

# Network

FAMILY HEALTH INTERNATIONAL, VOL. 19 NO. 3, SPRING 1999



BEST AVAILABLE

Community-based  
Distribution

# Network

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*A community-based worker discusses family planning options during a home visit in Bangladesh, in the cover photograph by Beryl Goldberg.*

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# Community-based Distribution Serves Unmet Needs

By reaching out into rural communities and isolated city neighborhoods, community-based distribution (CBD) programs can serve unmet needs for contraception. Where contraceptive prevalence is very low, community programs can also generate demand for family planning.<sup>1</sup>

While there are many variations, community-based distribution programs in general seek to take contraceptive methods and family planning information to people where they live, rather than requiring people to visit clinics or other locations for these services. The approach often involves community members who are trained to become family planning workers.<sup>2</sup>

That community services can increase contraceptive use has been observed throughout the world. Contraceptive use is further enhanced when CBD workers can offer clients a wide variety of methods, either directly or by referral.

In Turkey, CBD workers distribute combined oral contraceptives (OCs) and condoms, and make referrals for clients desiring intrauterine devices (IUDs) or voluntary sterilization. In an Ankara settlement of 110,000 low-income people, the percentage of women using modern contraceptives has risen to 74 percent after four years, from 36 percent. In other areas served by the Family Planning Association of Turkey, similar increases have been seen: to 62 percent from 21 percent in Adana-Mersin, and to 50 percent from 32 percent in Istanbul.<sup>3</sup>

In a CBD program in Mali, contraceptive use nearly tripled in villages where OCs were added to barrier methods, which were already available. No health centers or commercial contraceptive sales were available in the area being served. Before OC introduction, contraceptive prevalence was about 12 percent in 54 villages where condoms and spermicides had been offered. Contraceptive prevalence increased to 31 percent in 18 villages six months after OCs were also offered, while prevalence increased less, to 21 percent, in the remaining 36 villages where OCs were not offered. Prior to the program, which included activities to motivate potential clients, contraceptive prevalence was only 1 percent.<sup>4</sup>

"After training, Malian CBD workers were able to give accurate information about OC use to new clients, identify contraindications to OC use, prescribe pills safely, and monitor all clients taking the pill," says Dr. Seydou Doumbia, a Mali-based Population Council program associate who helped analyze the impact of this CBD project in Mali.

Introduction of injectables to the CBD mix remains limited. But, in Mexico, the monthly combined injectable Cyclofem has been distributed by CBD workers. Higher continuation rates were observed among some 650 rural women served by the CBD workers than among approximately 2,800 urban and suburban women who visited health centers: 37 percent versus 24 percent after one year, respectively.<sup>5</sup> In Ghana, the three-monthly injectable depot-medroxyprogesterone acetate (DMPA) was offered by CBD workers to over 1,000 women in a pilot study by the Navrongo Health Center.<sup>6</sup>

Two pioneering studies conducted in rural Bangladesh between 1975 and 1981 concluded that a CBD program offering a wide choice of methods, skilled counseling, rigorous follow-up, care of side effects and good referral systems was more effective than one based on one or two methods distributed by unskilled workers. Moreover, higher acceptance and continuation rates were maintained over time.<sup>7</sup>

When OCs and condoms were distributed to men and women in 150 villages primarily by illiterate, elderly and widowed women, only 17 percent of female clients reported using pills three months after distribution. After 18 months, pill use prevalence had declined to 9 percent. Knowledge of condoms increased over time, but the method never became popular. In the second study in 70 villages, injectables were added to the mix of methods and literate, married women from the villages distributed contraceptives. A referral system for helping clients with side effects also was established, since side effects from pills were common and discouraged some users. After a year, contraceptive prevalence had risen to 32

percent, from 10 percent. The one-year continuation rate for DMPA was 69 percent. (A project to replicate this initial success with DMPA was less encouraging, with a one-year continuation rate for DMPA of 30 percent. This decrease was attributed to staff shortages, unpredictable client-worker contact, lack of medical backup and training, and lack of technical support.)<sup>8</sup>

— Kim Best

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# Ways to Expand Contraceptive Choices

Community workers use checklists to determine whether clients can safely use certain methods.

**B**arrier methods (condoms and spermicides) and oral contraceptives (OCs) are available through many family planning community-based programs. With proper training, community providers can also give injectable contraceptives.

Community-based distribution (CBD) workers can refer individuals to clinics or hospitals, or to mobile teams of medical professionals who provide long-lasting or permanent methods, including intrauterine devices (IUDs), implants, or male and female sterilization.

While offering each client a range of contraceptive choices is ideal, choices may be limited by lack of supplies, poor referral systems or restrictions upon which methods CBD workers are allowed to offer. Restrictions on CBD provision of certain hormonal contraceptive methods are primarily due to safety concerns. For example, community workers who supply OCs must know how to identify contraindications.

## CHECKLISTS

To address such concerns, checklists for community-based distribution of oral contraceptives and injectables have been distributed by a U.S. Agency for International Development (USAID) working group.<sup>1</sup> The checklists indicate whether a CBD worker can safely provide one of the methods or should refer the client to a higher level of care. The checklists were developed by FHI in collaboration with a

team of international experts, based on World Health Organization (WHO) eligibility guidelines for contraceptive use.<sup>2</sup>

There are few medical contraindications to use of oral contraceptives. "Most of the time, CBD workers can safely offer OCs and injectables," says Dr. Roberto Rivera, FHI's director of international medical affairs, who participated in developing WHO eligibility criteria and the USAID checklists. "But the checklists are a preliminary screening tool." When there is doubt, he says, clients should be referred to clinics or other services that have staff who are better prepared to make eligibility decisions.

While useful, checklists do not replace counseling. Counseling is essential to ensure that clients make informed and voluntary choices. Workers must also be able to teach clients how to use methods correctly and consistently, manage side effects, and recognize warning signs of serious complications.

"In particular, CBD workers — like providers at higher levels of care — must be prepared to counsel about side effects for which women are often unprepared," says Dr. James Foreit, a Population Council senior associate who has conducted CBD research in Latin America and Asia. For example, the progestin-only injectables, depot-medroxyprogesterone acetate (DMPA) and norethindrone enanthate (NET-EN), tend to produce irregular and prolonged bleeding for the first three to six months of use, and later are associated with amenorrhea.

The checklist to initiate OC use contains 12 questions to identify women who might have contraindications. It screens for cigarette smoking, an important indicator of cardiovascular risk among pill users, especially those older than 35 years. Some older checklists do not ask about smoking habits. By using updated eligibility criteria, the new checklist also reduces the number of women who might be denied the pill unnecessarily. Older checklists often include questions to screen for varicose veins or epilepsy, conditions for which OC use is not contraindicated. Older checklists also often include general questions about headaches. However, WHO criteria contraindicate OC use only when headaches are severe, recurrent and are accompanied by focal neurological symptoms.

Some countries may require a pelvic examination before use. Recommendations by an international panel of experts, however, state that a pelvic examination is not necessary for safe use of OCs.

While blood pressure screening is not necessary for OC use, it may be appropriate in some situations to optimize safe use of OCs. For example, blood pressure screening for women at risk of high blood pressure may be appropriate, since the estrogen component of OCs can have a minor effect (usually insignificant) on blood pressure.<sup>3</sup> OC provision by CBD workers is contraindicated for women with moderate or severe hypertension or hypertension with related vascular disease, according to WHO criteria.

