.2%). Accordingly to that change the overall contraceptive prevalence (including traditional methods) increased as well. In the year 2004 the overall contraceptive prevalence was 45.2%, which is a significantly increase of about 16% compared to the year 2000 (see table 9).
The contraceptive prevalence figures for the study area are higher than the ones reported in the council health plan 2004[3] for Lushoto District (24% total FP use among women of child bearing age). Figures for overall usage rate of pills and injections do not differ substantially from those published by the PHC 2002[4], which were 15.8% for pills and 65.1% for injections.

Table 9: Current use of FP in different years and in non-CBD villages

Characteristics	Contraceptive mix					
Contraceptives	**Year: 2000 N=139**		**Year: 2004 N=213**		**Non-CBD villages N=95**	
	N	**%**	**N**	**%**	**N**	**%**
Sterilization	7	5.0%	3	1.4%	2	2.1%
Norplant	-	-	1	0.5%	-	-
IUD	1	0.7%	4	1.9%	-	-
Oral Pill	36	25.9%	49	23.0%	18	18.9%
Injection	78	56.1%	140	65.7%	60	63.2%
Physical barriers	5	3.6%	8	3.8%	1	1.1%
Safe period, abstinence	12	8.6%	8	3.8%	14	14.7%
Contraceptive prevalence (modern methods)	**26.6%**		**43.2%**		**39.5%**	
Confidence interval	22.7% - 30.8%		38.7% - 47.8%		32.8%-46.6%	
Contraceptive prevalence (including traditional methods)	**29.6%**		**45.2%**		**46.3%**	
Confidence interval	25.1% - 33.4%		40.7% - 49.9%		39.4% - 53.4%	

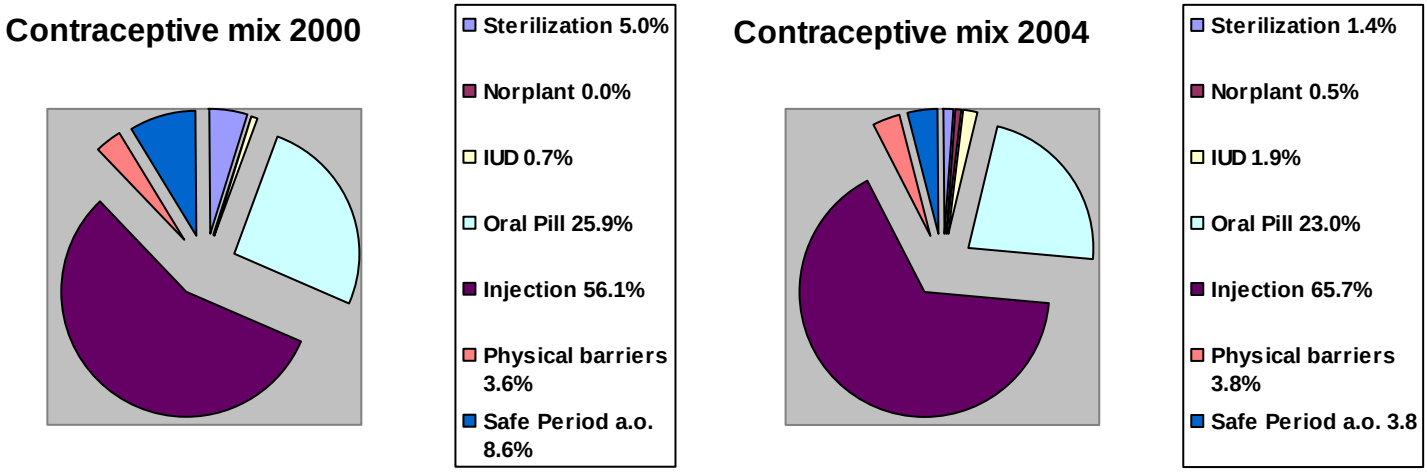
The contraceptive prevalence in villages without CBD programme (39.5%) does not differ significantly from those with CBD programme (43.2%). If this number would be the only indicator this could question the impact of the CBD programme (for further discussion see

[3] Comprehensive Council Health Plan for January-June 2004, Lushoto District Council, Ministry of regional administration and local government, page 3.
[4] Annual Health Care (PHC) Report Lushoto District Council, January 2002 to December 2002

outcome parameters). However, numbers for the non-CBD villages are low, resulting in a large confidence interval.

Looking at the same six villages trough time the following was found: The contraceptive mix hasn't substantially changed in the period between 2000 and 2004. Still some changes are worth mentioning. The most noticeable changes are that the percentage of injection increased about 10% and safe period/natural methods decreased about 5% (see figure 1). Both of these changes fit into a hypothesis that CBDs are able to assist people use pills instead of traditional methods. Eventually some of the users of pills may later shift towards injections as a more convenient method. Yet, this hypothesis cannot be proven or disproved with this data.

Figure 1: Contraceptive mix in Lushoto Division in the year 2000 and 2004



Because of small numbers it is difficult to state something about the differences in use of FP regarding schooling and marital status. Altogether there seems to be no substantial differences in schooling and marital status regarding use of FP (see table 10).

Table 10: Current use of FP in respect to schooling and marital status

Characteristics	**Current use of modern family planning methods**					
Schooling	**Year: 2000 N=127**		**Year: 2004 N=205**		**Non-CBD villages 2004 N=81**	
	N	**%**	**N**	**%**	**N**	**%**
Yes	117	31.0%	189	45.1%	76	40.6%
No	22	21.8%	16	28.6%	5	27.8%
Current marital status	**Year: 2000 N=127**		**Year: 2004 N=205**		**Non-CBD villages 2004 N=81**	
	N	**%**	**N**	**%**	**N**	**%**
Not yet married [1]	-	-	11	28.2%	3	17.6%
Living with husband	119	31.0%	156	48.8%	68	46.6%
Divorced	3	20.0%	4	26.7%	-	-
Separated	3	30.0%	5	50.0%	1	50.0%
Husband living far away	7	14.3%	13	27.1%	4	21.1%
Widowed	2	9.5%	-	-	-	-
Consensual union	3	30.0%	16	42.1%	5	31.3%

[1] not asked in 2000

Table 11: Current use of FP in respect to age groups

Characteristics	Current use of modern family planning methods					
Age groups	**Year: 2000 N=127**		**Year: 2004 N=205**		**Non-CBD villages N=94**	
	N	**%**	**N**	**%**	**N**	**%**
15-19 years	4	11.4%	10	21.7%	1	4.2%
20-24 years	32	26.4%	58	45.3%	24	38.1%
25-29 years	39	33.9%	67	48.9%	28	47.5%
30-34 years	27	32.1%	42	45.2%	15	51.4%
35-39 years	10	17.5%	20	43.5%	10	50.0%
40-44 years	8	24.2%	6	40.0%	2	33.3%
45-49 years	7	21.2%	2	20.0%	-	-

Table 11 shows the distribution of age groups among current users of modern FP. There are differences between the years 2000 and 2004 in nearly all age groups. In nearly all age groups (except the 45-49) percentage of users of modern FP increased. Again because of small numbers a statistically significant difference can't be proven and the result can be interpreted as a trend that is explained by a higher overall contraceptive prevalence.

