


SERVICE SUSTAINABILITY STRATEGIES IN SEXUAL  
AND REPRODUCTIVE HEALTH PROGRAMMING

Community-based distribution



## What is community-based distribution?

Community-Based Distribution (CBD) is a non-clinical, health delivery outreach approach, whereby trained volunteer or salaried community agents who are not health professionals operate with relative autonomy (without day-to-day supervision) to provide low technology and safe services and information. In the case of sexual and reproductive health programmes, CBD agents are usually supported by a clinic-based programme, which provides access to a broader range of health services. Most CBD agents are selected by and answerable to the community in which they live and work.



Many CBD programmes focus exclusively on family planning, providing non-clinical methods of contraception such as oral contraceptives, condoms and spermicides and information on and referrals for clinical methods. Some, however, provide a wider range of sexual and reproductive health services, and selective primary health care services, such as oral rehydration therapy, malaria treatment, intestinal parasite treatment, nutrition education and supplements, child immunisation, maternal health, referral and information on sexually transmitted infections (STIs) including HIV etc.

CBD programmes vary enormously in scale and design. Some large programmes cover national populations while others cover small geographical areas and target specific populations. A range of service delivery approaches are employed in CBD, including the use of house-to-house visits, community meeting places, and fixed depots sited in convenient community locations. Whether a particular agent deployment scheme makes sense depends upon the institutional and local context. However, if agents are volunteers, the fixed depot approach is probably most effective. CBD programmes are also run and managed by a variety of public and non governmental organisations, such as ministries of health, women's groups, trades unions and religious groups.

CBD programmes also vary by organisational structure. Some are bureaucratic, top-down, externally resourced (by government/donor), with salaried staff. Others use traditional social structures and institutions, through a decentralised organisation in which CBD agent participation is voluntary, and services are provided through existing networks or groups. Some programmes combine the two: large-scale, bureaucratic and externally resourced but operating through and with the support of community structures and institutions.

Most CBD programmes serve rural populations, on the basis that access constraints and needs are greatest outside towns and cities. Programmes with urban catchment areas tend to work in the poorer communities. It is therefore widely assumed that CBD clients are poorer than those of social marketing and facility-based programmes. However, few (if any) CBD programmes routinely monitor the socio-economic status of their clients.



## Financing CBD Programmes

Some CBD programmes use a community health insurance approach that involves the annual collection of a small sum of money from each household in a catchment area. This system of financing requires well-organised local government or community structures, and as such can be complicated and difficult to manage. Virtually all households must participate in the scheme to make it equitable. Some programmes rely upon non-financial community contributions such as labour, materials or land.

Many CBD programmes charge a nominal fee for services, and award a percentage of the fee to the agent. A small number of programmes have set up or are piloting more extensive fee-for-service schemes, and others have introduced social marketing into their programmes. However, fees often prohibit access to services for the poor.

The most effective CBD programmes are those which are externally financed, from a combination of donor funds, local or national government budgets for health or other development budget lines, and/or cross-subsidies from other income generating elements of large programmes. Such programmes invariably employ salaried agents, and adopt professional/bureaucratic supervisory and monitoring systems. Although often derided as being unsustainable, there is clear evidence that such programmes have minimal management requirements and their operations can expand rapidly.

Some CBD programmes employ full-time paid employees, others rely on part-time volunteers. Some volunteer CBD programmes provide their CBD agents with monthly allowances and/or other non-salaried financial incentives and inducements (such as retaining a share of sales revenue, stipends to offset travel and subsistence etc). Other CBD programmes relying on part-time volunteers provide them only with non-monetary incentives. Some programmes pay their agents according to numbers of clients recruited or volume of service provided; and all programmes provide some form of non-monetary incentive in the form of working tools to their CBD agents (bicycles, boots, umbrellas, uniforms, badges, study tours, certificates for best performance etc). Those CBD programmes which provide monetary incentives derive these from user fees, community-financing schemes, or from external sources.

## Agent Compensation and Motivation

The issue of compensation is important since it raises the question of how CBD can reach the poorest, be participatory and also sustainable. Strategies for compensating CBD agents determine agents' self esteem and hence motivation. Volunteerism alone is fraught with dysfunctions and only works in small organisations with a strong sense of identity and headed by charismatic leaders. Programmes that use volunteers often have a high turnover of 'staff', and suffer recurrent recruitment and training costs. Volunteers cannot necessarily be held accountable to any given organisation so have the freedom to decide when to work, how many hours to work and where to work. CBD models that utilise full-time paid agents or provide financial incentives for agents are far more successful than those using volunteers.



