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Best Practices in CBD Programs in sub-Saharan Africa: Lessons Learned from Research and Evaluation

December 2, 2002
Washington, D.C.

Frontiers in Reproductive Health Program (FRONTIERS)
Family Health International
Advance Africa

Jim Phillips, Population Council

Executive Summary

Community-based distribution (CBD) is the use of non-professional local distributors or agents to provide family planning methods – typically condoms, pills, and spermicides – and referral for other services. Family planning programs in Africa, Asia, and Latin America have implemented CBD programs for the past 30 years based on the conviction that providing contraceptive methods at the community level increases access to and acceptability of family planning, particularly in rural areas where the health care infrastructure is weak.

There is a large body of evidence on the effectiveness, cost, and sustainability of CBD models. Most evidence supports using CBD where appropriate conditions exist. However, major changes have taken place in the context in which programs operate, including the onset of the HIV/AIDS pandemic, enhanced access to family planning services, and increased demand for related reproductive health care. These changes call for a review of CBD's relevance—particularly in sub-Saharan Africa.

This seminar was organized collaboratively by the Population Council's Frontiers in Reproductive Health Program (FRONTIERS), Family Health International (FHI), and Advance Africa and attended by participants of the U.S. Agency for International Development (USAID) and its collaborating agencies (CAs). The one- day event: (1) summarized evidence on the effectiveness, impact, cost, and sustainability of various CBD models; (2) identified best practices in African CBD programs; and (3) described how CBD programs can meet reproductive health needs in sub-Saharan Africa.

Key issues reviewed included: effectiveness, cost, and sustainability of CBD programs; distributor selection, training, and supervision; products and services; integration of new services; evaluation of CBD programs; and mobilization of sustainable support.

Conclusions

- CBD has been effective in bringing family planning services to underserved or remote areas—in sub-Saharan Africa as well as in other regions.
- A substantial market for CBD exists in sub-Saharan Africa. Program managers should focus on areas where the health care infrastructure is weak or where contraceptive use is low.
- Managers should seek to improve the effectiveness and efficiency of CBD programs by setting clear goals and routinely monitoring their achievement.
- Numerous CBD models have the potential to succeed. Focusing on local best practices in selecting, training, and supervising agents can increase programs' chance of succeeding.
- Programs are just beginning to evolve to meet clients' changing reproductive health care needs, including HIV prevention and referral.

- CBD programs that are clearly not meeting their goals should consider revising agents' roles, or even closing out the CBD services. Similarly, in settings in which contraceptive prevalence or access to services via other means has increased, phasing out of CBD services should be considered.

Recommendations and Next Steps

- Disseminate lessons learned more widely;
- Improve documentation of CBD costs and best practices, including commercial approaches and the cost of scale-up;
- Encourage development of national networks for CBD programs;
- Develop national policies and guidelines for CBD agents and programs; and
- Integrate CBD programs into larger regional and national level health care programs to ensure sustainability.

I. The Need for CBD in sub-Saharan Africa

CBD was first tested in Asia and its use developed further in Africa and Latin America. In sub-Saharan Africa, CBD models have been used for over 30 years to provide family planning services. A typical model of CBD has been for local distributors to target married woman to offer information, temporary family planning methods (typically condoms, pills, and spermicides), and referral to clinics for more long-term methods or, more recently, for treatment of reproductive health problems. However, numerous alternative models have been shown to function effectively (see Box 1).

Changes in social conditions, including the onset of the HIV/AIDS pandemic, enhanced access to family planning services, and increasing demand for related reproductive health care services have affected the relevance of CBD programs.

Box 1. CBD: Varying Models

CBD programs vary by sponsor (government, nongovernment, and market-based organizations), type of distributor compensation (volunteer or paid), mode of operation (home visits by CBD agents or depots where clients seek services), and location (rural or urban). Any model can function successfully, provided the program fits local needs and is adapted to local practices.

Where contraceptive prevalence is high and a range of family planning methods are available through other outlets, community-based programs may not be cost-effective. In certain areas—where long-term methods are preferred or where extended postpartum abstinence is traditionally practiced to space births—CBD might provide little additional benefit. Nevertheless, CBD programs remain appropriate in areas where the health care infrastructure is weak and there is an unmet need for family planning.