Other indicators that might influence/validate the user rate include mean age of users, mean number of live births and the prevalence of pregnant women in the survey. The latter one and mean age seem to be in the same sphere across the surveys (see table 12).

Table 12: Comparison of mean age and mean live birth among current FP user

Survey	Mean age of users		Mean Number of live birth among users of FP		Prevalence of pregnant women in the survey
CBD Villages 2000	29.1	Std Dev 7.22	3.8	Std Dev 2.36	10.9% Conf Limit: 7.0% - 16.0%
CBD Villages 2004	27.4	Std Dev 5.79	3.0	Std Dev 1.45	9.1% Conf Limit: 5.6% - 10.7%
Non-CBD Villages 2004	27.8	Std Dev 5.98	3.2	Std Dev 1.86	11.9% Conf Limit: 7.6% - 13.2%

D. Women's intention of giving birth within the next year:

In CBD villages 93.3% (N=446/475) of all women don't want to get pregnant in the year to come. Asked how they would feel if they get pregnant next week 89.9% (N=365/406) of all women answered they would be unhappy. For further discussion see the paragraph about unmet need (page 15).

E. Problems faced in obtaining contraceptives

Only 4 women (1.9%; N=204/208) ever experienced difficulties in obtaining contraceptive supplies. One woman reported that staff was not available and two women reported that the method was not available (method used was oral pill and condom; all are from Ngulu, Yoghoi and Miegeo). This matches with the results from 2000 where only 5 women reported difficulties in obtaining contraceptives.

Even in the two villages without CBD programme no problems of obtaining contraceptives were reported.
At first sight this seems to be a surprising result. However, knowing that in villages without CBD programme a monthly mobile clinic was established that also provides injections and pills this result can easily be explained. The availability of FP seems to be quite good in the whole of Lushoto District.

F. Reason for non-use of family planning methods

Table 13 shows the reasons for non-use of FP methods. No major differences were observed between 2000 and 2004 except breastfeeding, which as a reason for non-use of FP increased in 2004 compared to 2000.

Table 13: Reasons for non-use of family planning methods

Reason for non use	Year: 2000		Year: 2004		Non-CBD villages	
	N	%	N	%	N	%
Want more children	35	11.1%	23	8.7%	13	11.1%
Fear of side effects	35	11.1%	20	7.6%	7	6.0%
Husband/partner objects	10	3.2%	21	8.0%	6	5.1%
Method/service not available	16	5.1%	-	-	-	-
Health reasons	14	4.4%	10	3.8%	2	1.7%
Sterility	15	4.7%	7	2.7%	2	1.7%
Religious reasons	6	1.9%	3	1.1%	-	-
Breast-feeding	43	13.6%	64	24.3%	32	27.4%
Pregnant	35	11.1%	40	15.2%	22	18.8%
No partner [1]	-	-	54	20.5%	24	20.5%
Menopause [1]	-	-	9	3.4%	3	2.6%
No money [1]	-	-	-	-	-	-
Don't know any method, need advice [1] [2]	-	-	5	1.9%	1	0.9%
Don't know/ no answer	107	33.9%	7	2.7%	5	4.3%
Total	**N=316**	**100%**	**N=263**	**100%**	**N=117**	**100%**

[1] Not possible answers in the questionnaire 2000
[2] Recoded from answer "other"

G. Husband knowing about use of contraceptive

Since 'husband/partner objects' is a reason for non-use of FP it is not surprising that there is a group of women who did not tell their husbands about the use of FP. This percentage of women increased significantly from 15,9% (year 2000) to 28.3% (year 2004) (see table 14). It might have assisted to increase the overall contraceptive prevalence that there are women who don't ask for permission or use FP even though they know about their husband/partner disagreeing.
It is worth noticing that more Moslem women hide the use of FP than Christian women (CBD villages 2004: Christian 17/59 – 28.8%; Islamic 42/59 – 71.2%, non-CBD villages 2004: Christian 2/16 – 12.5%, Islamic 14/16 – 87.5%).

Table 14: Percentage of women who answered that their husband doesn't know about use

Does your husband know that you are using FP?	Frequency	Percent	CI
CBD Villages 2000	20/126	15.9%	10.0% - 23.4%
CBD Villages 2004	60/152	28.3%	22.3% - 34.9%
Non-CBD Villages 2004	16/92	17.4%	10.3% - 26.7%

H. Unmet need of family planning

Table15: Percentage of women who don't want another child in the year to come

Don't want another child in the year to come	Frequency*	Percent	CI
CBD Villages 2000	379/431	87.9%	84.4% - 90.8%
CBD Villages 2004	409/438	93.4%	90.5% - 95.4%
Non-CBD Villages 2004	164/180	91.1%	86.0% - 94.8%

*(only women who weren't pregnant at the time of the interview)

Table 16: Unmet need of family planning

Characteristics		Year: 2000 N=431	Year: 2004 N=438	Non-CBD villages N=180
Women who don't want to give birth in the year to come [1]		**N=379 87.9%**	**N=409 93.4%**	**N=164 91.1%**
Out of these:				
Not using contraceptive method:		N=253 58.7%	N=207 47.3%	N=75 41.7%
Because of:	Sterility [2]		-5 N=202 46.1%	-1 N=74 41.1%
	Menopause	-15 N=238 **55.2%**	-8 N=194 **44.3%**	-3 N=71 **39.5%**
	Breastfeeding	-42 N=196 45.5%	-63 N=131 29.9%	-27 N=44 24.5%
	No partner available [3]		-51 N=80 18.3%	-21 N=23 12.8%

[1] Only women who weren't pregnant at the time of the interview
[2] In the year 2000 is no differentiation between sterility and menopause; it is combined in one answer
[3] This wasn't a possible answer in the survey 2000

Both unmet need (table 16) and women who do not want another child in the year to come (table 15) show a similar trend. Women seem to put more space between births and at the same time the unmet need for FP methods decreases. However, both trends are not statistically significant.

