Community-based distribution of contraceptives

A guide for programme managers

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Preface

Community-based distribution (CBD) is a strategy that relies on trained non-professional members of the community to provide health services directly to other members of the community. In the case of family planning, these services provide information and temporary contraceptive methods, usually the pill, condoms and other barrier methods. Other primary health care services may also be provided through CBD, including oral rehydration therapy and treatment for malaria.

CBD is frequently confused with another innovative strategy for distributing contraceptives called contraceptive social marketing (CSM). The main difference between the two strategies is that CSM operates through commercial channels, while CBD operates through community networks and non-professional personnel. In addition, the fees charged for contraceptives are usually higher in CSM programmes than in CBD programmes.

This book is intended for use by programme managers, administrators and service providers who are responsible for planning, implementing and evaluating CBD programmes. It shows how to develop a programme that is appropriate to the needs of the community, and how to ensure that it receives support from the public, as well as from the medical community.

Successful delivery of CBD services is essentially linked to the education of potential users, and hence this book includes specific recommendations on training of CBD personnel as well as on service delivery. Chapters on monitoring and evaluation and on issues of particular relevance to CBD are also included, along with several annexes that provide sample materials that can be adapted to local needs.

This guide is one of a series of technical publications on family planning that have been issued by the World Health Organization since 1976 (see inside back cover). It summarizes the knowledge and experience of experts in CBD from around

the world, including a review group that met in Washington in December 1989.

Comments and queries on this publication should be addressed to: Maternal and Child Health and Family Planning, Division of Family Health, World Health Organization, 1211 Geneva 27, Switzerland.

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Introduction

It is now universally accepted that family planning services are essential to promoting birth spacing to reduce maternal and infant mortality.

It has been estimated that if family planning services were more widely available, up to 42% of maternal deaths could be averted in developing countries; the mean proportion of maternal deaths that could be averted is 24% (Sai, 1986).

The world fertility survey (Sathar & Chidambaram, 1984) showed that use of family planning methods varied widely, from 69% in south-east Asia to 11% in Africa. The survey also revealed that approximately 300 million couples in the reproductive age range did not want more children, but were not using any method of contraception. These figures indicate a significant unmet need for family planning.

However, simply keeping up with demand at current levels will be a challenge. In 1990, the United Nations Population Fund (UNFPA, 1991) estimated that the fertility rate among women in the developing world was 3.8 births per woman and that the contraceptive prevalence rate (the proportion of married women of reproductive age who practise contraception) was 51%.

According to UNFPA projections, based on the current level of contraceptive prevalence, the number of family planning users will have increased by about 108 million by the end of the decade, owing to the growing numbers of women entering the reproductive age range each year. Moreover, if contraceptive prevalence were to be increased to 59% of married women of reproductive age, the number of family planning users would grow by 186 million by the year 2000 (UNFPA, 1991). Annex 1 provides the current UNFPA projections for the growth in both contraceptive acceptors and contraceptive supply requirements in developing countries between 1990 and 2000.

Clearly, family planning services must be significantly expanded to cope with this demand. In developing countries resources are often scarce and many of those in greatest need live in urban slums or rural areas without ready access to clinic-based health and family planning services. Community-based distribution (CBD) of contraceptives can be used to supplement other government and private family planning services to meet this challenge to make family planning more widely available. It involves providing information and family planning methods (usually the pill and barrier contraceptives) in community settings, basing these services on the needs and resources of the community.

In most CBD programmes, people for whom these methods are not suitable, or who wish to use another method, are referred to a family planning clinic or other health facility. CBD can be an important addition or alternative to clinic-based services. It is usually less costly than clinic services, easier for many people to reach, and available in a wider range of settings.

CBD exemplifies WHO's commitment to primary health care by making essential health care available to individuals and families in the community in an acceptable and affordable way and with their full participation.

The primary health care approach has evolved over the years, partly in the light of experience gained in basic health services throughout the world. However, it means more than simply extending basic health services. It has social and developmental dimensions and, if properly applied, should influence the way in which the rest of the health system functions.

Community-based distribution is also compatible with the trend, in many countries, towards the decentralization of health services and the involvement of the community in the provision and support of its own health services. CBD services have been operating for over 20 years, during which time many models have been developed and tested. By the mid-1980s, CBD services were available in more than 40 countries, largely in Asia and Latin America, but also in Africa and other continents (Fincancioglу, 1984). To date, most CBD programmes have been operated by nongovernmental organizations (NGOs), although public sector institutions are increasingly adopting this approach.

Policy-makers, health planners, and family planning providers have recognized that CBD can be a highly cost–

effective means of improving access to family planning services in remote communities. Furthermore, because the community is directly involved, the services are more likely to be accepted, and they can be integrated with existing health services.

The chapters that follow provide guidance for planning, implementing and evaluating CBD programmes. But first, it will be useful to define some of the terms that are used throughout the guidelines:

Clinic-based services: family planning services provided in a formal setting such as a hospital, clinic, health post or other medical facility. Such services can usually offer a more complete range of services than CBD distributors.

Distributor: a community worker who distributes contraceptives and information about family planning directly to the community. Distributors may also be known by other names, such as fieldworkers, educators, promoters, canvassers or depot-holders. While distributors are usually volunteers, in some programmes they may receive modest salaries or a proportion of the fees charged for contraceptives.

Supervisor: a community worker who supports and oversees the work of the distributors and provides the crucial administrative link between the central office and the field. Supervisors provide guidance and technical assistance to distributors, identify those in need of refresher training, and collect and analyse service data. They are also usually responsible for carrying out information and education campaigns in the community and maintaining links with influential community members and groups.