II. CBD: What the Research Shows

Research from Asia, Africa, and Latin America shows that a variety of CBD models have proven effective in specific situations. Generalizations about specific components are difficult to draw, as settings differ greatly. However, research has shown that CBD can be effective and there is consensus on basic results:

- **There is a substantial need for family planning and reproductive health services in the region, particularly in rural areas.** Surveys of 21 sub-Saharan countries with a combined total of 46 million rural women of reproductive age (between 15 and 49 years) showed that 18 percent had unmet needs for family planning and reproductive health (DHS 2002).

- **CBD can increase and sustain family planning use, particularly when the unmet need is high.** The national CBD program in Zimbabwe helped

increase CPR to over 50 percent in the late 1980s; CBD accounted for about one quarter of contraceptive use (Diallo 2002). In Mali, a program to provide family planning information, condoms, and referrals to clinics for other methods increased CPR from 1 percent to 11 percent within a year, with a subsequent rise to 21 percent when pill delivery was introduced.

- **CBD programs can help increase the acceptability of family planning, particularly in traditional societies.** CBD programs have been established and their acceptability has been documented in many African countries, including Burkina Faso, Côte d'Ivoire, the Gambia, Ghana, Kenya, Nigeria, Rwanda, Sudan, Tanzania, and Zimbabwe (Askew 2002; Lauro et al. 1991).

- **Men as well as women can serve as local distributors of family planning methods.** Though the majority of CBD agents have historically been women, evidence shows that clients and communities may also accept men as CBD agents and welcome the information and services they provide. Due to their differing networks, male and female distributors may have little overlap of potential clients (Green, Joyce and Foreit 2001).

- **The long-term effect of CBD on national fertility in sub-Saharan Africa is unclear due to low coverage and lack of clarity on the appropriate indicators of success.** Research on the impact of CBD programs is often limited to indicators such as couple years of protection (CYP), total number of users or CPR rather than fertility. Where CBD programs are small, major impacts at the national level are not expected. In rural Ghana, CPR may not be an appropriate measure of impact owing to the prevailing denial of contraceptive use among known adopters (Phillips 2002).

- **The cost effectiveness of CBD is highly variable.** Cost and cost effectiveness of CBD programs often vary depending on the program setting, how long it has been functioning, the strategies used for training and supervision, and the number of clients served (Janowitz 2002).

Jim Phillips, Population Council

Though many CBD programs have been successful, questions remain about the goals, appropriateness, and cost effectiveness of CBD in 21st century sub-Saharan Africa. To meet the upcoming challenges, including the HIV/AIDS pandemic, changes in African sociodemographics, and budget constraints, managers should use evidence to identify and use those best practices identified over time.

III. Best Practices: Maximizing the Impact of CBD Programs

Many types and models of CBD programs can succeed. Although success is based partly on how CBD programs meet local needs, research has identified certain guidelines for best practices to enhance the performance of agents and programs.

Improving agent performance. The following determinants of agent performance are potentially under the control of managers:

- *Characteristics of distributors*. Studies show that factors associated with productivity of agents include status in the community, literacy, and agents' own use of family planning.

- *Size and location of the catchment area*. To maximize performance, program managers must consider the location, size, and population of agents' catchment areas. Long travel distances for agents—or their clients—can lead to agent dropout or poor utilization of services.

- *Setting of client visit*. Many programs, such as the large Bangladesh CBD program, direct distributors to visit clients at home (see Box 2). While home visits may be effective where women cannot leave home easily, they are a costly means of delivering services. Programs in Bangladesh are investigating alternatives to home visits such as supply depots or the use of commercial outlets.

Box 2. Home Health Workers: Cost effective?

Contraceptive use has increased substantially in Bangladesh as a result of the efforts of 35,000 home health workers. However, the large staff drove up the costs of this largely donor-supported program; and workers often conducted brief resupply visits and provided little information or counseling.

A small study in an urban area tested a switch from home visits to provision of methods at specific community locations. Findings showed that contraceptive use did not change, but women were much more likely to use pharmacies than the new community service points (Janowitz 2002).

- *Training*. Experience from Latin America indicates that on-the-job training can result in greater provider knowledge and lower training costs than off-site training. Studies have demonstrated positive results from several other strategies, including refresher courses, use of a training algorithm, and training focused on specific client groups, such as youth or single women. Where trainees cannot attend multiple-day training, providing training on non-consecutive days has also proven effective (Townsend 1991), though this will likely be costly.