In the whole study area (CBD and non-CBD villages together) 8.1% (55/680) among all women answered they don't want any more children at all (CI: 6.2% - 9.3%).
Out of them 49.1% (27/55) are using a modern family planning method, 12.9% (4/55) are using safe period or natural methods and 50.9% (28/55) don't use any FP method at all.
From those who don't use any FP method 75% (21/28) are not currently in danger of getting unwanted pregnant because of different reasons (N=2 are already in their menopause, N=7 are pregnant, N=7 don't have a partner and N=5 are breastfeeding).
Out of all women who don't want any more children at all 38.5% (20/52) answered they would plan to use sterilization. 9.6% (5/52) answered they would plan to use Norplant and 11.5% (6/52) would plan to use IUD.

V. Long-term methods

A. Knowledge of long-term methods

In all eight villages women were asked if they knew any of the three following long-term methods: sterilization, Norplant, IUD. Nearly a third of all women knew one of the above-mentioned long-term methods. The best-known method was IUD (34.1%) followed by sterilization (33.1%) and Norplant (26.9%) (see table 17).

Table 17: Knowledge of long-term methods Q31

Knowledge of	Answer	Frequency	Percent	95% CI
Sterilization	No Yes N = 678	450 228	66.4 33.6	62.7% - 69.9% 30.1% - 37.3%
Norplant	No Yes N = 677	495 182	73.1 26.9	69.6% - 76.4% 23.6% - 30.4%
IUD	No Yes N = 678	447 231	65.9 34.1	30.5% - 37.8% 62.2% - 69.5%

It is worth noting that knowledge about a long-term method might not be deep in many cases – often the only knowledge present was the mere existence of a certain method without any further insight. Unfortunately the depth of knowledge wasn't part of this study and would be an interesting topic for further research.
In Q16 all women were asked if they were able to mention one modern family planning method. There were several possible answers. The interviewers were trained not to read out possible answers so that the knowledge of FP doesn't suffer from that influence.
There are slight differences between the result of Q16 and Q31, both questions asking about knowledge of long-term methods. Probably different ways of asking the questions account for this inconsistency. However, the difference is not substantial and the figures of Q31 fit with those from Q16.

B. Intention of use

The overall intention of use for any long-term method in the future is high. Nearly half of all women asked answered they would like to use a long-term method in the future (49.2%). This number seems to be far too high for an expression of real intention to use - it should rather be interpreted as an expression of what the women can imagine to do in the far future, after reaching the wanted number of children. Also, this question is suffering from cultural and language issues.

Table 18: Intention of use a long-term method (Q33)

Intention of use	Answer	Frequency	Percent	95% CI
Sterilization	No Yes N = 679	520 159	76.6% 24.4%	73.2% - 79.7% 20.3% - 26.8%
Norplant	No Yes N = 679	596 83	86.5% 13.5%	83.6% - 88.9% 11.1% - 16.4%
IUD	No Yes N = 679	587 92	86.5% 13.5%	83.6% -88.9% 11.1% - 16.4%
Total	No Yes N=679	345 334	50.8% 49.2%	47.0% - 54.6% 45.4% - 53.0%

The highest positive answers can be found for sterilization (23.4%) followed by IUD (13.5%) and Norplant (12.2%).

There are cases in which woman answered they would like to use a long-term method even though they didn't know the method before. That's possible because all interviewers were nurses who explained the method in case of lack of knowledge. This could have led to a courtesy bias in answers. Therefore it is necessary to distinguish between those who have known the method before and those who haven't. Applying this, the number of women who expressed the intention to use a long-term method is decreasing (see Table 19) but still substantial.

Table 19: Intention of use and knowledge of the method N=665

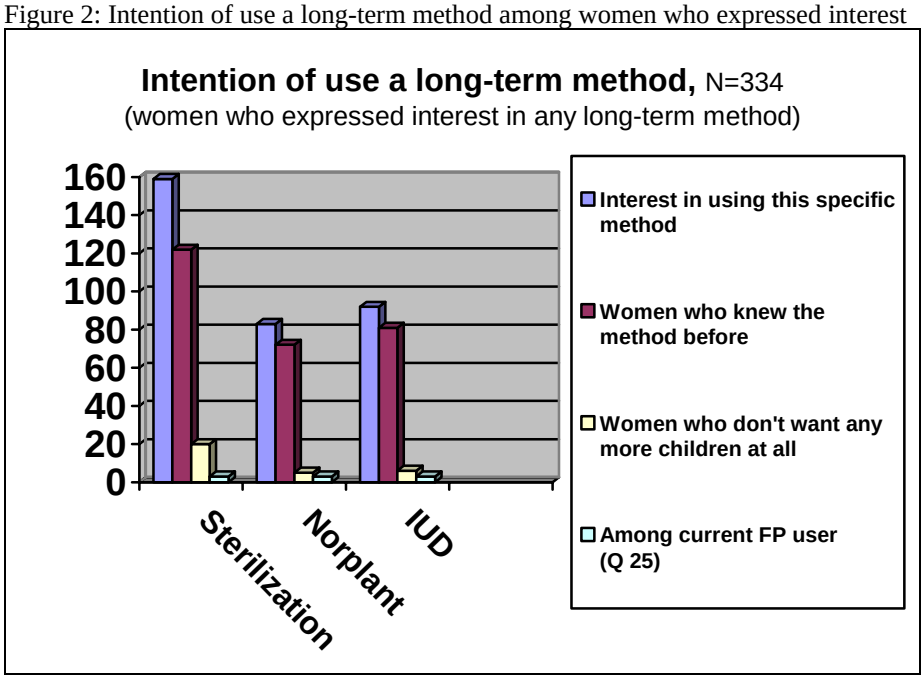
Intention of use	Intention of use Total	Knowledge existing	After explanation
Sterilization	23.8%	18.4%	5.5%
Norplant	12.3%	10.9%	1.5%
IUD	13.5%	12.3%	1.6%

All percent quotations are the percentage out of N=665

C. Need and demand for long-term methods

From those women who are interested in use of a long-term method (N=334) the biggest part expressed to use sterilization (159/334) followed by IUD (92/334) and Norplant (83/334).
As already mentioned prior knowledge of a long-term method is an indicator for "real intention" to use. If only those women are counted who were in possession of prior knowledge numbers slightly decrease – see table 19.
Among those women who are currently using FP only 12 women out of 286 answered they would like to use another method and specified it as a long-term method (Sterilization: 3/286, Norplant: 3/286, IUD: 3/286).