WHO and the International Federation of Gynecology and Obstetrics have concluded that many years of experience with OC distribution and use show that pill provision by CBD workers is no more risky than provision at a clinic by a medical practitioner. If CBD workers have backup support from clinics, they can safely deliver oral contraceptives.<sup>4</sup>

In Matamoros, Mexico, a survey showed that some 100 clients obtaining OCs through CBD were as healthy as 135 clients obtaining OCs through other sources, and that the CBD program did not put women at greater risk of ill health or death than other distribution systems. Researchers noted that "if pills are contraindicated for very few women in the population, elaborate examination procedures are likely to have the overall effect of

putting more women at risk of unwanted pregnancy than would be protected from inappropriate pill use."<sup>5</sup>

The USAID checklist for progestin-only injectables contains eight questions to identify women who might have a condition making them ineligible. Such questions include whether a woman's menstrual period is late and she thinks she might be pregnant; if she has had a stroke or heart attack; or has diabetes, breast cancer or serious liver disease. Answering "yes" to any of these questions suggests a possible or definite contraindication to the method's use. Evaluation by a provider at a higher level of care should be offered.

A survey of some 300 women in Nepal, where DMPA is popular, revealed a very low prevalence of medical conditions that would contraindicate DMPA initiation by CBD workers. Furthermore, such conditions would have been easily identified by the checklist. Only 10 of the women had conditions identified as contraindications to DMPA use (five were pregnant, four could be pregnant, and one woman suffered from abnormal uterine bleeding). Five other women had cardiovascular problems that would contraindicate initiation of DMPA by a CBD worker. Researchers concluded that well-trained CBD workers supplied with

checklists could have identified all of these conditions and could have safely delivered DMPA to other clients.<sup>6</sup>

#### LACK OF SUPPLIES

Maintaining adequate contraceptive supplies is often difficult. In 1996, Population Council researchers interviewing CBD workers in seven of Kenya's largest CBD programs found that one-third of the workers reported having run out of supplies within the previous six months. On the day of the interviews, about 25 percent lacked either pills or condoms.<sup>7</sup> In Zimbabwe, there were 700 CBD workers in 1993 whose role was to provide a regular supply of OCs, and to monitor blood pressure and side effects. However, more than half of them did not have blood pressure cuffs to monitor pressure.<sup>8</sup>

Providing DMPA and NET-EN injectables through CBD raises important supply issues. "In an experimental study in a rural area of northern Ghana, for example, provision of DMPA through CBD has been found to be generally successful," says Dr. James Phillips, a Population Council senior associate who has conducted CBD research in Africa and Bangladesh. "Resupplies of contraceptives usually can be purchased at a regional health ministry store, but we have

RICHARD LORD



A FAMILY PLANNING COUNSELOR IN JORDAN EXPLAINS VARIOUS CONTRACEPTIVE METHODS DURING A HOME VISIT. OFFERING EACH CLIENT A RANGE OF CONTRACEPTIVE CHOICES IS IDEAL.

seen local supplies run out. Because CBD workers in the study have a Jeep, they have been very fortunate. This allows them to drive great distances to resupply themselves at other health ministry stores." Many CBD programs, however, are not so well equipped.

In addition to the drug itself, adequate supplies of syringes and needles are necessary. "The tendency to develop logistics systems for injectables alone without thinking about needles and syringes can be a big problem," says Dr. Phillips. If both DMPA and NET-EN are offered, two different needle sizes must be maintained because of different viscosities.

As is true with giving any injection, CBD workers must ensure that their needles are sterile. A sterile needle and a sterile syringe must be used only for one injection, since nonsterile or contaminated needles and syringes can transmit disease. Reusable metal needles and glass syringes should be sterilized in a steam sterilizer for 20 minutes at 121° C, or in boiling water in a container with a lid for 20 minutes. Required boiling time increases, however, with increasing altitude, and boiling may not kill infectious organisms at high altitudes.<sup>9</sup> Single-use (disposable) syringes and needles must be discarded safely, especially in areas with high prevalence of HIV/AIDS.

#### REFERRAL SYSTEMS

There are several obstacles to successful referrals by CBD workers. "First there may not be a clinic to refer a client to," says Dr. Foreit of the Population Council, "or distance may make referral prohibitive. For lack of time or money, the client may not want to go to a clinic that offers other methods, or the CBD worker may lack the motivation or ability to make an effective referral."

In Saradidi, Kenya, for example, volunteer health workers began providing family planning information and services in 1980 and contraceptive use rose in just three years from less than 1 percent to 17 percent of some 180 currently married women of reproductive age who were interviewed. Yet, nearly two-thirds of clients referred by helpers to a clinic for examination and supplies did not go to the clinic.<sup>10</sup>

Paying CBD workers referral fees when they send clients to clinics for long-term methods, such as the IUD and sterilization, might strengthen the referral system but could be abused. Clients could be coerced into choosing a long-term method. However, a study in 1989 of two family planning agencies with posts in the outskirts of Lima, Peru, where more than 2,500 women receive IUDs each year, found no evidence of coercion or abuse in IUD referrals made by CBD workers who received small referral fees. Interviews with approximately 250 women who obtained IUDs in this way also revealed that most users thought they had received adequate counseling about the method before and after insertion.<sup>11</sup>

"If you pay CBD workers for referrals for methods they themselves cannot provide, the number of referrals does increase," says Dr. Foreit, who helped conduct the study in Lima. "This financial compensation could pose an ethical problem. But if a CBD worker is already earning a commission for distributing OCs, the incentive for making a referral for a different method is not very compelling. In fact, it might be more profitable for a CBD worker not to make the referral."

When referrals are not possible or effective, mobile outreach teams or camps may allow clients of CBD workers access to contraceptive methods usually available only at clinics or hospitals. While concerns have been raised about service quality and lack of method choice, outreach camps play a significant role in expanding accessibility.

In Nepal, outreach camps are an important way to meet couples' demand for sterilization services in rural areas where hospital- or clinic-based services are not available throughout the year. In 1996, 42 percent of all sterilization clients received services from such camps. A study that compared the experiences of 445 women who had been sterilized in public hospitals and 372 women who underwent the procedure in temporary camps found no evidence that the camp approach led to the sterilization of women for whom the procedure was inappropriate. The percentage of women who regretted having been sterilized was similar for hospital and camp patients.<sup>12</sup>

Furthermore, quality of care did not appear to be compromised in the camps. Quality of care included the degree to which clients' decisions to accept sterilization were

based on informed choice, as measured by clients' awareness of various family planning methods. More than 90 percent of both hospital and camp patients knew about at least one of four temporary methods (pills, injectables, implants and IUDs).

— Kim Best

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# Motivating Community-based Workers

Many models for community-based family planning exist. In some, workers are paid; in others, they are volunteers. Some workers live in the village they serve, others do not. Some go door-to-door, while others work from home or another central location. Some programs use mobile clinics or establish small outposts for a variety of health services.

Similar questions tend to arise, in spite of the model used. What is the best way to motivate workers? What is the impact of paying workers or offering other incentives? How much supervision and training are needed? How can the quality of a community program be evaluated?

"The research record generally shows that paid workers perform better than volunteers," says a Population Council review of more than 200 reports and studies on African community-based distribution (CBD) projects. "When agents are paid, supervision can be rigorously exercised, programs can be implemented rapidly, work routines can be standardized and designed to cover populations, and service quality can be maintained." CBD programs that use volunteer workers are more complex to manage, the review says.<sup>1</sup>

A recent study in Tanzania evaluated the cost effectiveness of different ways of reimbursing workers in three CBD programs. Two of the programs employed part-time volunteers who received in-kind payments while the third program employed full-time workers who were paid salaries. The study measured visits per worker because couple years of protection (CYPs) tend to include factors that are not confined to a worker's efforts. For example, changing a program's policy regarding the number of pill cycles distributed per visit alters CYP costs, even when a worker's efforts remain the same.

The program that paid workers a salary was the most effective in terms of having the highest number of visits per worker. However, this program was not the most cost effective of the three. When considering supervision and training costs, one of the programs using part-time volunteers had the lowest cost per visit.<sup>2</sup> "In considering factors that affect the performance of CBD workers, program managers need to consider all costs that motivate performance, not just payments to workers," says Dr. Barbara Janowitz of FHI, a coauthor of the study.

