Every country's health system and infrastructure is unique. Just as there is no single correct community-based distribution (CBD) model for family planning, there is no single universal plan for integrating CBD of depot-medroxyprogesterone acetate (DMPA or Depo-Provera) into an existing health system. However, several technical and logistical issues that are essential to consider before proceeding with such integration include:

- Assessing the costs of introducing and sustaining CBD of DMPA
- Providing training
- Ensuring quality of care
- Maintaining supplies and distribution systems

Assessing the costs of introducing and sustaining CBD of DMPA

A review of family planning programs and their service delivery methods in 14 developing countries reported that, overall, social marketing programs cost the least per client per year, followed by clinic services, CBD services alone, and clinic services combined with CBD services. The ranking was different for some countries. Costs per client depend on local conditions, the maturity of programs, and volume of sales.[1] Overall, CBD programs can be more expensive than clinic-based programs; however, CBD programs can serve the contraceptive needs of many underserved women, especially rural women who find it difficult to access clinic-based services.

Introducing DMPA to a new or existing CBD program may raise program costs for several reasons. CBD workers and their supervisors will need training. CBD workers will require technical and practical training on counseling, injection techniques, and keeping records. Supervisors will need to know how to manage the logistics of ensuring DMPA supplies and how to maximize the quality of DMPA provision.

If a CBD program is mature and strong (with well-trained and highly motivated workers), the cost of adding DMPA will be relatively low compared with the cost of adding DMPA to a weaker CBD program. A newer or more fragile CBD program (e.g., with high staff turnover or weak supervisory systems) may have to be strengthened, at additional expense, to successfully incorporate DMPA provision into its services.

When adding another service (such as DMPA provision) to CBD workers' duties, issues such as CBD worker incentives may also need to be considered. Several CBD programs have experimented with systems for paying and motivating CBD workers. Some employ full-time, salaried CBD workers to reduce turnover. Some employ an incentive program with commissions to motivate workers. Still others attract volunteers using a variety of nonfinancial incentives, including prestige, bicycles, uniforms, and study tours.[2] Each health system will need to determine which mix of regular payments and/or non-salaried incentives works best within the local context and budget to motivate CBD workers to provide quality DMPA services.

Providing training

Most CBD programs that have introduced injectable contraceptives have devoted one to two weeks to training new CBD workers. Part of this time involves classroom training about how to screen clients for medical conditions that would rule out their use of DMPA, counsel clients about common side effects, and keep records. Time is further devoted to developing

KEY POINTS

- CBD programs can reach many women, especially rural women, whose contraceptive needs are not being met by clinic-based services.
- Technical and logistical issues for integrating CBD of DMPA include:
  - assessing costs
  - providing training
  - ensuring quality of care
  - maintaining supplies and distribution systems

CBD workers' ability to use checklists to determine clients' medical eligibility for DMPA use, counseling, give injections, and learn to make clinic referrals, if necessary. Training should be participatory; skills development can be reinforced by using approaches such as role-plays, scenarios, and observation of trained providers. Training programs may require successful completion of a written exam, skills observation, or other tests for a CBD worker to be "certified" to provide DMPA.

Several curricula and counseling guides are available to support the training process, and these tools can be adapted to meet a particular country's needs.[3]

Ensuring quality of care

Quality of care can be maximized by establishing a quality-assurance system to ensure that CBD workers use proper screening, counseling, and injection procedures. Some programs have set up schedules for supervisors to visit trainees and evaluate their performance three to six months after initial training. Periodic refresher courses for CBD workers are also strongly encouraged.

Maintaining supplies and distribution systems

A logistical system for predicting demand, delivering supplies, and avoiding stock-outs must be developed to ensure supplies of DMPA, needles, and syringes. Several excellent guides are available to assist with supply forecasting and logistics.[4] CBD providers will also need information on how and where to obtain supplies. Fortunately, DMPA can be stored at room temperature (no refrigeration necessary), has a shelf life of four to five years,[5] is now on the World Health Organization's (WHO's) essential drug list, and is generally available across most of Africa.

Note: The conventional term "community-based distribution" (CBD) is used throughout these briefs for the sake of consistency. However, the concept of distributing commodities to individuals in communities is gradually being replaced by that of delivering not only commodities, but also services. Thus, the term "community-based services" (CBS), which embraces activities carried out through such vehicles as agricultural extension programs, drug shops, pharmacies, and literacy programs, is increasingly used. Likewise, alternative terms – such as community health workers (CHWs), community reproductive health workers (CRHWs), community health officers (CHOs), or village health workers (VHWs) – have been used to more accurately describe more specific categories of community-based paraprofessionals.

1 Barberis M, Harvey PD. Costs of family planning programmes in fourteen developing countries by method of service delivery. *J Biosoc Sci* 1997;29:219-33.

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4 John Snow, Inc./DELIVER. *PipeLine Software Tool.* Boston, MA: John Snow, Inc./DELIVER, 2004. Available: *portalprd1.jsi.com/portal/page?_pageid=93,3144386,93_3144434:93_3144448&_dad=portal&_schema=PORTAL&p_tab_url=DEL_SOFTOOLS_TAB&p_le_render_type=SUBPAGE&p_le_pg_name=DEL_TOOL_SOFT_PL_PG1;* Centers for Disease Control and Prevention (CDC). *Pocket Guide to Managing Contraceptive Supplies.* Atlanta, GA: CDC, 2000. Available: *portalprd1.jsi.com/pls/portal/docs/PAGE/DEL_CONTENT_PGG/DEL_PUBLICATION_PG1/DEL_GUIDE_HANDBK_PG1/ENG_POCKET_GUIDE.PDF;* World Health Organization (WHO). *Procuring Single-Use Injection Equipment and Safety Boxes: A Practical Guide for Procurement Staff and Programme Managers.* Geneva, Switzerland: WHO, 2003. Available: *www.who.int/injection_safety/toolbox/docs/en/Procurement.pdf.*

5 Upjohn. DMPA package insert.

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