Figure 2: Intention of use a long-term method among women who expressed interest



D. Comparison of CBD and non-CBD villages

The knowledge of long-term methods doesn't differ between CBD and non-CBD villages. However, the intention of using a long-term method in the future differs significantly between CBD villages and non-CBD villages. In CBD villages 53.3% of the women expressed the future intention to use a long-term method whereas in non-CBD villages only 39.7% of the women asked expressed the same (see table 20). This supports the hypothesis that CBDs increase the demand for such services.

Table 20: Intention of use a long-term method (Q 32)

Intention of use any long-term method	Answer	Frequency	Percent	95% CI
CBD villages 2004	No Yes N = 475	222 253	46.7% 53.3%	42.2% - 51.3% 48.7% - 57.8%
Non-CBD villages 2004	No Yes N =204	123 81	60.3% 39.7%	53.2% - 67.1% 32.9% - 46.8%

VI. Outcome parameters of the CBD programme

Even though one of the main objectives of the current study is an evaluation of the long-term impact of the CBD programme, the task itself is rather challenging. Interpretations about a "dose-response-relationship" have to be made with caution.
Table 21 tries to give a comprehensive summary of CBD activity per village (only study villages included) over time. While recovering the information, it became soon clear that CBD activity is quite fluctuating.

If CBD activity for the year 2003 is compared between the villages (table 22) it can be seen that CBD coverage and CYP distributed are highly correlated. Contraceptive prevalence itself as outcome (pills only) is not always correlating nicely with the "input". Due to small numbers confidence intervals are considerable. Contraceptive prevalence is also influenced by activities not related to CBD work like mobile clinics and pills given in the hospital in Lushoto.

Table 21: CBD Coverage

Year	Yoghoi	Irente	Miegeo	Ubiri	Ngulu	Kwemashai
2000	2 started in January 7 since April 10 since November	4	5; but only 2 worked	7	5 started in April; 4 since July	8 started in April 5[1] since July
2001	10 started in January 11 since May	2-5	5	9	7	8
2002	11	3-5	5	9	7-11	8 10 since April
2003	9	3-4	6-7	10	8	10

Source: M.Nyenga, Lushoto, CBD reporting files 2000-2003

[1] according to the reporting file five out of eight were actually working

Table 22: Outcome for pills per village

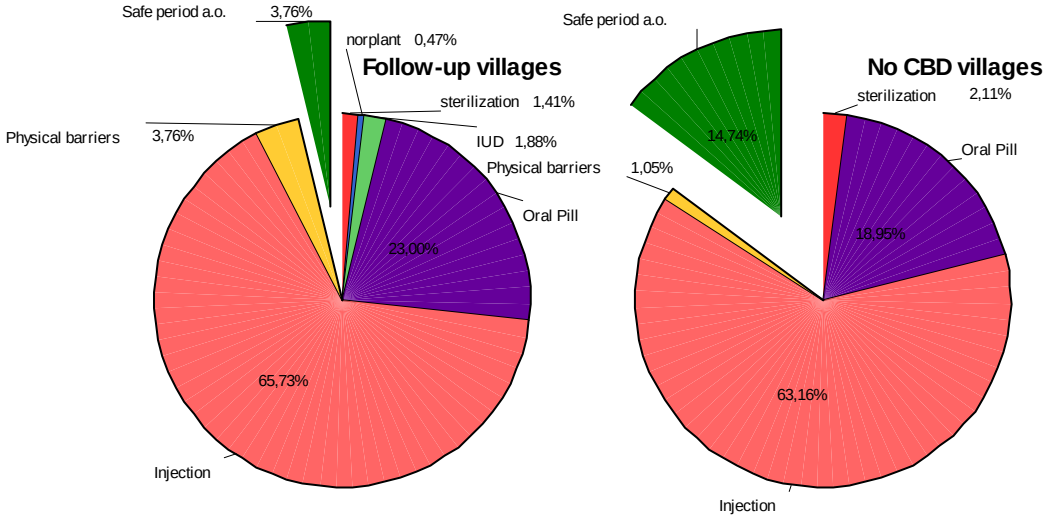
Village	Contraceptive Prevalence Pills only in 2004 (% out of women who use FP)		CI of contraceptive prevalence	CYP pills distributed by CBDs in 2003	CBD Coverage	Total population
Yoghoi	(10/39)	27%	13.8% - 44.1%	191	10	2378
Irente	(7/50)	14%	5.8% - 26.7%	29	3	2469
Miegeo	(11/27)	40.7%	22.4% - 61.2%	83	6	1436
Ubiri	(11/41)	26.8%	14.2% - 42.9%	85	10	3945
Ngulu	(7/30)	23.3%	9.9% - 42.3%	100	8	2102
Kwemashai	(3/28)	10.7%	2.3% - 28.2%	151	9	3352
Mgwashi	(7/50)	14%	5.8% - 26.7%	Non-CBDs	Non-CBDs	3601
Magila	(11/45)	24.4%	12.9% - 39.5%	Non-CBDs	Non-CBDs	2785

Table 23 shows that CBD villages and non-CBD villages did not differ statistically significantly as far as percentage of pill users are concerned. Again, small numbers are a concern that should be taken into consideration once future research is addressed.

Table 23: Comparison percentage user of pills 2000, CBD villages 2004 and non-CBD villages 2004

Use of pills (out of current FP user)	Frequency	Percent	CI
CBD Villages 2000	36/127	28.3%	20.7% - 37.0%
CBD Villages 2004	49/213	23.0%	17.5% - 29.2%
Non-CBD Villages 2004	18/95	18.9%	11.6% - 28.3%

Figure 3: Contraceptive mix in Follow-up villages and in non-CBD villages



In non-CBD villages a statistically significant higher percentage of women were still using traditional methods (see figure 3). The figures are 8 out of 213, 8.3%, CI: 1.6% - 7.3% for follow-up villages and 14 out of 95, 14.7%, CI: 8.3% - 23.5% for non-CBD villages.
One could argue that this “share” of clients is a potential target group that could be reached in a CBD programme.