Using number of visits and couple years of contraceptive protection to measure effectiveness, a study in Kenya also concludes that pay may be "a powerful determinant of performance."<sup>3</sup> CBD programs in Kenya use various reimbursement schemes, including full-time paid agents, part-time agents with nonmonetary incentives, and part-time agents who receive an allowance for expenses. Paid agents are more motivated than others, says Karugu Ngatia, assistant director of the National Council of Population and Development (NCPD), which coordinates all CBD activities in Kenya.

## SUPERVISION

While paid workers may perform better, both the Tanzania and Kenya studies found that other factors also affect worker output and program performance, especially supervision and community involvement. "CBD agents who are supervised more frequently tend to meet with more clients," the Kenya study concluded.

The Kenya study found a statistically significant relationship between the frequency of supervision and the agents' output. Recommendations to strengthen supervision included the use of supervisory

checklists, maintaining a firm monthly schedule and using full-time, field-based staff to supervise CBD agents.

To be meaningful, supervision requires more than simply checking records and stocking commodities. "The real question about supervision is not how often to provide it, but what you provide," says Dr. James Foreit of the Population Council, who has conducted CBD studies in Latin America. One study in Brazil, for example, found that reducing supervisor visits from monthly to quarterly resulted in "substantial potential savings in supervisors' salaries and travel at no cost to program performance (new acceptors, revisits, distributor turnover)."<sup>4</sup>

Community involvement is another important motivator for agents. New CBD programs in Burkina Faso and Togo will allow community leaders to select agents. In Tanzania, agents and supervisors in one program meet quarterly with local leaders to review the program, giving the community a sense of ownership.<sup>5</sup>

## TRAINING

"Most observers agree that the quality and intensity of agent training is the most important single determinant of program quality and impact," concludes the Population Council review of CBD studies. Training generally works better when it is competency-based, incremental and practical.<sup>6</sup>

In general, CBD workers receive some kind of initial training and then periodic refresher courses. Usually, the refresher training requires the workers to go to a central location for a course lasting several days. "In general, this is expensive and not everybody comes," says Dr. Foreit. An alternative is to take the training to the workers, through a continuous approach that incorporates refresher training into ongoing supervision.

Other types of training approaches have proven difficult to implement. A study in Peru found on-site training through supervisors works in theory, but using it successfully has not been easy. The study compared group training with individual training through supervisors. The individual approach used a checklist to help the supervisor determine what an agent needs to learn, which took less time and was cheaper than group training.<sup>7</sup>



AT A MARKET IN CHACAN, PERU, A COMMUNITY-BASED FAMILY PLANNING PROMOTER USES AN ILLUSTRATION TO EXPLAIN HOW CONTRACEPTION WORKS.

In Paraguay, a CBD program uses flowcharts in a small handbook with tabs to train agents. A worker follows the flowcharts, flipping to a particular page depending on each client's answers to specific questions. For example, a person is asked if she wants to use contraception. If the answer is yes, the book tells the agent to go to a page that illustrates basic information on a variety of method choices. One study concluded that this method of training agents achieved the largest gain in quality and was the least expensive approach over other training options.<sup>8</sup>

Offering a variety of methods is an important aspect of quality family planning services. CBD workers, however, can only offer certain methods and may emphasize those over methods that require a referral. A study in Kenya found that community-based distributors tended to emphasize oral contraceptives more and explore medical contraindications less thoroughly than did clinic providers.<sup>9</sup> CBD training should include clinical and nonclinical methods, so agents are able to discuss a range of choices. Agents should be encouraged to refer clients to clinics when appropriate.

— William R. Finger

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## COMPARING CBD PROGRAM COSTS

While community-based distribution of family planning services can be a cost-effective approach, some studies have found other delivery approaches are often less expensive. Cost, however, is only one factor. Without a community distribution strategy, experts say, some people in many countries would receive no services at all.

"Comparing costs of clinics and CBD (community-based distribution) programs is not useful unless the programs serve the same audience," says Dr. Barbara Janowitz, an FHI economist who has studied community programs in Tanzania, Bangladesh and other countries. "Generally, you need CBD because you cannot reach the population through a clinic program."

Many studies of CBD program costs have used couple years of protection (CYPs), a traditional family planning measurement. Distributing 13 cycles of oral contraceptives produces one CYP, for example, since that many pills provide one year of protection.

A study of family planning programs in 14 developing countries comparing costs this way found community distribution to be among the most expensive options. Clinic-based sterilization cost only U.S. \$1.85 per CYP in two countries, while community-based distribution programs in five countries averaged \$9.93.<sup>1</sup>

The CYP measurement has important limitations. While all program costs are generally included, the cost burden to clients, such as travel expenses to a clinic, are not. Also, CYP cost calculations do not take into account different failure rates among methods, client preferences, informed choice, or a client's need to use condoms for disease prevention.

Some experts suggest that other indicators are more useful, such as ways to measure access to an expanded method mix.<sup>2</sup>

For example, the Planned Parenthood Association of South Africa included the costs clients pay (travel and time lost from work) to evaluate clinic and community-based distribution costs. Clinics provided only injectables, oral contraceptives and condoms, not methods that result in a high number of CYPs — such as sterilization and intrauterine devices — which would skew calculations in favor of clinics. CBD workers

provided pills and condoms. When client costs were included, CBD was cheaper, about U.S. \$42 per CYP compared to U.S. \$44 per CYP at clinics. Also, the CBD cost declined to U.S. \$25 per CYP in the second year, since community agents often provide only information during initial visits. The study did not attempt to calculate the value of supplying information.<sup>3</sup>

"CBD is comparable in cost to clinic provision, and may, in fact, provide significant money savings," concluded Edina Sinanovic, a health economist at the University of Cape Town Medical School, who conducted the study. The study found that CBD services may also save money by allowing professional clinic staff to devote more time to services that require more expertise.

Other evaluations examine the cost per visit to a household. A study in Kenya compared cost effectiveness of seven CBD models serving rural and urban areas, examining both the cost per client met or visited and cost per CYP. Three urban programs used agents working from clinics, while the four other programs served rural areas with home visits or village-based CBD workers. Although costs varied, the location served was not a significant factor in costs per visit or CYP. "Rural and urban CBD programs can achieve similar levels of cost effectiveness," the study found. "For the less cost-effective programs, the reason is not because of where they operate."<sup>4</sup>

In another analysis, the Population Council and FHI worked with Centro Médico de Orientación y Planificación Familiar (CEMOPLAF) in Ecuador to evaluate the cost of outreach services to remote rural areas. CEMOPLAF had found that rural residents are reluctant to spend the time and money to visit clinics in distant towns. CEMOPLAF developed a system in which providers from two clinics traveled to remote areas. Providers from one clinic attracted enough clients to reduce average costs below the level achieved before the outreach effort began. Providers from the other clinic did not, primarily because of competition from commercial providers and because their services were offered at an inconvenient location.<sup>5</sup>

Asociación Probienestar de la Familia Colombiana (PROFAMILIA), the International Planned Parenthood Federation affiliate in Colombia, examined three CBD approaches. One used social marketing, supplying small rural drugstores at wholesale prices. In the second approach, CBD instructors serving about 70 CBD posts received wage incentives. The third approach used two-person teams (each with a man and woman), who promoted family planning at health posts, hospitals and schools rather than making household visits.

From a cost perspective, all three strategies were effective. The social marketing experiment actually resulted in a profit, although government and pharmaceutical company decisions have limited its usefulness. A Population Council study of the approaches recommended using such commercial approaches when there is sufficient demand for services.<sup>6</sup>

— William R. Finger

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## OFFERING CBD AND OTHER SERVICES

Community-based family planning programs can be combined with additional health services, including disease prevention, prenatal and antenatal care and oral rehydration therapy. In some cases, income-generating activities are included.