Information, education and communication (IEC) activities: activities designed to educate the community about family planning and its benefits and to inform potential users about the CBD programme, the services it offers, and the location of its distribution points. IEC activities require careful planning and many use information channels such as presentations, lectures, community events, group meetings, printed materials and the mass media (e.g. radio, newspapers and television). They are sometimes referred to as outreach activities.

Logistics: the process and systems that govern the procurement, transport, storage, distribution and management of products or commodities, such as contraceptives.

Contents

1. Understanding community-based distribution

This chapter highlights factors that may be used to identify communities in need of CBD services, as well as factors that are essential to the success of such services. The concept of CBD is explained and compared with that of contraceptive social marketing. A hypothetical CBD programme is presented to indicate the issues that affect CBD services. This is followed by a chart that illustrates the kinds of people who work as CBD distributors in programmes around the world.

Community-based distribution (CBD) can be a practical, cost–effective alternative to traditional clinic-based services for expanding access to family planning for underserved populations. Populations in need of CBD services can be identified by the following factors:

- Low prevalence of contraceptive use.
- Lack of awareness of family planning.
- Low use of existing family planning services.
- Located far from family planning clinics.
- Shortage of trained medical personnel.
- Lack of resources to expand clinic services.
- Presence of cultural barriers impeding attendance at clinics.

In many developing countries there are an average of 7000–10 000 people per physician, with similar ratios for nurses and nurse–midwives. Clearly, these health professionals cannot meet even the basic health needs of the population. To compound

this problem, the majority of these professionals are located in urban areas and are concerned with health services that require comparatively sophisticated training and equipment (Rosenfield, 1986).

Therefore, clinic-based family planning services are unlikely to be available in many communities, particularly those in poor urban or rural areas. For these communities, CBD is often the only means of gaining access to family planning services. CBD services are also usually more cost–effective than clinic-based services. (For additional information about how to analyse the cost–effectiveness of family planning service-delivery strategies, see Reynolds & Gaspari, 1986 and PACT,[1] 1986).

However, CBD is not primarily a mechanism to save money, but rather an effective means of ensuring that people have access to a variety of primary health care services in the community. In addition, because the community is involved in the provision of the CBD services, those services are more likely to be accepted and used by the community members.

Thus, even when sufficient resources and facilities exist to support clinic-based services, CBD can be an effective strategy for making family planning services both more available and acceptable to underserved groups or communities in remote areas. Many people who do not regularly use health facilities may be much more receptive to community-based services. They may have difficulty reaching health facilities, or they may be unwilling to discuss personal matters such as family planning with health professionals.

CBD and contraceptive social marketing

CBD is frequently confused with another innovative strategy for contraceptive distribution, known as contraceptive social marketing (CSM). CSM aims to expand the availability of temporary contraceptives (primarily condoms and pills) by subsidizing their sale, without prescription, through existing commercial channels such as pharmacies, shops and street vendors. In this way, CSM caters for the *informed consumer*.

CBD, in contrast, relies largely on community networks and non-professional, non-commercial personnel for both the promotion and distribution of contraceptives at prices generally

[1] Private Agencies Cooperating Together.

lower than those found in CSM programmes. In CBD programmes, information and education are as important as the contraceptives. This kind of information is not usually available through commercial channels.

The differences between CBD and CSM are less obvious, however, when CBD programmes distribute contraceptives for a fee through commercial outlets such as small shops, hawkers, market traders and street vendors. In fact, many programmes contain elements of both strategies and several CBD programmes have shifted to CSM as they have expanded.

Factors affecting the success of CBD

Community-based distribution is based on three vital ingredients, all of which must be present if the programme is to be successful (Table 1):

—support from the sponsoring institution, the community, and the distributors;

—accessibility of the services;

—quality of the services.

Description of a hypothetical CBD programme

The following is a brief description of a hypothetical CBD programme, which is based on the experiences of various programmes from around the world and is intended to help summarize the main points of this chapter.

Background

The CBD programme was developed by a local nongovernmental organization involved in promoting child health and nutrition. Four years ago, the agency became aware that there was a very low prevalence of contraceptive use in the poor areas of the cities and rural areas. Interviews in these areas revealed that three problems were preventing contraceptive use:

1. A lack of knowledge about contraceptive methods.
2. Difficulty of access to methods and information owing to the absence of local family planning services, and the long distances to clinics.

Table 1. Factors affecting the success of CBD programmes

Support	Accessibility	Quality
Strong commitment of the sponsoring institution.	Services offered at popular locations.	Sponsoring institution adheres to standards and protocols for contraceptive distribution.
Participation of members of the community.	Dependable supply of contraceptive methods.	Adequate training for personnel.
Adequate numbers of dedicated distributors.	Travel time and cost required to reach service points kept to a minimum.	Users receive all the necessary information to permit them to make informed choices.
CBD is acceptable within legal, ethical and cultural norms.	Waiting time to receive services kept to a minimum.	Contraceptives are medically approved, have not reached their expiry dates, and are locally known and trusted.
Financial and material support from the sponsoring institution, the community, and donor agencies.	Services affordable to all potential users, including those on a low income.	Client–provider confidentiality is respected.
Plans in place to ensure the sustainability of the CBD programme.	Services provided in culturally acceptable settings.	A follow-up system exists to maintain contact with users.
	Referrals offered for other family planning services.	