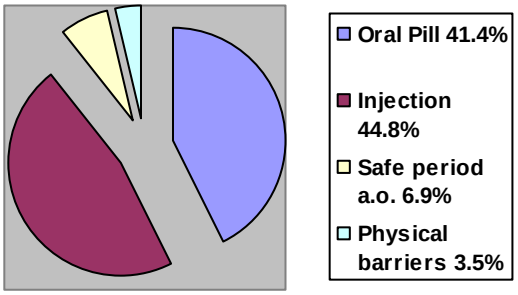
A. Prevalence per village

Even though the numbers are small and the confidence intervals are accordingly wide there are some statistically significant differences between the single villages.
The overall contraceptive prevalence in Irente is higher than in Kwemashai and Magila (Magila is a no-CBD village).
A comparison for overall contraceptive methods with use of pills in single villages (table 24) suffers from the same problem of small numbers. Also for some villages CBDs are not the only source of contraceptive methods (for example Irente is quite close to Lushoto hospital).
Altogether drawing conclusions about CBD work impact and contraceptive prevalence per village (overall and for pills only) remains a rather speculative undertaking at this point. Further research is needed to look into that topic.

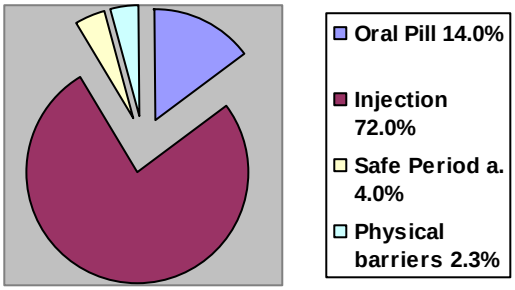
Table 24: Contraceptive prevalence per village

Village	Contraceptive Prevalence in 2004	Confidence intervals of contraceptive prevalence	Total population
Yoghoi	45.6%	34.3% - 57.2%	2378
Irente	55.8%	**44.7% - 66.5%**	2469
Miegeo	34.2%	23.7% - 46.0%	1436
Ubiri	50.6%	39.3% - 61.9%	3945
Ngulu	39.0%	28.0% - 50.8%	2102
Kwemashai	31.6%	**21.4% - 43.4%**	3352
Mgwashi	45.7%	35.2% - 56.4%	3601
Magila	34.5%	**25.8% - 44.0%**	2785

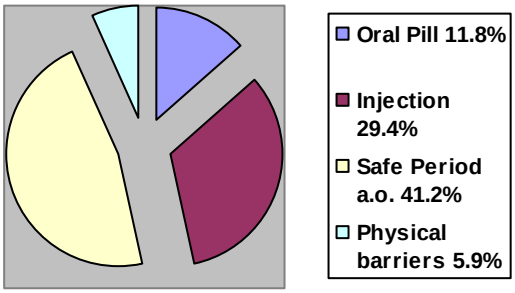
Figure 4: Current contraceptive mix compared to contraceptive mix in 2000



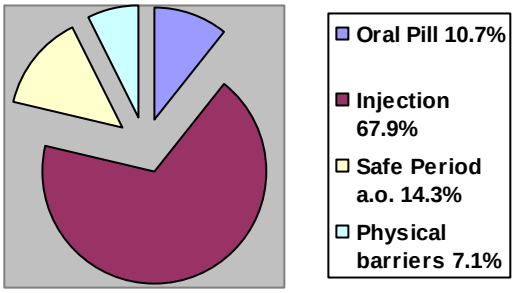
2000: Irente N=28
Contraceptive prevalence: 35.8%



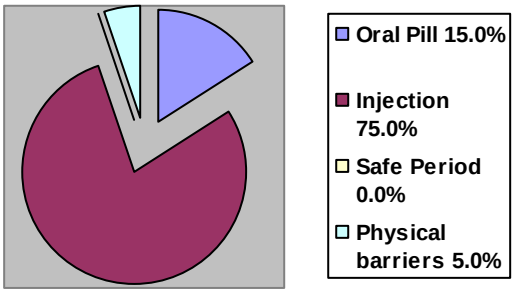
2004: Irente N=47
Contraceptive prevalence: 58.1%



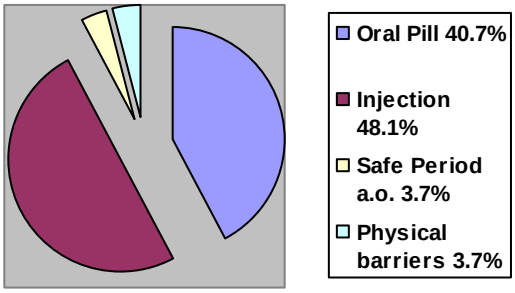
2000: Kwemashai N=15
Contraceptive prevalence: 21.8%



2004: Kwemashai N=28
Contraceptive prevalence: 35.5%



2000: Miegeo N=19
Contraceptive prevalence: 21.8%



2004: Miegeo N=26
Contraceptive prevalence: 35.5%

The figures above can serve to initiate hypotheses about the stages of CBD work and different "paths" existing in different social realities. However, numbers are too small to provide any statistically significant results. Trends can still be seen:

- Kwemashai: Here the trend is that traditional methods have greatly decreased over time – hopefully indeed caused by CBD counseling activities.
- Irente: Overall contraceptive prevalence has increased. It seems as if pills have decreased. However, in the light of the overall increased prevalence it could be that the absolute number of pills clients in Irente remained the same and that more women were referred to get injections. This makes sense as Irente is indeed close to Lushoto town.
- Miegeo: Overall contraceptive prevalence has increased like in Miegeo. The contrary trend to Irente is happening here. Absolute number of injections might have stayed the same whereas number of pills clients might have increased.

- Kwemashai, Miegeo and Irente could be in different or subsequent "stages" of the process. It might be that women clients are "recruited" away from traditional methods (Kwemashai) first to pills (Miegeo) and then – if they trust the service – are referred to getting injections as the last step. The "age" of CBD activities in the three villages mentioned would fit to that hypothesis. Additional support for that hypothesis comes from the fact that out of the 45 women who changed methods 27 switched from pills to injections.

VII. Maternal health and delivery indicators

Table 25: Maternal Health indicators

Indicator	**Year: 2000**		**Year: 2004**		**Non-CBD villages**	
	N	**%**	**N**	**%**	**N**	**%**
Pregnant at time of the survey	N=478		N=475		N=202	
No	430	89.9%	432	90.9%	178	88.1%
Yes	48	10.1%	43	9.1%	24	11.9%
Was pregnancy planned?	N=48		N=41		N=19	
No	28	58.3%	11	26.8%	8	42.1%
Yes	20	20.0%	29	70.0%	10	52.6%
No answer			1	2.4%	1	5.3%
History of abortion	N=478		N=473		N=192	
No	404	84.5%	413	87.3%	174	90.6%
Yes	74	15.5%	60	12.7%	18	9.4%
Abortion treated at:	N=74		N=60		N=18	
Dispensary	1	1.4%	3	5.0%	3	16.7%
Health Centre	-	-	1	1.7%	2	11.1%
Traditional Healer	17	23.0%	1	1.7%	3	16.7%
Hospital	48	64.9%	34	56.7%	7	38.9%
Home, no treatment	8	10.8%	19	31.7%	3	16.7%
No answer	-	-	2	3.3%	-	-
ANC during last pregnancy	N=433		N=443		N=181	
No	10	2.3 %	8	1.8%	3	1.7%
Yes	423	97.7%	435	98.2%	178	98.3%

The number of unplanned pregnancies decreased statistically significant which fits together with the lower unmet need for FP already discussed above. The percentage of unplanned pregnancies was 58.3% in 2000 (CI: 43.2% - 72.4%) and 26.8% in 2004 (CI: 14.2% - 42.9%).

