SWEDD
AUTONOMISATION DES FEMMES ET DIVIDENDE DÉMOGRAPHIQUE AU SAHEL
SAHEL WOMEN'S EMPOWERMENT AND DEMOGRAPHIC DIVIDEND

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SWEDD SERIES: OPERATIONAL BRIEF

LAST KILOMETER COMMUNITY-BASED DISTRIBUTION (CBD) OF RMNCAH SERVICES AND SUPPLIES

The research informing this brief was led by the Centre Humanitaire des Métiers de la Pharmacie (CHMP) and focused on the SWEDD project. The information will guide the implementation of SWEDD+

This operational brief is part of a series that retrospectively documents the process of implementing the interventions of the Sahel Women's Empowerment and Demographic Dividend (SWEDD) project. It describes good practice, challenges and lessons learned in implementing CBD. It summarizes the literature review and conversations with key respondents in Côte d'Ivoire, Mali and Niger between December 2022 and January 2023. The implementation experiences described in this brief and the guide of the same name serve to inform the implementation of such community-based distribution in SWEDD+ and other CBD projects in countries in the Global South, particularly in West and Central Africa.

Evidence of successful CBD models:

- "The value of community services in improving contraceptive uptake particularly when CBD workers can offer their clients a wide range of methods, either directly or by referring them to other services." (Best, 1999, for models in Turkey, Mali and Bangladesh)
- In Madagascar, "a subsequent evaluation reported that 1,662 clients had accepted the DMPA offered by a community health worker during the first seven months of provision. Forty-one per cent adopted family planning for the first time or resumed their contraceptive practice. Almost all intended to continue to obtain the DMPA from a community health worker and most said they would recommend the service to a friend" (Hoke et al, 2012).

References: Best, 1999; Hoke et al., 2012

Phases of CBD implementation

Phase 1: Estimation of RMNCNH product requirements

- Quantification of RMNCNH products required for activities and authorization of their distribution.
- Coordination of needs assessment activities by an organization providing leadership.

Phase 2: Communication and awareness-raising among beneficiaries

- Involvement of key players such as religious leaders, traditional chiefs and young people in communication and awareness-raising about CBD.
- Use of a youth-focused strategy that involves young people taking the message to other young people and which includes community health workers (CHWs) to conduct outreach communication at community level.

Phase 3: Recruitment, training and remuneration of CBD agents

- Recruitment by the community, village chiefs and/or religious leaders on the basis of specific criteria that vary from country to country.
- Basic training for agents, with additional training as required.
- Choice of type and amount of remuneration, which varies from country to country.

Phase 4: Deployment of RMNCNH products and family planning

- Deployment through dedicated distribution channels or through a master plan for the supply and distribution of essential medicines, depending on the country.
- A pilot phase (Côte d'Ivoire) to evaluate and select the most appropriate model for the country's context.

Phase 5: Data management, supervision and monitoring of CBD

- Data collection training for CBD agents (CBDA)
- Regular supervision of CBDAs, with the means of supervision varying from country to country.

> *Coordination of needs-estimation activities helps to ensure that RMNCNH products are available on time.*
>
> **National stakeholder, Mali**

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CBD, as part of the SWEDD project, is an intervention that aims to improve the supply of reproductive, maternal, neonatal, child and nutritional health (RMNCNH) services and products to the population by bringing them closer to the communities through various strategies. Implementation in the various countries was integrated into national community health strategies and followed five phases.

Difficulties identified:

- Incorrect needs-estimation, which can lead to CBD stock-outs;
- Limited involvement of men (husbands) as beneficiaries, which may limit women's adherence to contraceptive methods;
- Remuneration based on the sale of products to beneficiaries, which does not provide CBD agents with a stable and sustainable income;
- Mobility difficulties due to inadequate means of transport, particularly during the rainy season.

SUMMARY OF KEY LESSONS

Phase 1: Needs-estimation for RMNCNH products	1	Effective coordination of needs assessment activities and the involvement of the various stakeholders (agency managing mother and child health, agency managing the supply chain, and partners supporting the purchase of RMNCNH products) help to ensure that products are available on time.
Phase 2: Communication and awareness-raising among beneficiaries	2	It is important to take account of and include awareness-raising among men (husbands) upstream of CBD to improve women's adherence to the methods offered during CBD.
	3	The involvement of religious leaders, traditional chiefs and young people in communication and awareness-raising is a key success factor in mobilizing people around CBD.
Phase 3: Recruitment, training and remuneration of CBD staff	4	An important factor in the success of CBD is the availability of trained and motivated community actors (who are committed and financially rewarded) to raise awareness among beneficiaries, collect and report data and, depending on the country, offer contraceptive methods.
	5	The lack of suitable means of transport limits the ability of CBDAs to carry out their activities in certain areas that are difficult to access.
	6	The remuneration arrangements for CBDAs influence the ability of countries to retain them.
Phase 4: Deployment of RMNCNH products and the offer of the FP service	7	Deploying products according to an established master plan and established distribution channels helps to improve their traceability and timely availability at community level.
	8	In addition to the availability of logistical resources, effective fleet management (servicing, maintenance, fuelling, etc.) ensures the effective deployment of RMNCNH products.
	9	The diversification of CBD strategies enables it to offer a wider range of FP services.
Phase 5: CBD data management, supervision and monitoring	10	Training CBDAs to use the tools and involving them in data collection will improve the quality of data feedback.
	11	Supervision of CBDAs by the various levels of the health system and NGOs promotes effective decision-making to improve CBD strategies.
	12	Contracting with NGOs to implement CBD is an asset for coordinating and monitoring the various stages of CBD.

Sources: Best, Kim. 1999. Community-based distribution fills the gaps. Family Health International (FHI); Hoke, Theresa, et al. 2012. Community distribution of injectable contraceptives: introduction strategies in four sub-Saharan African countries. International Perspectives on Sexual and Reproductive Health 38(4): 36-42.

This brief is based on a guide that sets out the process in detail. It is one of a series of four briefs and guides aimed at documenting the experiences of SWEDD interventions to improve the provision of reproductive health services. These include Community-Based Distribution (CBD) interventions to bring services and products closer to communities, experience in building the capacity of health-care staff, particularly midwives (establishment of Centres of Excellence, mentoring) and the deployment of these midwives to make up for the shortage of staff on the ground, particularly in rural areas.

For more information on the documentation of the processes involved in this intervention and on the SWEDD project, visit the SWEDD project's virtual resource platform: www.sweddknowledge.org