Also, community-based distribution (CBD) workers are beginning to provide family planning services to youth and unmarried women, going beyond the traditional service population of married couples. Some examples of these integrated approaches include the following:

- In 1969, the three-year-old Thailand National Family Planning Program sought to increase services to rural areas by allowing midwives to provide oral contraceptives. Midwives learned to use a checklist to identify relevant health concerns and refer a woman to a physician if necessary. After six months, pill use increased substantially in areas where the approach was used, compared to a modest increase in pill use in other areas. Continuation rates at six and 12 months were also higher among women served by midwives, compared with women who received pills from physicians.<sup>1</sup>

- A study in rural Mali examined the impact of adding family planning services to an existing primary health care system. Some health workers in two districts provided contraceptives and information, while workers in two different districts provided only family planning information. Client surveys showed contraceptive use and knowledge increased more among people served by health workers who provided contraception. For example, men's ever use of condoms increased from 9 percent to 35 percent among people served by this group, and from 7 percent to 16 percent when only information was given.<sup>2</sup>

- In an effort to add family planning to an existing community-based delivery system, a project in India has begun training 47,000 village medical private practitioners in the Uttar Pradesh state to provide family planning services. Providers practice a combination of traditional and modern medical practices; some have formal medical training while others do not. Four to six days of training includes family planning counseling,

provision of condoms and pills, sexually transmitted disease prevention, and making referrals to obtain intrauterine devices (IUDs) or sterilization. Since participants are private practitioners, no supervisory system is used. The effort results in "a definite improvement in counseling skills and knowledge of pills, condoms, IUDs and sterilization," says Meenakshi Gautham, project manager in India for the U.S.-based INTRAH program.

- In Honduras, community volunteers were trained to make referrals for family planning and other health services based on a checklist of simple questions involving each client's general and reproductive health needs. Volunteers contacted nearly 1,200 women in 11 villages and approximately 60 percent of the women were referred for services. Using "simulated clients" to evaluate the approach, volunteers made appropriate referral decisions 85 percent of the time, considered to be a successful result. The incorrect decisions were equally divided between clients who should have been referred but were not and clients who were referred when no service was needed.<sup>3</sup>

- In Tanzania, community-based agents were as much or more productive if they provided other health services as well as family planning. A study compared the output of agents who only provided family planning and maternal and child health referral services with agents who provided these services in addition to other activities. Each agent providing the additional services saw an average of 147 clients per year, resulting in 21 couple years of protection (CYPs), while other agents on average saw 110 clients per year, with 18 CYPs. Agents said that providing a broader range of services made them more productive. Agents not providing such services as information and referral services about sexually transmitted diseases expressed a need to receive training for a broader range of services. The agents "pointed out that their community members ask them questions and request services beyond family planning."<sup>4</sup>

- In a survey of Kenyan CBD clients, where many different models are used, about 90 percent of respondents favored agents who can provide counseling, including information about sexually transmitted diseases. Most of those interviewed also supported CBD workers discussing family planning with young adults (80 percent) and unmarried women (83 percent). Scientists concluded that CBD agents should be trained more thoroughly in other reproductive health issues and encouraged to act as sources of information for other community members, especially youth.<sup>5</sup>

- Intervention projects have shown that community family planning workers contribute to better maternal health. In Bangladesh, door-to-door family planning workers were trained to counsel pregnant women about how to recognize obstetric emergencies and the importance of seeking treatment promptly if the symptoms appear. To assist illiterate women, the workers used pictorial cards such as one showing labor pain lasting more than 12 hours as a reason to seek treatment.<sup>6</sup>

— William R. Finger

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## FOUR CBD PROGRAMS

### CARE PROJECT ENLISTS COMMUNITY SUPPORT

PACARA SULLICANI, Peru — Seasonal rains make their mark quickly on the highlands in southeastern Peru. Streams that are usually of little concern to travelers are swollen and intimidating: their muddy beds and banks suck ferociously at the tires of vehicles fording them. Even with a four-wheel-drive truck, reaching the remote, farming community of Pacara Sullicani from Juli — the nearest town with basic health services — takes at least two hours.

When weather conditions are ideal, transportation to or from Pacara Sullicani still is not easy. Nor do most members of this small community of about 200 people wish to travel. Few people in the nearest town will speak their language, Aymara. Meanwhile, time and attention must be devoted to the care of the cattle and sheep grazing in the vast plains of Pacara Sullicani, and the quinoa, beans and purple-flowering potatoes cultivated here.

Crops are not as abundant as they once were. The land tends to be overworked, and there is less land for each person due to repeated divisions among family members over many generations. No longer can it feed many people. Nor are large families now needed to maintain it.

“The economy of this area makes it very hard for us to raise large families,” says Felix Montufa, a farmer and volunteer family planning promoter who lives in the community.

Standing before the dried brown mud and thatch room that he built to provide family planning consultations, Montufa explains how he was enlisted to do family planning work, which occupies about two days each week. “I have been providing other community services since 1987 and I was chosen by the community leaders to be a reproductive health promoter,” he says. “I do this now because I know that if couples

have six or eight or 10 children, it is not good for my community. I like to know that I’m doing something good for my people.”

Montufa is one of 700 community promoters of contraception working in communities near Puno through a project of CARE-Peru and the Peruvian Ministry of Health (MINSA). This eight-year-old project, called the Multisectoral Project of Population and Reproductive Health (PMP), serves approximately 300,000 families throughout the country. Community promoters can distribute condoms, vaginal tablets and oral contraceptives. For longer-acting or permanent methods, they make referrals to a MINSA health post, center or hospital.

The project in the department of Puno is only three years old, but makes family planning available to some 9,000 people in the area. In other locations in Peru where PMP projects began earlier and are more

developed, maternal health, adolescent issues and sexually transmitted disease prevention are offered in addition to family planning.

In the past, the project was exclusively financed by major donor agencies — the U.S. Agency for International

Development and the United Kingdom’s Department for International Development. But donors and MINSA now share the costs, and MINSA will assume all logistical and financial responsibility by the year 2001.

“The goal has been to get communities involved,” says Dr. Irma Ramos of CARE-Peru, PMP project coordinator, “and for CARE-Peru to provide technical support to MINSA to increase access to, and improve, reproductive health services for underserved people living in extreme poverty. Before we began the program, MINSA had reached

#### PERU

#### 4,000 CBD workers

- ▲ Population: 25 million
- ▲ Terrain: coastal, tropical forests and rugged mountains
- ▲ Area: 1.28 million sq km



FELIX MONTUFA, VOLUNTEER PROMOTER, LEAVES HIS CONSULTATION ROOM WITH CONTRACEPTIVE SUPPLIES.

out as far as its health posts with reproductive health services. It could go no further. We facilitated an expansion of those services into rural communities. And, in turn, MINSA was very helpful in involving the communities and will hopefully be able to provide the ongoing stability to make the program sustainable."

In the first years of the program, CARE-Peru initiated contact with community leaders, and, with MINSA, helped the leaders recruit their own promoters. CARE-Peru also worked to improve a poor contraceptive supply system; trained and supervised community promoters; and designed reporting forms to allow for proper accounting of services and supplies. Reports from promoters provide the health ministry with otherwise unavailable information about contraceptive use and reproductive health among members of remote communities. CARE-Peru staff members also have provided clinical reproductive health, communication, sexuality and gender training for MINSA medical professionals at health centers, and taught them to form, train, supervise and supply networks of promoters.

With CARE-Peru's logistical support, MINSA personnel also continually evaluate the performance, knowledge and practices

of promoters through meetings and supervisory visits in the community, refresher courses, and follow-up visits to users. Promoters receive immediate feedback and are classified according to the level of their performance; those receiving poor evaluations often are dismissed.

### CONSULTING ROOM

Montufa is a fairly new promoter, with less than a year's experience, but he takes his volunteer work seriously. Inviting visitors into his tidy consulting room — painted sky blue and filled with posters, flip charts, brochures and other materials about family planning — Montufa indicates meticulously detailed notes, written in a firm, steady hand, within a notebook and on individual cards. The notes summarize the use of various contraceptive methods by his clients: 22 users among 60 couples in the community. They also include referrals Montufa has made for longer-acting or permanent methods, such as injectables or intrauterine devices. "At first, I mostly distributed condoms and made referrals for injectables," he concludes, reviewing his records. "But now vaginal tablets are more popular."