- *Supervision.* Supervision itself can constitute a major expense, but several alternative models have proven effective, including group supervision and

selective supervision, in which supervisors meet with high-performing or low-performing agents.

Controlling costs and moving toward sustainability. Both donor and government funding of programs will probably continue to be inadequate, while population growth and the AIDS crisis will increase the demand for contraceptive services and the need for new HIV prevention strategies in Africa. Program managers need to identify strategies that will improve the efficiency of CBD programs. Areas for potential cost savings include:

- *Compensation strategies and program management.* There are several models for compensation, each with its own advantages and disadvantages for programs (see Box 3). Though salaried workers are associated with higher productivity, studies show inconsistent findings; in some, volunteer agents have outperformed paid distributors. However, high productivity does not necessarily imply program cost-effectiveness, as other programmatic factors affect overall costs. Training and supervision, for example, can constitute a significant proportion of program costs. A study in Tanzania showed that training accounted for between 21 and 38 percent of CBD program budgets, while supervision accounted for between 9 and 56 percent (Janowitz et al. 2000).

Box 3. Strengths and Weaknesses of Compensation Schemes

Volunteer—low recurring costs but high turnover and possibly increased need for training new agents

Salaried—lower turnover, smaller staff, but higher recurrent costs

Stipend-based—lower turnover and recurrent costs, but requires a good monitoring system

Commission only—strong incentives to produce, low recurring cost, but requires good monitoring
(Homan 2002)

- *Commercial models.* Program managers might look to the commercial sector to address questions on how products reach households, and on whether direct sales is the best way to create a demand for family planning products.

- *Logistics*. Making sure the product is available is crucial to a program's success. Data from Nigeria suggest that CPR is higher when product availability is higher (Aronovich 2002). Managers need a sound logistics system that includes methods of forecasting supply needs, distribution, procurement warehousing, storage, and end-dates for perishable products. Programs should conduct a periodic analysis of logistical systems to ensure reliable delivery of supplies to clients.

- *Planning.* Programs should develop clear goals and monitor their achievement. Managers launching programs should consider their scale-up

as part of the overall plan—or, if appropriate, incorporate closeout procedures into proposals and work plans.

IV. Positioning CBD for the Future

The scale of many CBD programs in Africa has never grown beyond pilot project size, and the large majority of programs are donor-funded. To adapt and thrive in sub-Saharan Africa, programs must be relevant to the local situation (see Box 4). Managers should regularly evaluate whether CBD is, or remains, relevant in the local setting, and eventually may need to reconsider agents' roles and responsibilities, and seek ways of scaling up programs or integrating them into larger health care systems.

Box 4. Adapt the Program to Local Needs

The impact of CBD programs depends on the fit between the CBD model and the local situation. If the local situation changes, the CBD program must change. For example:

Zimbabwe: Responding to declining agent productivity and Zimbabwe's HIV/AIDS crisis, the national CBD program launched a pilot project to expand agents' roles to target a broader client base and to provide counseling on HIV/AIDS. In the first nine months, pill distribution increased by 54 percent, and CBD agents in the eight pilot districts held 447 group meetings on sexually transmitted infections (STIs) and HIV/AIDS (Diallo 2002).

Uganda: A pilot program is comparing the performance of nurses with that of CBD agents trained to administer injectable contraceptives (Stanback 2002).

Ethiopia: About 50 percent of nongovernment agencies implementing CBD programs have integrated maternal and child health into their programs and provide additional services such as immunizations (Diallo 2002).

Can CBD be integrated into other programs?

One option for expanding the coverage of CBD programs might be to integrate community-based services into existing reproductive or other health programs. Managers should seek partners who can integrate CBD programs into broader health care networks at regional or national levels. These partners can include donors, ministries of health and in some cases, agencies focused on other areas such as child health or education. Additional links may be necessary to ensure sustainable supply chains. Health sector reform and decentralization may offer opportunities to integrate CBD within district-level health plans, as has been the case in Kenya (van den Hombergh 2002).

In some settings, managers have or are considering adding services such as:

- Additional methods, such as injectables, standard days methods, emergency contraception, and the use of dual protection;

- Information, screening, and referral services for sexually transmitted infections including HIV/AIDS;
- Other products such as malaria treatments, vitamin supplements, oral rehydration solution;
- Information on pregnancy, prenatal and postnatal care, and child health and nutrition; and
- New clients—such as men, youth, pregnant women, or persons living with HIV/AIDS.