Location of delivery is significantly different between the year 2000 and 2004 (see table 26).

Table 26: Delivery indicators

Indicator	Year: 2000 N	Year: 2000 %	Year: 2004 N	Year: 2004 %	Non-CBD villages N	Non-CBD villages %
Place of Delivery	N=432		N=444		N=181	
Home	341	78.9%	283	63.7%	119	65.7%
Dispensary	5	1.2%	28	6.3%	26	14.4%
Health Centre	1	0.2%	4	0.9%	6	3.3%
Hospital	85	19.7%	127	28.6%	29	16.0%
On the way	-	-	2	0.5%	1	0.6%
Delivery assisted by	N=424		N=443		N=177	
Doctor, nurse or midwife	95	22.0%	166	37.5%	73	41.2%
Trained TBA	10	2.3%	55	12.4%	34	19.2%
Untrained TBA	93	21.5%	77	17.4%	35	19.8%
Relative, neighbor, friend	209	48.4%	63	14.2%	29	16.4%
Mother	25	5.8%	82	18.5%	6	3.4%
Complications during delivery			N=440		N=176	
No complications			420	95.5%	164	93.2%
Bleeding			7	1.6%	4	2.3%
Prolonged labor			10	2.3%	4	2.3%
Asphyxia of the newborn			1	0.2%	1	0.6%
Unusual position of the child			2	0.5%	3	1.7%

Home deliveries decreased and deliveries in dispensaries and hospitals increased (see table 27). This could be seen as a result of the efforts of the (DHMT, CBD, possibly also TBA) to encourage women to deliver in health facilities instead of delivering at home. The differences between CBD villages 2004 and non-CBD villages for hospital and dispensary deliveries are easily explained by knowing that the next hospital is in Lushoto which is a distance from 26km or 34km respectively. All CBD villages are scattered around a perimeter of about 10km.

Table 27: Confidence intervals for locations of delivery

Survey	Home delivery		Hospital, Dispensary, Health Centre	
	%	Confidence interval	%	Confidence interval
CBD Villages 2000	78.9%	74.7% - 82.6%	21.1%	17.4% - 25.3%
CBD Villages 2004	63.7%	59.1% - 68.2%	35.8%	31.4% - 40.5%
Non-CBD Villages 2004	65.7%	58.3% - 72.6%	26.9%	26.9% - 41.1%

The changes in location of delivery go along with changes in assistance by birth attendants (see table 28). Deliveries attended by a doctor, nurse or midwife are increasing as well as the deliveries attended by trained TBAs. At the same time deliveries attended by relatives, neighbors or friends are decreasing. The percentage of untrained TBAs hasn't changed.

Table 28: Confidents limits for birth attendants

Survey	Doctor, nurse, MW %	CI	Trained TBA %	CI	Relative, neighbour, friend, mother %	CI
CBD Villages 2000	22.0%	18.2% - 26.3%	2.3%	1.2% - 4.4%	54.2%	49.5% - 58.9%
CBD Villages 2004	37.5%	33.0% - 42.2%	12.4%	9.6% - 15.9%	32.7%	28.3% - 37.1%
Non-CBD Villages 2004	41.2%	33.9% - 48.9%	19.2%	13.7% - 25.8%	19.8%	13.9% - 25.7%

A. Awareness and perception of HIV risk

Asked if they know a woman in the family or in the village who died during pregnancy only 18.3% answered with “yes”. This is considerably less than in the year 2000.
Asked if they know a woman in the family or in the village who died of AIDS 27.4% answered with “yes”. This is a little bit less than in the year 2000 but not a remarkable change.
In the perception of the population HIV still might not be the “biggest danger to health”. This could be a result of the way HIV is still handled as a taboo topic. Many women answered they possibly know a woman who died because of AIDS but that they are not sure.

Table 29: Perception of risk of death during pregnancy compared to other important health risks

Indicator	Year: 2000 N	%	Year: 2004 N	%	Non-CBD villages N	%
Aware about women’s death in cause of pregnancy	N=478		N=474		N=203	
No	289	60.5%	385	81.7%	179	88.2%
Yes	189	39.5%	86	18.3%	24	11.8%
Aware about women’s death by AIDS	N=475		N=474		N=203	
No	305	64.2%	344	72.6%	165	81.3%
Yes	170	35.8%	130	27.4%	38	18.7%

VIII. Annex:

A. Questionnaire used in 2004

Rapid Assessment Questionnaire

Reproductive Health Status
Women 15 – 49 years of age

Personal Identification

Study No:_____

Region: _____ District: _____Division:_____

Village: _____ **Household No:** _____

Name of Interviewer: _____ **Date:**_____/_____/____

Respondent's Name:_____**Age:**_____

Occupation: _____**Religion:** _____

Name of Household Head:_____ **Sex of household head: M / F**

Interviewer information for the client: This questionnaire is aimed at getting information from the community level to better plan and offer services of reproductive health, which is family planning, mother child health services and youth friendly services.
You don't have to answer You are not feeling comfortable with. Information gathered in this questionnaire will be dealt with in a confidential manner. Data will be anonymized, which means names will be stripped off and nobody will be able to track individuals from the way they answered.

1. Have you ever attended school?

(1) Yes (0) No **Go to Q3**

2. How many years of formal schooling you completed?

(1) 7 years or less (2) 8 – 10 years (3) More than 10 years

3. Can you read and write Kiswahili?

(1) Yes (0) No

4. What is your current marital status? (0) not yet married (1) Living with husband (2) Divorced (3) Separated (4) Husband living away (5) Widowed (6) Consensual Union

5. Do you have any sexual partner now?

(1) Yes (0) No

6. How old were you when you first got married or started to live with partner?

(1) Less then 15 yrs (2) 16 – 18 yrs

(3) 19 – 25 yrs (4) More than 25 (99) DK / NR

7. Have you ever given birth including stillbirth?

(1) Yes (0) No **Go to Q10**

8. How many times have you given birth to stillborn?

(1) Number _____ (99) DK / NR

9. How many live births did You have?

(1) Number _____ (99) DK / NR

10. Have you ever had an abortion?

(1)Yes (0) No **Go to Q12**

11. Where did you get treatment?

(1) Dispensary (2) Health Center

(3) Traditional Healer (4) Hospital

(5) Home, no treatment (6) Other_____

12. Are you pregnant now?

(1) Yes (0) No **Go to Q15**

13. At the time you became pregnant – did You

(1) want to become pregnant?