## Recruitment and Training of CBD Agents

No single predetermined set of characteristics defines the optimum CBD agent and there are no guiding principles for gender, age, marital status, religion, educational level or professional background of good agents. Younger agents appear to be more open to new ideas, are more literate, and more likely than their elders to change their own health practices. Older agents, however, may be more respected in their community, better able to influence other community members, and less likely than younger agents to migrate away from their community.

Despite recent shifts to employ male distributors, the majority of CBD agents in many programmes are still women. Once trained, women CBD agents often become prominent community members, and are seen as a valuable community resource. Their training and subsequent CBD activities in the community enhance their status, better equip them to interact with male-dominated structures, and empower them in their own lives. As such, a good CBD programme may not only address the needs of clients and potential clients, but those of CBD agents themselves.

It is important that agents are selected from and by the communities they serve. The selection of agents by the community is an opportunity to introduce the community to the CBD programme and to impart a sense of ownership of the programme.

Most CBD agent training programmes are short and intensive and take from a few days to six weeks. Training focuses on the benefits of service and product use, correct use of methods of contraception, side effects of those methods, mechanisms for referral, the distribution system, record keeping, and – in more sophisticated programmes – on skills and techniques for communication and community mobilisation. In integrated CBD projects, training also focuses on sexual health, selected primary health care and/or community development.

### Effective CBD agent training

- prepares agents to perform a range of specific tasks as specified by programme design and organisational structure
- trains agents in how to communicate with clients and how to mobilise and organise clients at community level
- provides regular refresher training to maintain agents' skills and knowledge, focusing in particular on how to address practical problems (such training is most effective if provided on a one-to-one basis and provided by the agent's direct supervisor)
- is undertaken by trainers who have direct CBD field experience.

## Supervision and Management of CBD Agents

CBD programmes may rely on full-time staff as supervisors of CBD agents, on part-time supervisors based at and providing services at clinics, or on volunteer supervisors. Some programmes require their CBD supervisors to use supervisory checklists; others provide little or no formal guidelines on what to check during supervision. Some programmes involve community leaders; others have little or no community participation in the management and supervision of CBD activities. Community involvement is crucial at the design and planning stage of a CBD programme but appears to be less important for day-to-day programme management, although regular community liaison is necessary throughout a programme.

Although it is not possible to identify a single most appropriate model for the supervision of CBD agents, since the `best' in CBD must always be site-specific, effective supervisors should be supportive rather than directive. When the supervisory role is limited to that of inspector or disciplinarian the programme is compromised. Control-oriented top-down supervision is dysfunctional. Supervisors should be pro-active, forward-looking and motivate CBD agents through resource mobilisation, conflict resolution, and encouragement of innovation. Supervision must also be continuous and provide workers with rapid feedback. CBD agents who receive regular individual supervisory contacts express satisfaction with their supervision and have a higher volume of client visits than agents who receive only group-based supervision or infrequent individual supervisory contacts. Studies have shown that volunteer agents who receive adequate supervision and no monthly allowances perform better than agents who receive a monthly allowance but lack adequate supervisory support.

The effective CBD agent supervisor should

- **monitor** agent performance
- **motivate** agents to perform better
- **evaluate** agent competence
- **teach** new skills
- **solve** problems
- **discuss** clients' problems with agents
- **foster** teamwork



## Monitoring CBD Impact and Effectiveness

**The dominant measure of CBD impact at programme level is the demographic change attributable to CBD.**

**Process monitoring and social impact monitoring of CBD programmes are virtually non-existent.**

The dominant measure of CBD impact at programme level is the demographic change attributable to CBD, with the most common indicators being contraceptive prevalence rate (or Couple Years of Protection [CYP] as a proxy), along with service/product acceptance rate and continuation rate.

The acceptor rate is the most common intermediate impact measure used in CBD because acceptor data are the easiest to obtain and because the most common short-term CBD objective is an increase in acceptors. However, acceptor rates are of limited use in monitoring and evaluation. They underestimate impact because they do not reveal indirect effects such as couples who are stimulated to adopt family planning or to use condoms but who obtain supplies from another source. They also (like CYP) reveal nothing about the quality of use – whether methods are used correctly, length of time they are used etc.

The continuation rate is the proportion of acceptors continuing to use a service or product for a given period of time after first acceptance. High continuation rates are conventionally associated with high client satisfaction, use effectiveness and/or strong motivation to regulate fertility/improve health, although there is little by way of empirical evidence to support this assumption.