In his records, Montufa has also noted the dates, subjects and attendance for various talks that he has delivered in the Aymara language to community members.

"During these community chats," says Dr. Ramos, "promoters generally use pictures rather than text because their clients may be illiterate. They also talk in one of the local dialects on a level that people can understand. They are trained not only to discuss family planning methods, but also self-esteem, responsible parenting, hygiene, how sexual relations and love are related, the importance of prenatal checks, gender issues, men's reproductive health needs, and other related matters. Offering information, education and counseling that takes into account the whole individual is fundamental to removing misconceptions that clients may have held all of their lives.

"Sometimes, people attending these talks are embarrassed by the pictures or information. But, in our experience, curiosity and interest soon conquer this timidity. Although many people do not want others in the community to know how they feel about family planning, their desire not to have many children is often very strong."

"Such promoters greatly help bridge both a geographic and a cultural gap between clients, who are generally Quechua or Aymara Indians, and medical professionals," says Dr. Luis Tam, CARE-Peru health sector director. "Their involvement helps prevent misunderstandings and allows clients to obtain information that is truly meaningful to them."

Two contracepting women from Pacara Sullicani attest to this. Both say they want no more children. Sosana Huayta, one of eight children and the mother of three, says that she is glad that Montufa has given her the means to control her fertility. Maria Valezques, one of six children and the mother of two, says Montufa "has been good for us and our community."

Such expressions of gratitude from community members are powerful incentives for voluntary promoters. In the highlands of Peru, strong traditions and communal bonds prevail. In recognition of their work, communities often bestow special status upon promoters and exempt them from communal labor. After training, promoters receive certificates, identity cards, free uniforms and other materials. CARE-Peru and MINSA are testing other incentives to encourage quality work by community promoters, including free health services for the promoters and their immediate family members, as well as reductions in the cost of medicine.

However, many promoters express indifference to the idea of being paid for their work. Leonardo Chino Aroquipa of the community of Posoconi, sitting on the roan horse that he usually rides to make home family planning visits, explains that he has long attended births in the middle of the night "because I like serving my community. I am 38 and have four children, more than I would have liked, but I did not know about family planning before. I want others to know, and I will keep doing this work even though I do not get paid just because I like it. I now have 18 contraceptive users, all men."

Rosa Quispe Hihuaña, a mother of three and promoter since 1997, proudly says that she has 31 contraceptive users among 73 couples in her sector of the community of Collina Pampa. Is her work difficult? "Yes, because sometimes the people do not want to use contraception and tell me that their personal lives are not my affair. Other people sometimes ask difficult questions. Also, men did not accept me at one time, but many have

changed their minds. Because I do not receive any pay, people are not so suspicious of my intentions.”

Do older people in the community — long accustomed to large families — object to the idea of family planning? “No, because most have suffered very much to raise so many children,” says Hihuaña. “And, not infrequently, women see my family planning sign and come to visit with their adolescent daughters.”

Although both CARE-Peru and MINSA officials consider this CBD model to be successful, its success was not achieved easily. Nor is its sustainability assured.

“Because this model required that CARE-Peru train MINSA professionals to provide reproductive health services independently and train, supervise and supply CBD workers, it was perhaps slower and more difficult than some other CBD models,” says Dr. Ramos, project coordinator.

Beat Rohr, national director of CARE-Peru, emphasizes the importance of government leadership. The community program “has largely prospered because the present government favors health care reform in general, wishes to improve reproductive health, and offers free contraception to every citizen.”

Ultimately, the success and sustainability of such a program depends upon the people living in the remote communities, says Dr. Ciro Castillo Rojo Salas, director of the MINSA health unit in San Román. “Family planning is not an unknown concept for them,” he says. “Many people in the highlands have a long history of trying to control their fertility, and they may very much welcome better ways to help them do so.” □

— Kim Best

## CITY LIFE ISOLATES MANY CLIENTS

JULIACA, Peru — A volunteer family planning promoter carefully negotiates her way across a puddle covering much of the road on the outskirts of this commercial city. Because she also lives in this neighborhood, the immense puddles and densely populated streets are familiar terrain.

Firmly and confidently, she steps on rocks strategically placed from one side of the puddle to the other. Then, reaching a narrow strip of solid ground, she stops and waits for an obstetric nurse and nurse’s aide whom she is accompanying on family planning home visits. They stop at the door of a mother of two who had been given oral contraceptives at a PLANFAMI clinic, but did not return for a scheduled visit.

It is not difficult to understand why. The rainy season has made streets nearly impassable. Also, the mother tells the visiting team, “I decided not to come to the clinic because I was not having problems with the pill.”

Nevertheless, the team counsels her about her health, makes sure she knows what to do if she misses a pill, and gives her a new supply of pills for another three months. Finally, they encourage her to discuss reproductive health concerns with her maturing daughters (11 and 14 years old). She agrees, although somewhat reluctantly.

“Women tend to be timid and fear criticism from the community, so it is very important to protect their privacy,” says the community promoter, who was selected by people in her neighborhood to serve in the position. “They fear the promoter will gossip, so you have to win their trust.”

One of her clients, a 33-year-old mother of two, admits “I did not like it when she approached me at first. But we were neighbors, and she talked to me in my language, Quechua. I was using the rhythm method for two years after the birth of my last child, but then she told me about the vaginal tablets and I decided to try them. I like them. Now I’m thinking about using the condoms she provides in addition to the tablets for extra security.”

The need for home services during the rainy season is particularly acute. “People really struggle to get to clinics at this time of year,” says Juan de la Riva, executive director of PLANFAMI. “Women are accustomed to staying home, and are scared to travel, even across town to a clinic.”

The visiting team is one of several PLANFAMI efforts to reach people, he says. Funded by the U.S. Agency for International Development and receiving technical assistance from Pathfinder International, PLANFAMI operates four clinics within 90 kilometers of its base clinic in Puno. Typically, an obstetric nurse and nurse aide from each clinic make home visits, riding into the countryside on a motorcycle or in a well-equipped van that offers injectables and intrauterine devices, in addition to other methods. PLANFAMI also holds reproductive health discussions and makes video presentations in the countryside, traveling by van with electric generators to supply power.

Volunteer community promoters are given uniforms, backpacks, health materials and contraceptives, an identification card, and transportation to training sessions. Otherwise, they receive no compensation.

PLANFAMI has other innovative efforts. The organization works with a local police station that often feeds impoverished street children to encourage the children’s mothers to attend monthly PLANFAMI reproductive health discussions and video presentations, and to receive medical examinations and contraceptives.

PLANFAMI also offers reproductive health services to male and female inmates at a prison, where conjugal visits are allowed. And another effort works with tricycle taxi drivers in Juliaca.

“Not only do taxi drivers know where prostitution takes place in the town, but they themselves are very much at risk for sexually transmitted diseases,” notes Mary Vandembroucke of Pathfinder International, who assists PLANFAMI. “Working directly with these men can be very important.” ■

— Kim Best



MARY VANDENBROUCKE/PATHFINDER

PROMOTERS IN JULIACA.

## BANGLADESH REFINES A SUCCESSFUL PROGRAM

The Bangladesh family planning program, which operates one of the world's largest, oldest and most successful community-based delivery systems, is beginning to shift its emphasis toward community clinics. The change is designed to improve efficiency and to address changing cultural needs.

Rather than focusing on door-to-door visits to all couples eligible for contraception, a system used for more than 20 years, the program is encouraging many couples to obtain contraceptives from centralized locations, such as village clinics. In addition, the government has begun to integrate family planning at clinics into a broader package of health services that includes antenatal and postnatal care, child immunization and communicable disease prevention.