Long-term strategies should include involving stakeholders and providing continuing support for community agents. Program managers should conduct regular meetings with stakeholders, including community members, related organizations, and ministries of health to ensure that programs are meeting their needs. Managers must ensure that agents remain motivated and have the training that accompanies new responsibilities.

IV. Conclusions

- CBD has been effective in bringing family planning services to underserved or remote areas—in sub-Saharan Africa as well as in other regions.
- A substantial market for CBD exists in sub-Saharan Africa. Program managers should focus on areas where the health care infrastructure is weak or where contraceptive use is low.
- Managers should seek to improve the effectiveness and efficiency of CBD programs by setting clear goals and routinely monitoring their achievement.
- Numerous CBD models have the potential to succeed. Focusing on local best practices in selecting, training, and supervising agents can increase programs' chance of succeeding.
- Programs are just beginning to evolve to meet clients' changing reproductive health care needs, including HIV prevention and referral.
- CBD programs that are clearly not meeting their goals should consider revising agents' roles, or even closing out the CBD services. Similarly, in settings in which contraceptive prevalence or access to services via other means has increased, phasing out of CBD services should be considered.

Recommendations and Next Steps

To conclude the seminar, participants developed the following recommendations to address the concerns of a range of stakeholders:

- Disseminate the lessons learned more widely to policy makers and program managers.
- Improve the documentation of CBD costs and best practices, including the exploration of commercial approaches and the cost of scale-up.
- Encourage the development of national networks for CBD programs.

- Develop national policies and guidelines for CBD agents and programs.
- Integrate CBD programs into larger regional and national level health care programs to ensure sustainability.

Best Practices in CBD Programs in sub-Saharan Africa: Lessons Learned From Research and Evaluation

Monday, December 2, 2002
Academy for Educational Development Conference Center
1825 Connecticut Ave. NW, 8th Floor

Population Council, FRONTIERS
Family Health International (FHI)
Advance Africa

Community based distribution (CBD) programs have been used for over thirty years to increase access to family planning services. In that time, a large body of empirical evidence on CBD strategies has been generated through research and evaluation. The seminar's objective is to acquaint USAID and CA staff with evidence on the effectiveness and sustainability of different CBD models, and on best practices as they relate to program operating systems.

OBJECTIVES

- Identify the market for CBD services in sub-Saharan Africa
- Discuss the sustainability, cost and effectiveness of different CBD models
- Review evidence on best practices in CBD operating systems such as training, logistics, others
- Highlight findings on integration of family planning and other services in CBD programs.

AGENDA

8:30 – 9:00 Coffee and Registration

Introduction: Definition and Background to CBD in Africa

9:00 – 9:15 Welcome - John Townsend, PopCouncil, FRONTIERS and Margaret Neuse, Director, Office of Population and Reproductive Health, Bureau of Global Health, USAID

9:15 – 9:30 CBD in Africa: Definition and Overview - Ian Askew, PopCouncil, FRONTIERS

9:30 – 9:45 The Emerging Market for CBD in Africa - Issakha Diallo, Advance Africa

9:45 –10:00 Discussion

10:00 – 10:45 Panel 1 CBD Models: Effectiveness, costs and sustainability

- CBD: Role of home visits and posts – Barbara Janowitz, FHI
- Navrongo/CHPS – James Phillips, PopCouncil
- Issues of phasing in and phasing out of CBD – Diouratie Sanogo, PopCouncil, FRONTIERS

10:45 – 11:30   Discussion

11:30 – 11:45   Break

11:45 –12:30   Panel 2 Best Practices: The distributor

- Distributor selection, replacement and location – Laura Raney, PopCouncil, FRONTIERS
- Payment and motivation – Rick Homan, FHI
- Training and supervision – Ricardo Vernon, PopCouncil, FRONTIERS

12:30 – 1:00   Discussion

1:00 – 2:00   Lunch

2:00 – 3:00   Panel 3 Best practices: Products and services

- Contraceptive methods – John Stanback, FHI
- Logistics – Dana Aronovich, JSI/DELIVER
- Integration of other products and services – Ndugga Maggwa, FHI
- Preparing for Sustainability – Henri vd Hombergh, GTZ

3:00 – 3:45   Discussion

3:45 – 4:00   Break

4:00 – 4:30   Wrap up and next steps – Advance Africa

Appendix 1: Participant List

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