Few programmes attempt to measure the extent to which CBD programmes are meeting sexual and reproductive health needs. A CBD programme in Zambia's Eastern Province is monitoring client perceptions of positive changes that result from the programme, as a proxy for meeting needs. Positive changes reported include better birth spacing, healthier mothers and children, improved nutritional status, protection from STIs including HIV, reduction in teenage pregnancy, improved sexual relationships, reduction in unwanted pregnancies and abortions, and of pregnancies in older women. Negative changes are also monitored, and include side effects from hormonal contraception, careless disposal of condoms, inadequate choice of contraceptive methods, problems with referral, and negative changes in behaviour (such as increased marital conflict). Once an unmet need or negative change is identified, the CBD programme should seek to understand the factors responsible through small-scale operations research.

Routine monitoring, by definition, must rely upon data collected by front-line workers (CBD agents and their immediate supervisors). Monitoring forms must therefore be simple and easily understood by workers, and focus – in addition to routine information on the number and frequency of visits and contraceptive or other services provided – on basic client profiles. CBD programmes rarely collect client profiles, but this information would provide important guidance on programme efficiency, equity and future strategy.

Process monitoring and social impact monitoring of CBD programmes are virtually non-existent. As well as routine programme information, monitoring should focus on:

- Quality of care
- Responsiveness of programmes to client's needs
- Access (e.g. does providing information and commodities to clients in their homes reduce monetary costs and extend social and psychological support for health behaviour that would otherwise not arise?)
- Client profiles by socio-economic status: such data are essential for judging the extent to which CBD programmes serve the poor and vulnerable, and thus meet equity and poverty-focused objectives. While income measurement is difficult, proxy socio-economic status indicator data – household assets, type of housing or education levels – could be collected routinely. In assessing whether vulnerable groups are using CBD services, indicators of occupation, parity, age and ethnic group are relevant.



The ability of CBD agents to provide quality of care – especially to communicate effectively with clients and potential clients (including addressing informed choice and side effects), to access referral systems, and to ensure a regular supply and range of contraceptives – depends to a large extent on the organisational structure of the programme. Most significantly, programmes need to provide adequate training and supervision, logistical support, remuneration for workers, and inspire the support of local community and political leaders.

Few CBD programmes routinely monitor quality of care, and research suggests that quality of care may be lacking in many CBD programmes. The community-based distribution of oral contraceptives in particular requires adherence to monitoring and screening procedures. The use of comprehensive checklists by CBD agents and the training and supervision of CBD agents in the screening and referral of clients and maintenance of client records are key elements of quality assurance. A further measure of quality is CBD agents' ability to provide support and information on issues such as correct methods of breastfeeding, symptoms of sexually transmitted and reproductive tract infections, management of diarrhoea and malaria, and sexuality. Pivotal in the provision of such advice and support is the nature of the interaction between CBD agents and their clients.



## Quality of Care

CBD programmes should reflect attention to, and respect for, the perspective of the client or potential client as a whole person, and not merely his or her reproductive potential. This has important implications in terms of the ability of a CBD programme to provide adequate referrals for clinical contraception and also other health care services and products. It also requires that CBD agents listen carefully to their clients and establish what they want. Communication between CBD agent and client should be facilitated by their sharing of social and cultural attributes, the reduced social distance and enhanced trust between provider and client (compared to medical facility-based interactions), and because interactions take place in private and locally accessible settings. Home visits give the agent an opportunity to build up rapport with the client, offer a broad range of services and provide support. However, as the CBD agent usually initiates interaction – as distinct from clients seeking advice or services from clinics – she/he must provide comprehensive advice to ensure informed choices. Longer time spent by the CBD agent with the client, greater frequency of visits, and better quality of care are all associated with higher probability of subsequent behaviour change (including service/product utilisation).

Because of the reliance upon output measures, some CBD programmes over-emphasise acceptance levels at the expense of explanation and follow-up. There is a tendency towards persuasion rather than meeting needs in CBD method-oriented (rather than client-oriented) approaches. CBD agent compensation strategies must factor this into programmes, and address abuse by agents. Referrals, for example, represent a loss of income to agents, and some CBD programmes now provide financial reward for referrals.