"A lot has changed with women in Bangladesh over the last 20 years," says Nancy Piet-Pelon, who followed the Bangladesh shifts closely in her former position as Asia regional director for AVSC International. "A major reason this program began was that women were not allowed to leave their homes alone, and that has changed. Their status has changed. Now, women want to use family planning and can leave their home to get supplies." (For a discussion of gender-related issues involving community distribution programs, see article on page 17.)

Small community clinics are beginning to offer both family planning and other health services. Health assistants and family welfare assistants with more training than door-to-door village workers will provide most of these needs, explains Dr. Mohammad Alauddin, country representative for Pathfinder International, a U.S.-based service delivery organization that works in rural areas of Bangladesh.

### SUSTAINABILITY

Door-to-door distribution throughout Bangladesh, using workers called family welfare assistants, has been among the factors in rising contraceptive use. Demographic surveys show about half of all married women of reproductive age are using contraception, up from 7 percent in 1975 when community-based distribution began.

In recent years, however, a series of studies raised concerns about the current system. With the maturity of the program, the demand for services has increased as more and more women enter their reproductive years. Meeting the growing

demand requires efficient use of clinical facilities and of home service delivery workers. A 1996 study by the Bangladesh Ministry of Planning, with assistance from FHI and Associates for Community and Population

Research, found that family welfare assistants typically spent only a few minutes with each client.<sup>1</sup> "Visits that take only about four minutes may not be adequate. For example, the client may not learn very much about how to handle side effects," says Dr. Barbara Janowitz, an FHI economist who coauthored the study.

Under a long-standing system, family welfare assistants were supposed to visit all couples eligible for contraception every two months, regardless of whether the couple was interested in family planning or was already obtaining services elsewhere. Targeting clients who are more likely to need services is one strategy that can improve effectiveness.<sup>2</sup> An analysis by John Snow, Inc., a U.S.-based organization that specializes in contraceptive logistics management, questioned an emphasis on methods that require routine visits and supplies, such as oral contraceptives.<sup>3</sup>

*Continued on page 16*

BANGLADESH

### 30,500 CBD workers

- ▲ Population: 125 million
- ▲ Terrain: alluvial plain and hills
- ▲ Area: 144,000 sq km

BERYL GOLDBERG



WOMEN VISIT OUTSIDE THEIR HOMES IN DHAKA, BANGLADESH.

## ZIMBABWE'S "CLINICS UNDER TREES" INCREASE ACCESS

RICHARD LORD

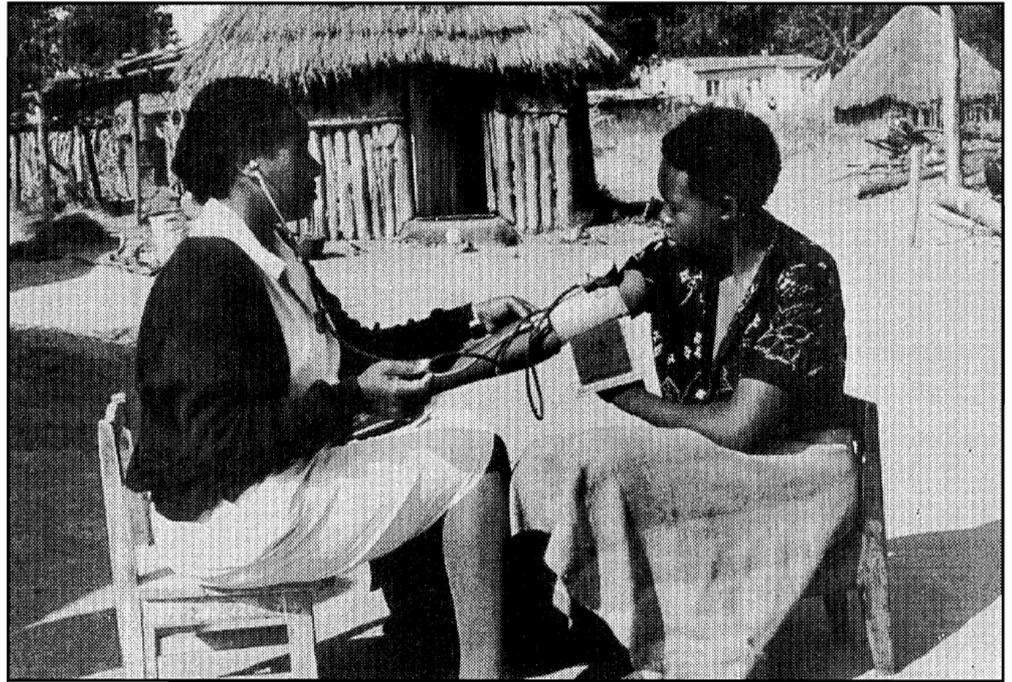
HARARE, Zimbabwe — Sibonindaba Moyo rides her bicycle along the red dirt roads, traveling from village to village in the Goromonzi farming area near Harare. In her waterproof satchel she carries oral contraceptives and condoms, which she will sell to the women and men she meets along the way.

Moyo is one of more than 700 community-based distributors of contraceptives employed by the Zimbabwe National Family Planning Council (ZNFPC). While making her rounds, she will discuss the benefits of family planning with people who have never used contraception. She will bring new supplies of pills and condoms to women and men who have already begun family planning, and will refer clients seeking other methods to health clinics. This is her routine as she conducts "clinics under the trees."

In Zimbabwe, community-based distribution (CBD) workers are an integral part of their community, which officials believe has encouraged the use of family planning. "People feel comfortable with one of their own," says Thandy Nhliziyo, ZNFPC assistant director of service delivery.

The family planning program in Zimbabwe, considered one of the most successful in Africa, began nearly a half century ago. Initially, services were clinic-based, but by the mid-1970s, the first CBD workers, known as "pill agents," began working to increase access to contraception.

Zimbabwe's fertility rate has fallen from 6.6 births per woman in the late 1970s to 4.3 in 1994, and its contraceptive prevalence rate is one of the highest in Africa — 48 percent of married women of reproductive age are using a modern method. High levels of contraceptive use are due in large measure to the CBD program, which serves nearly a fourth of the country's family planning clients. However, in spite of its successes in reaching clients, fertility levels are considerably higher in rural areas than in cities (4.9



A FAMILY PLANNING PROMOTER IN ST. FRANCIS, ZIMBABWE.

versus 3.1 births, respectively). The pill is the most widely used method (33 percent of all married women).<sup>1</sup>

Most CBD workers are women. They are selected by community leaders who nominate three candidates. After initial training in Harare, the finalist continues training under a supervisor in the community, and eventually must pass a written exam. ZNFPC encourages CBD workers to participate in local activities, such as club meetings or even simply doing laundry at the river with other women. Their presence shows they are interested in the community's welfare and is also a reminder that family planning is readily available, since workers often attend with their satchel of pills, condoms and family planning information.

"We tell them your working hours are from 8 a.m. to 4:30 p.m., but if someone comes at 8 in the evening and needs condoms, or they are going out of town and need more

pills, you cannot say 'I closed at 4:30,'" says Hope Monica Sibindi, a ZNFPC provincial manager.

Very often, a CBD worker is the first, if not the only link, to any type of health care for families in her community. In addition to family planning information, CBD workers can dispense analgesics for headaches. They can provide information on HIV/AIDS — what it is and how it is transmitted. They discuss breastfeeding with new mothers, explain the importance of hand washing as a means of disease prevention, talk about the immunization schedule for infants, and discuss purification of water.

Zimbabwe's CBD program is highly organized and structured. Supervisors, typically experienced CBD workers with additional training, are responsible for monitoring the work of 10 to 12 workers. In turn, nurses manage supervisors.

For three weeks each month, a worker typically travels throughout her territory. The fourth week of the month is devoted to administrative tasks, including ordering

contraceptive supplies, training and record-keeping. During group training, workers practice counseling skills by role-playing.

A pilot program funded by the Rockefeller Foundation seeks to expand services to younger adults. Traditional midwives and teachers serve as CBD workers or "family friends" and visit young people in their homes to discuss contraception and reproductive health. Parents were skeptical at first, but "but now they are calling CBD workers for assistance," says Sithokozile Simba, ZNFPC service delivery manager.