(2) want to wait until later?

(3) not want to have any more children at all?

(99) DK

14. How long would You like to wait after the birth of the child you are expecting before the birth of another child?

___ ___ months / years (cross the one that does not apply) **Go to Q16**

(0) don't want any more children

15. How long would You like to wait from now until the birth of a (another) child?

(1) ___ ___ months / years (cross the one that does not apply)

(2) Says that she can't get pregnant

(3) After marriage

(4) Others _____

16. Can you mention one modern method of Family Planning?
(possible to tick more than one)
(Don't read out possible answers!!!)

(1) female sterilization

(2) male sterilization

(3) IUDs

(4) Norplant

(5) Oral pills

(6) Injection

(7) Condoms

(8) Foam, Jelly

(9) Diaphragm

(0) No **Go to Q18**

17. Do you know where you can obtain this method?

(1) Health Center (2) Pharmacy

(3) Hospital (4) Dispensary

(5) CBD (6) Other _____ (99) DK/NR

18. Are you or your husband / partner currently using any family planning method?

(1) Yes (0) No **Go to Q29**

19. Which method are You using now?

(1) Sterilization (2) Norplant (3) IUD

(4) Oral pill (5) Injection (6) Condom, Foam, Jelly, Diaphragm

(7) Safe Period, Withdrawal, Abstinence, traditional methods

(8) Other_____

20. For how long have You or your husband continuously been using the current family planning method?

(1) since the birth of the last child (2) before the birth of the last child (3)

No child yet, use since _____

21. Have You been using a different family planning method before using the one You are currently using?

(1) Yes (0) No **Go to Q24**

22. Which one did You use before?

(1) Sterilization (2) Norplant (3) IUD

(4) Oral pill (5) Injection (6) Condom, Foam, Jelly, Diaphragm

(7) Safe Period, Withdrawal, Abstinence, traditional methods

(8) Other_____

23. Why did You change the method?

(1) side effects of the old method (2) new method was easier to handle

(3) no stock of previous method (4) new one easier to get

(5) because of professional advice (6) other _____

(99) NR, Don't know

24. Would you like to use another method?

(1) Yes (0) No **Go to Q26**

25. Which one?

(1) Sterilization (2) Norplant (3) IUD

(4) Oral pill (5) Injection (6) Condom, Foam, Jelly, Diaphragm

(7) Safe Period, Withdrawal, Abstinence, traditional methods

(8) Other_____

26. Did you ever face any difficulties in obtaining Family Planning supplies?

(1) Yes (0) No **Go to Q 28**

27. What was the main difficulty?

(1) Price (2) Distance to health centre

(3) Staff not available (4) Method not available

(5) Other Reasons_____

28. Does your husband know that you are using Family Planning methods?

(1) Yes (0) No

29. What is the most important reason you are not using any modern Family Planning method?

(1) Want more children (2) Fear of side effects

(3) Husband / partner objects (4) Method / service not available

(5) Health reasons (6) Sterility

(7) Religious reasons (8) Breast-feeding

(9) Pregnant (10) No partner (11) Menopause (12) No money (13)

Other_____ (99) DK / NR

30. Where would you prefer to get Family Planning services?

(1) Health Facility (2) Pharmacy

(3) CBD (4) Supermarket, Store

(5) Other_____ (99) Anywhere, NR, DK

31. Do You know the following long term methods?

a) Sterilization: (1) Yes (0) No

b) Norplant: (1) Yes (0) No

c) IUD: (1) Yes (0) No

32. If answer No 25 was Sterilization, Norplant or IUD go to Q 34

Do You plan to use any of those long term methods in the future?

(1) Yes (0) No

33. If Yes, which one?

a) Sterilization: (1) Yes (0) No

b) Norplant: (1) Yes (0) No

c) IUD: (1) Yes (0) No

34. What are advantages / disadvantages of sterilization?

(1) permanent method

(2) danger of infection

(3) no more worries about any other method

35. When did you give the last delivery? Date_____/_____/_____

36. Did you receive antenatal care during your last pregnancy?

(1) Yes (0) No (99) DK / NR

37. Where did the delivery take place?

(1) Home (2) Dispensary (3) Health Center (4) Hospital

(5) on the way (99) DK / NR

38. Do you remember having any complications during delivery?

(1) No complications (2) Bleeding

(3) prolonged labor (4) Asphyxia of the newborn

(5) unusual position of the child

(6) Others _____

39. Who attended the delivery?

(1) Doctor, Nurse, MW (2) Trained TBA (3) Untrained TBA, CHW

(4) Relative, Neighbour, Friend (5) my mother (6) alone

(7) Other _____ (99) DK / NR

40. How will you feel if you become pregnant within the next week? (don't ask a pregnant woman)

(1) Happy (0) Unhappy (99) Does not matter

41. Do You know any woman in your family, or in this village who died during pregnancy or during delivery or after delivery?

(1) Yes (0) No

42. Do You know any woman in your family, or in this village who died because of malaria in pregnancy?

(1) Yes (0) No

43. Do You know any woman in your family, or in this village, who died because of AIDS?

(1) Yes (0) No

44. Have You ever been asked questions like this before?

(1) Yes (0) No

B. Overall view of CBDs in Lushoto district

Table 30: Supervisor and CBD's in Lushoto 2003

Supervisor	Ward	Villages	CBD's 2003	Training year*	CBD's trained*
Rabia Mkindi	Lushoto	Dochi	3	1995	2
		Kwembago	4	1995 2000 2000	1 2 2
		Irente	3-4	2000	4
		Yoghoi	9	2000	10
Juma Rashidi	Kwai	Milungui	5	2001 2003	3 2
		Kwemakame	5	2001 2001	3 1
		Kireti	4	2001	4
Arested Kimanya	Gare	Masange	3	2001	4
Apasiana Massawe	Soni	Soni	1	1995	2
		Shashui	5	1995 2000 2002	2 2 4
Maajabu Mtoo	Malibwi	Kwekamga	7	1995 2002	3 5
		Mziragembei	4-9	2002 2003	4 5
Ayubu Senkondo	Makamya	Bombo	4	2002 2003	1 2
		Mavului	3	2002 2003	1 2
		Mdando	3	2002 2003	1 1
Mary Sekimweri	Malibwi	Mtambwe	5	2002 2003	2 6
		Mbwei	2	2002 2003	6 5
		Mazumbai	3	2002 2003	6 2
Zainati Lukuta	Mlola	Masashai	4-5	2002	4
		Ungo	4-5	2002	4
Mary Chando	Lushoto	Magamba	4	1995 2000	1 3
		Migambo	5	2001 2002	3 2
		Kwesimu	1 3	1995 2000	5