## Components of an Effective CBD Programme

- Community involvement at the planning stage
- Recruitment of supervisors of CBD agents from the ranks of CBD agents
- CBD agent recruitment guided by community opinion rather than pre-determined criteria – although most programmes seem to benefit from recruiting both male and female agents
- Training of CBD agents which is incremental, competency-based and practical
- Recognition that inadequately-trained agents under-perform
- Recognition that exclusively volunteer schemes do not work
- Adequate links to health services and clinics for referral and clinical services



## Cost Effectiveness

Cost-effectiveness analysis in CBD compares the cost per unit of output (new clients, client contacts, CYPs etc.) across different programmes or for the same programme at different times. However, there are numerous problems with cost-effectiveness analysis in CBD programmes:

- cost data are difficult to collect and to interpret
- the emphasis on outcome indicators (such as new acceptors) misses some of the most important dimensions of the CBD agent's role as provider of support and information, and contributor to legitimising social objectives and to community empowerment
- cost-effectiveness analysis in CBD consistently overlooks the client's perspective, for instance the time and costs saved by having services in close proximity, and the anonymity, confidentiality and privacy provided.

Research indicates that the cost per unit of output for CBD programmes is consistently lower than for clinic-based service delivery approaches throughout Asia and Latin America. As with most programme approaches, CBD incurs high initial costs, but cost-effectiveness improves with time. Integrated health and family planning CBD programmes are less cost-effective in terms of CYP than family planning only programmes. CBD programmes which adopt a home visiting strategy, although less cost-effective, lead to more contraceptive/condom use than those that rely exclusively on the client collecting supplies from a local depot. The highest output programmes are those which rely on full-time salaried agents, which despite higher costs also tend to be more cost-effective than programmes relying on part-time volunteers.

## How and why CBD programmes fail

**Research indicates that the cost per unit of output for CBD programmes is consistently lower than for clinic-based service delivery approaches**

- Under-utilisation of existing research and data on best practice
- Failure to adapt CBD approaches to local social settings
- Failure to seek local political support at planning and recruitment stages
- Failure to develop adequate and appropriate client support and referral systems
- Failure to see beyond a premature focus of cost recovery
- Failure to address quality of care
- Failure to provide appropriate and ongoing training and supervision of CBD agents
- Inability to address high turnover of CBD agents

## Sustainability

Sustainability is conventionally conceptualised in terms of technical capability (including the capacity of a programme to continue providing services without external technical assistance) and financial sustainability (including a programme's ability to continue service provision without donor support). Unlike in Asia and Latin America (where national governments have increasingly taken over the funding of community-based programmes) all CBD programmes in Africa rely heavily on donor financing (although in Zimbabwe, Kenya, Tanzania and Botswana the national governments are making substantial contributions). However, with donor support, CBD programmes globally have made substantive improvements in technical capability.

Sustainability can also be measured in terms of sustainable outcomes and benefits, and the extent to which programmes contribute to widespread and continuing sexual and reproductive behaviour change. Lessons from family planning CBD programmes in Asia suggest that CBD appears to have played a critical role in launching demographic transitions, but may become unnecessary on the scale that it has been implemented in the past (if as seems likely Asia is witnessing sustainable fertility reductions). However, in sub-Saharan Africa, demand for family planning remains low in many countries. Expensive heavily subsidised large-scale programmes in Africa may be more sustainable than alternative CBD approaches simply because they produce self-sustaining demographic change in the long run.

## Recommendations

Removing health service delivery from the confines of the clinic creates unpredictable programming challenges that would benefit from a greater investment in operations research, pilot programmes, and problem-solving approaches. Such research and trials are crucial to developing CBD approaches that are suited to institutional capacities and social contexts.

No single operational formula for successful CBD programmes exists. However, mixed programme ‘models’ do not appear to work. In Zimbabwe, for instance, a bureaucratic top-down CBD programme with salaried agents is highly successful, whereas the Kenyan Ministry of Health’s attempt to use the bureaucratic top-down model with volunteer agents has not worked.

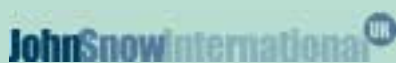
Apparently unsustainable elements of programmes can become the basis for sustainable benefits/outcomes (such as long-term changes in reproductive and health behaviour and health-seeking practices). More research is needed to determine the extent to which behaviour change is self-sustained as a result of CBD, and thus whether CBD is an appropriate short-term catalytic effort with major initial investments that can be scaled back over time.

CBD should be viewed as a component of a sexual and reproductive service delivery system, not a panacea or substitute.

Rigorous efforts in the policy, legislative and advocacy spheres are needed for the successful development and implementation of CBD programmes.

SERVICE SUSTAINABILITY STRATEGIES IN SEXUAL  
AND REPRODUCTIVE HEALTH PROGRAMMING PAPERS:

- Paper 1**      **Sustainability: Key concepts and issues**
- Paper 2**      **User fees**
- Paper 3**      **Social marketing**
- Paper 4**      **Community-based distribution**
- Paper 5**      **References and key readings**



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