#### ZIMBABWE

#### 800 CBD workers

- ▲ Population: 11.5 million
- ▲ Terrain: desert and savanna
- ▲ Area: 390,000 sq km

Sibindi says a popular view is that discussing contraception encourages adolescent sexual activity, although many studies indicate that sexual education delays the initiation of sexual activity. "We need to consider ways to meet the needs of young people without offending the community," she says. "Even talking with youth about sex is discouraged. We need to strengthen CBD workers' skills in how to deal with this."

— Barbara Barnett

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## Bangladesh

Continued from page 14

Lower fees charged at clinics than for services provided in home visits can be used to encourage clients to visit clinics. Also, long-term methods (intrauterine devices and sterilization) can be offered free, as a way to promote the use of those methods.<sup>4</sup>

However, studies also suggest caution about strategies that could weaken or eliminate door-to-door distribution. Without the household program, contraceptive prevalence in 1993 would have been about 25 percent in Bangladesh, instead of 40 percent, according to a Population Council study.<sup>5</sup> Home visits also reduce travel costs for clients, and waiting time. "In the case of contraceptive continuation, timely workers' visits may enable women to manage side

effects" by offering counseling or an alternative method, concludes Dr. Mary Arends-Kuenning of the Population Council.<sup>6</sup>

— William R. Finger

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# Gender Norms Affect Community Distribution

Access to family planning services can be influenced by society's roles for men and women.

Community-based distribution (CBD) of contraceptives can be helped or hindered by gender norms.

Community-based services that bring contraception counseling and information into people's homes can help women obtain control over their fertility, and thereby enhance their autonomy and self-esteem. CBD programs can compensate for the lack of health-care facilities available to men. And, community-based programs can improve the status of female workers, who may have limited opportunities for employment.

However, CBD programs that exclude men can perpetuate the notion that family planning is solely a woman's responsibility. Programs that focus on women alone ignore men's reproductive health needs. And by bringing services into the home, CBD programs can encourage women's seclusion and discourage their movement outside the community.<sup>1</sup>

"Gender affects decisions about family size, sexual relationships and prevention of sexually transmitted infections," says Dr. Jane Chege, program associate with the Population Council's Frontiers Project in Nairobi, Kenya. "Considering gender concerns from the program design stage will assist managers in determining how to exploit positive gender issues and overcome constraints imposed by gender norms. In view of the fact that CBD agents provide services at the household level, they are in an ideal position to address some gender concerns."

Because there are distinct societal roles for men and women, as well as rules about appropriate behavior, CBD programs can affect women and men differently. An FHI study in rural Mali illustrates this contrast.

The study, in collaboration with Save the Children/Mali, compared the impact of community-based programs on three groups of people: those who received family planning education alone, those who received education and contraceptive methods (condoms and spermicides), and those who received neither. Each group included some 500 participants. In the group that received methods and education, 10 percent of the women knew of one or more modern contraceptive methods prior to the study. After the study, the percentage increased to 99. Among the men, 43 percent knew of modern methods before the study, while 91 percent knew of methods afterward. The gap between male and female knowledge prior to the study may be explained by gender norms.

"One possible explanation for men's greater knowledge of modern methods at pre-test is that men had greater access to information," FHI scientists wrote. "While both women and men have access to radio, men generally spend more time listening to it and are, therefore, more likely to hear messages about family planning." In addition, researchers noted, men are more likely than women to travel to the cities, where information about family planning is more readily available. Men are also likely to learn about methods from male friends or family members.

And while men may learn about contraceptives, they typically do not share that information with their wives. In Mali, it is considered inappropriate for women to discuss sexuality issues with men or men to discuss such issues with women. However, the FHI study found that these gender norms can be changed and spousal communication can be improved. Among the three study groups, those who received both education and methods reported the largest increase in spousal communications — from 17 percent of women to 67 percent of women and from 14 percent to 77 percent of men.<sup>2</sup>

Gender norms can create barriers to contraceptive use, especially when adolescents are the clients. In many cultures, sexual activity for young unmarried women is frowned upon, while sexual activity among young men is an accepted sign of manhood.

This discrepancy was evident in Kenya, where CBD workers were more willing to serve adolescent boys than girls.

Although most workers (81 percent) said they would provide services to an unmarried boy with no children, only 26 percent would provide contraception to an unmarried girl who had not yet had a child.<sup>3</sup> “This probably reflects a general societal bias against unmarried women being sexually active and the fact that there are often myths that contraceptives inhibit fertility, so a woman should prove her fertility first,” says Dr. Ian Askew, director of operations research in the Population Council’s Nairobi office.

#### MEN OR WOMEN WORKERS?

A central question is whether the sex of community workers affects clients’ willingness to use a method and their access to services.

A 1993 study in the Democratic Republic of Congo, conducted by Tulane University in the United States, looked at the characteristics of successful community-based workers. Age was a factor, with older workers providing more contraceptive protection than younger workers. However, sex was not a factor. Four out of five study sites employed male and female CBD workers, and researchers found no significant difference in their performance.<sup>4</sup> CBD workers should be selected primarily on their willingness to work, researchers concluded.

Population Council researchers observed that community-based programs in Peru were an important source of information and methods for couples. However, more oral

contraceptives were distributed than condoms, and part of the reason was that the majority of workers were women.

To learn how effective men would be as CBD workers, the Population Council conducted a study with two family planning agencies, Promoción de Labores Educativas y Asistenciales en Favor de la Salud (PROFAMILIA) in Lima and Centro Nor-Peruano de Capacitación y Promoción Familiar (CENPROF) in Trujillo.<sup>5</sup> One of the first lessons learned was that men were more difficult to recruit as CBD workers than women, possibly because many were already working when approached.

In addition, female CBD supervisors were reluctant to involve men in what they considered “women’s work.” Among their comments: “Men only want to sell contraceptives. They don’t want to keep records and give talks.” “Men have less free time to do the work.” “Many are too embarrassed.”

In analyzing contraceptive distribution figures among male and female CBD workers, researchers found that men and women served approximately the same number of new clients each month. Researchers concluded that, in spite of difficulties in recruiting, men can be effective CBD workers, CBD programs can influence method mix by recruiting more men, and programs should recruit and train more male workers.

The sex of providers has other implications. A review of data collected by the International Centre for Diarrhoeal Disease Research, Bangladesh found that women who had had recent contact (within 90 days) with a community worker were more likely to use contraception, regardless of the worker’s sex. However, women who spoke with female workers were 2.8 times more likely to use a method, while those who had contact with a male worker were only 1.4 times more likely. Gender roles, which discourage women from discussing sexual issues with men, may be responsible for the difference.<sup>6</sup>

#### REACHING MEN

Community-based programs offer an opportunity to reach men, who are typically left out of family planning programs. By providing services in the home, CBD programs can help men maintain privacy for themselves and their spouses, and men can avoid the embarrassment of attending clinics

ROB COUSINS/PANOS PICTURES



SOME STUDIES INDICATE THAT A CBD WORKER’S SEX DOES NOT AFFECT A CLIENT’S WILLINGNESS TO USE METHODS. A HEALTH WORKER IN KENYA GIVES FAMILY PLANNING ADVICE.

that are designed to serve women. In addition, home visits can increase access to other services, such as screening or treatment for sexually transmitted diseases.

In Kenya, contraceptive use increased when men were included in CBD programs — both as workers and as clients. In the Kilifi District along the coast, the Family Planning Association of Kenya and the Population Council established three teams of community workers — one with 10 women, one with 10 men, and one with five men and five women. Workers were encouraged to work in places where men typically congregate — community meetings, sporting events, work places and drinking places — and to include men in discussions during home visits.