Supervisor	Ward	Villages	CBD's 2003	Training year*	CBD's trained*
Ashirafu Chamshama	Ubiri	Ngulu	8	2000 2002	7 4
		Kwemashai	10	2000	9
Maimuna Rhamadani	Ubiri	Miegeo	6-7	2000	6
		Ubiri	10	2000	10
Judica Mandia	Ubiri	Bombo	5	1995 2000	1 5
		Ngulwi	8	2000 2002	7 4
Delicia Msisiri	Gare	Gare	9	2000 2001 2002	5 2 5
		Boheloi	8	2000 2001	4 3
		Yamba	5	2000 2001	2 2

Source: M.Nyenga, Lushoto, CBD Reporting files 2000-2003
*Source: M. Nyenga, MCH Coordinator of Lushoto District

C. Contraceptives distributed by CBDs in Lushoto district 2000-2003

Table 31: Contraceptives distributed by CBDs in Lushoto district 2000-2004

Ward	Villages	Supervisor	Contra-ceptives	2000	2001	2002	2003
Lushoto	Migamba Migambo Kwesimu	Mary Chando	Pills Condoms	2047 3513	2863 7946	3291 12311	3157 9898
Ubiri	Bombo Ngulwi	Judica Mandia	Pills Condoms	1438 4723	2051 5561	2860 9563	2535 6382
Ubiri	Miegeo Ubiri	Judica Mandia until 2001	Pills Condoms	861 4029	1456 8066		
Ubiri	Miegeo Ubiri	E. Minja started 2002 Maimuna Rhamadani since Nov.2002	Pills Condoms			2333 11094	2360 10157
Soni	Soni	Rachel Shemlangwa	Pills Condoms	284 0	489 614		
Soni	Soni Shashui	Apasiana Massawe started 2002	Pills Condoms			781 900	788 319
Lushoto	Dochi Kwembago Yoghoi Irente	Rabia Mkindi	Pills Condoms	2764 7930	4323 16409	6022 19332	4479 12115
Ubiri	Ngulu Kwemashai	Iddi Mavura Ashirafu Chamshama since Nov.2002	Pills Condoms	1857 9686	4968 22748	5718 27088	3528 24647
Msale	Kwekanga Mziragembei	Maajabu Mtoo	Pills Condoms	1509 690	1440 705	2801 6654	3236 13737
Kwai	Milungui Kwemakame Kireti	Juma Rashidi started July 2001	Pills Condoms		928 2985	2498 12384	2203 9866
Gare	Gare Boheloi Yamba	Delicia Msisiri	Pills Condoms		2741 9200	5616 15075	4467 14901
Gare	Masange	Arested Kimanya started July 2001	Pills Condoms		135 780	237 805	225 1472
Makamya	Bombo Mavului Mdando	Ayubu Senkondo started March 2003	Pills Condoms				627 2058
Malibwi	Mtambwe Mazumbai Mbwei	Mary Sekimweri	Pills Condoms				1205 9276
Mlola	Masashai Ungo	Zainati Lukuta	Pills Condoms				412 2403

D. Tables: pills and condoms distributed in Follow-up villages over time

Table 32: Pills distributed by CBDs 2000-2003

Year	Yoghoi	Irente	Miegeo	Ubiri	Ngulu	Kwemashai
2000	936	498	282	579	1103	754
2001	1955	558	465	991	2545	2423
2002	2595	588	1239	1094	2943	2775
2003	2675	410	1164	1196	1413	2115

Source: M.Nyenga, Lushoto, CBD Reporting files 2000-2003

Table 33: Condoms distributed by CBDs 2000-2003

Year	Yoghoi	Irente	Miegeo	Ubiri	Ngulu	Kwemashai
2000	4887	1349	1439	2590	2666	7020
2001	9002	2590	2936	5130	5975	16773
2002	12896	3752	5316	5778	12434	14654
2003	8774	1900	3448	6709	10120	14527

Source: M.Nyenga, Lushoto, CBD Reporting files 2000-2003

E. Terms of Reference

Objective

To collect data on CBD activities in a household based survey in Lushoto.
To organize and carry out a follow-up study on the Lushoto CBD activities, using comparable methods with the baseline study from the year 2000.

Qualification required

- Experience in qualitative research.
- Able to select, train, organize and supervise a team of research assistants/interviewers.
- Some background in family planning.

Background

Based on routine data collection in the health system, CBD activities in Tanga region seem to have a considerable positive impact on contraceptive use in the areas they cover. However, this data is not reliable. In order to gain a better understanding of the impact of the CBD programme, household based data is necessary, and will be put in relation to the health system data.
At the start of the CBD activities in Lushoto in 2000, a baseline study was carried out. After almost 4 years of activities, a follow-up to this study, using comparable methodologies, will be organized.
In addition to the information collected in 2000, the information women have on long-term and permanent contraception will be further studied, as well as the need and demand for such methods. This will shed light on the anecdotal evidence that CBDs generate a considerable demand for these services.

Expected results

The following results are expected by the end of the consultancy:

- Data from women of reproductive age from 6 CBD villages and 2 villages without CBD activities are collected
- Data from interviews available in Epi-info format and analyzed
- Report on the findings
- Comparison of findings with baseline data
- Routine reporting of CBD-supervisors will be structured in a table giving information on the number of contraceptives distributed annually by each group of CBDs since 2000

Tasks of the consultant

- To adapt interview guidelines
- To involve/inform Lushoto health staff in all stages of the research
- To recruit, train, supervise and organize a team of 7 research assistants from Tanga region
- To organize data collection and entry
- To give a short feed back on findings in Tanga at the end of the research
- To analyze the data and write a report.

Time frame

Organization of the research in Lushoto in March 2004.

Reporting

The report and data will be forwarded to repro-gtz@africaonline.co.tz by April 13, 2004.