Communication between spouses increased for clients of all three teams, with the percentage of men who reported discussing family planning with their wives nearly doubling during the 18-month study. The greatest increase took place among clients served by the team with both male and female workers.<sup>7</sup>

“We found from service statistics that male agents tend to provide more condoms whereas female agents tend to provide more pills, suggesting that the sex of the agent is important in determining who they are best able to serve,” says Dr. Askew of the Population Council’s Nairobi office. “However, we did not find that one sex was more productive than the other. They seem to serve different groups.”

## WOMEN’S STATUS

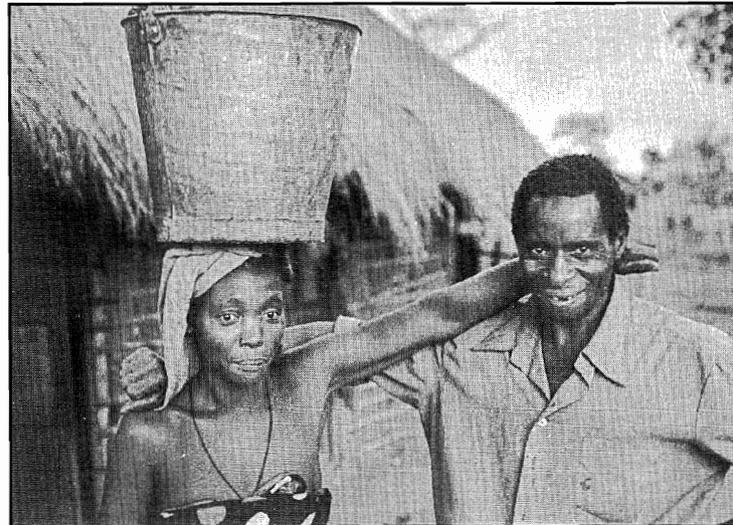
Some community-based contraceptive programs are offered as part of larger efforts to improve women’s status. The primary purpose of Maendaleo Ya Wanawake Organization, one of Kenya’s largest women’s organization, is to help women earn income. In addition to helping women improve income-producing skills, its 1,200 community workers also provide family planning services. “We found that women needed to do income-generating activities to sustain themselves, but they kept on having children, sometimes every year,” says Dorcas

Amolo, project director for reproductive health services, explaining how the two activities are related.

Other programs seek to give women control over fertility while accommodating existing gender norms. In Ethiopia, the Gargaar Relief and Development Association

respect within the community. Village workers are viewed as sources of information on family planning but also provide advice on marriage arrangements, children’s education, household spending, conflicts between spouses, and conflicts between women and mothers-in-law. Workers have persuaded fathers to let daughters attend school, intervened when husbands beat their wives, and referred families to health centers for treatment when needed.<sup>9</sup>

— Barbara Barnett



CBD OFFERS AN OPPORTUNITY TO REACH MORE MEN, WHO ARE TYPICALLY LEFT OUT OF FAMILY PLANNING PROGRAMS. THIS COUPLE LIVES IN KENYA.

started a CBD program in an area where women were too embarrassed to travel to clinics. Health workers came to their homes under the guise of neighborly visits. In Bangladesh, community-based distribution was begun to accommodate the custom of *purdah*, seclusion inside the home or family compound. While these efforts give women more control over their reproductive lives, they may also discourage women from traveling outside their homes. Visiting clinics could increase women’s mobility and self-confidence.

Community-based programs can influence the status of female workers, as well as clients. In India, women volunteers in the city of Hyderabad take responsibility for providing family planning services to 20 homes within their communities. Volunteers undergo extensive training and help identify community health problems, in addition to providing family planning services. Many of the nearly 5,000 volunteers have become respected community leaders.<sup>8</sup>

In a study of field workers conducted by the Matlab Family Planning and Maternal-Child Health Project in Bangladesh, female employees said their family planning work had helped them gain self-confidence and

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# News Briefs

## NORPLANT LEAVES

### UK MARKET

**B**ecause of commercial reasons, Norplant contraceptive devices will no longer be available in the United Kingdom as of October 1999.

Hoechst Marion Roussel, which distributes the subdermal implant in the United Kingdom under an agreement with U.S.-based Wyeth-Ayerst Laboratories, announced in April that demand for the device was too low to justify sales. The pharmaceutical company emphasized that it had complete confidence in the safety and effectiveness of Norplant, which is manufactured by Leiras, based in Turku, Finland.

Demand for Norplant declined after the British Medical Association advised physicians that the government was not allowing a high enough fee to

insert the contraceptive. As a result, many physicians discontinued Norplant insertions. The distributor also blamed legal actions by women who claimed they had suffered side effects.

"The combined effect has been to reduce demand for Norplant to levels that are no longer commercially viable," Hoechst Marion Roussel said in a written statement. "This was a commercial decision and confidence in the safety and effectiveness of Norplant remains unchanged." Norplant has been approved for use in more than 40 countries. It was approved in the United States in 1990.

### N-9 SPONGE RETURNS

**A** contraceptive sponge that uses nonoxynol-9 (N-9), removed from the market in 1995, is expected to be available again this fall.

A newly founded U.S. company, Allendale Pharmaceuticals Inc., recently bought the rights to make and sell the Today sponge from its previous owner, Whitehall-Robbins Healthcare. The former owner had discontinued making the sponge because needed modifications to its factory would have been too expensive.

The device, coated in N-9, is inserted into the vagina to cover the cervix. It can be inserted hours before sex and can be used for repeated intercourse for up to 24 hours. In contrast, spermicidal foams, jellies or suppositories and the female and male condoms should be used only once.

The sponge was an over-the-counter method that appealed to some women in several countries, with more than 100,000 users in the United States when production ended. Like other barrier methods, the sponge's low risk of side effects made it attractive to women who have problems with hormonal contraceptives. Some women considered it easier to insert

than other barrier methods. The sponge was particularly popular among women who had intercourse infrequently and nursing mothers who were advised not to use hormonal methods containing estrogen.

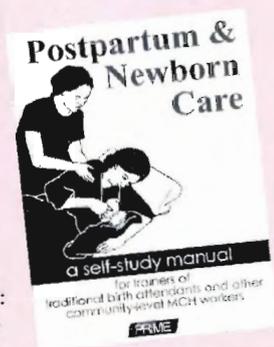
However, the sponge has a relatively high contraceptive failure rate, particularly among women who have already had children. The degree of protection against some sexually transmitted diseases is not fully understood, although it may protect against bacterial diseases, such as gonorrhea and chlamydia.

FHI conducted the safety and contraceptive efficacy studies that led to the U.S. Food and Drug Administration's approval of the sponge in 1983. The Today sponge works by killing sperm with N-9, trapping sperm and blocking the opening to the cervix. A sponge contraceptive that uses benzalkonium chloride instead of N-9 is available in European countries.

# Resources

## INTRAH POSTPARTUM MANUAL

**P**ostpartum & Newborn Care is a manual for trainers and supervisors of community-level maternal and child health workers. The manual includes chapters on postpartum assessment and care, nutrition and breastfeeding, family planning and newborn care. A suggested training timetable and list of resources are included. A copy is free to health and development professionals who order from developing countries, and U.S. \$9 to others. Check or money order should be payable to the University of North Carolina and sent to: INTRAH Publications Program, University of North Carolina at Chapel Hill, 1700 Airport Road, Suite 300, Chapel Hill, NC 27514, USA. Telephone: (919) 966-5636. Fax: (919) 962-7178. E-mail: [seudy@intrah.org](mailto:seudy@intrah.org).



## MEN'S SEXUAL HEALTH

**M**en's Sexual Health Matters provides ideas and activities for promoting men's sexual health through community-based health projects. Sexual health issues that concern men and strategies for working with men are examined, with examples from Africa, Asia and Latin America. The publication also provides information about male sexual functions and development. Single copies are free to developing country organizations and can be purchased by others for U.S. \$20 or £10. To obtain a copy, please contact: Publications Administrator, Healthlink Worldwide, Farringdon Point, 29-35 Farringdon Road, London EC1M 3JB, United Kingdom. Telephone: (44) 171-242-0606. Fax: (44) 171-242-0041.