

COMMUNITY BASED FAMILY PLANNING PROGRAMMES: LESSONS LEARNED FROM PREVIOUS IMPLEMENTATION STRATEGIES

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INTRODUCTION

Community-based distribution (CBD) of contraceptives was initiated in the 1960s in Asia and Latin America. The CBD concept was then, and is still, based on the simple premise that door-to-door delivery of services can create and satisfy demand in areas with poor access to fixed family planning outlets and where such demand would have been latent and unmet otherwise. Between 1975 and 2000, the number of CBD programmes in sub-Saharan African countries increased from five to twenty^(1,2). The focus of such programmes has been the delivery of short-term and barrier methods, (pills, foaming tablets, condoms) and the counseling of clients on how to use these methods, including related side effects.

The fact that CBD agents usually operate in disease-endemic and poverty-stricken areas, CBD programmes generally incorporate basic primary health-care activities. In addition, the recent growth of the HIV/AIDS scourge and the Cairo International Conference on Population and Development (ICPD), which brought to fore the currently acclaimed global reproductive health agenda, created some shifts in the traditional components of CBD programmes in developing countries. Most community-based distribution programmes now address reproductive and general health needs in addition to the traditional family planning services they provide.

What is CBD?

Family planning programmes often augment clinical services with social marketing, satellite clinics⁽³⁾ employer-based programmes, private-sector programmes, and other forms of family planning outreach such as home visitation by trained distribution agents. "Community-based distribution" (CBD) refers to programmes of non-clinical family planning service approaches that use community organization, structure, and institutions to promote the use of safe and simple contraceptive

technologies⁽⁴⁾.

In Africa, community-based family planning programmes typically focus on the provision of oral contraceptives, foam tablets, and condoms⁽⁵⁾. In order to promote methods that provide dual protection (from pregnancy and from sexually transmitted diseases [STDs]) as a conscious choice, a CBD programme's activities may include prevention strategies for AIDS and other STDs. Similarly, CBD may be conducted as a component of community health outreach. In some CBD projects, local volunteers operate health posts in village locations⁽⁶⁾ or volunteers may operate depots where family planning supplies and information are available⁽⁷⁾.

In some programmes, CBD employs salaried non-paramedical workers who visit households and provide condom and pill services⁽⁸⁾. CBD may also involve household visits from volunteers for contraceptive education or distribution or clinical referrals⁽⁹⁾. Alternatively, market traders may sell contraceptives alongside their other wares in traditional markets⁽¹⁰⁾. CBD contrasts with social marketing, which typically involves pharmacies rather than traditional market vendors, but CBD can be designed to have close operational links with social marketing efforts⁽¹¹⁾.

CBD is thus a complex concept, involving varied operational designs. Nonetheless, a common underlying assumption guides all CBD initiatives: Offering family planning services at non-clinical community locations expands the acceptability and convenience of contraceptives and reduces the costs of contraception, thereby extending use among clientele who seek contraceptives but will not use services that are confined to clinical settings^(12,13).

The theme of extending accessibility is neither new nor unique to the family planning field.

Agricultural innovations, for example, have been disseminated by extension agents⁽¹⁴⁾. This experience, together with the experiences of environmental, health, and community development programmes, has led social researchers to advocate community-based strategies for fostering behavioral change in traditional societies. By basing programmes within the communities they serve, communication and societal barriers to the spread of innovation are diminished⁽¹⁵⁾.

CBD Impact in Sub-Saharan Africa

Because of the Asian and Latin American legacies, CBD is viewed as the single most important family planning innovation^(16,17,1,18). However, apart from evidence that CBD increases contraceptive use in settings where unmet need is high, evidence that CBD is “successful” is limited. Only one study has demonstrated that CBD reduces fertility. No study has shown that CBD avoids negative social consequences or enhances the status of women in sub-Saharan Africa. Although CBD is justified as a means of meeting unmet need by making contraceptives available to women, one study has shown that CBD actually increases unmet need⁽¹⁹⁾. Although the assumption is generally made that geographic inaccessibility constrains contraceptive use, research has shown that social constraints play a greater role in determining unmet need than does geography⁽²⁰⁾. Perhaps the greatest strength of CBD is its potential to involve communities and foster male approval of family planning, thereby having an impact on spousal communication and unmet need, but this role has yet to be clarified.

One experimental study in Mali demonstrated that CBD increased spousal communication more than other family planning programme components were able to⁽²¹⁾. Thus, the impact of CBD on contraceptive use has been established, but the more general causal basis for this impact is poorly understood.

The success of a CBD programme typically is measured by assessing the extent to which CBD strategies increase contraceptive use, over and above levels that would be expected in the absence of such a programme. According to this basic criterion, evidence is accumulating that CBD can be successful in Africa. A study conducted in Mali demonstrated that CBD had an impact on contraceptive knowledge and contraceptive use⁽²¹⁾.

(An earlier Mali study demonstrated an increase in contraceptive prevalence from 1 percent to 31 percent over a two-year intervention period. Although no control group was used, the authors argued that their study demonstrated the effectiveness of a rural CBD programme in the Mali setting⁽²²⁾).

In the Gambia, CBD through traditional social institutions increased contraceptive prevalence by 10 percent among women most likely to practice contraception⁽²³⁾. In Kenya, the use of traditional health practitioners as CBD agents increased contraceptive prevalence by more than 17 percent⁽⁶⁾.

Two experiments in Ghana have demonstrated an impact on contraceptive use. One of these projects, in Danfa, used a mobile family planning clinic and comprehensive health-care approach to demonstrate that ever use of modern contraceptive methods increased by 23 percent in the experimental area receiving the most comprehensive health care over the project period. CBD services reportedly tripled contraceptive acceptance rates, although the Danfa experimental design does not allow for specific analysis of the effect of CBD on contraceptive prevalence^(24,25).

The second Ghanaian experiment, in Navrongo, showed that CBD increased contraceptive use in treatment areas relative to comparison areas. This change in reproductive behavior reduced the TFR by 0.4 births in the first year of project observation⁽¹⁹⁾. An ongoing Burkina Faso experiment has produced preliminary evidence that CBD doubled contraceptive prevalence from 4 percent to 8 percent in a rural district, and further effects may be found as this study continues⁽²⁶⁾.

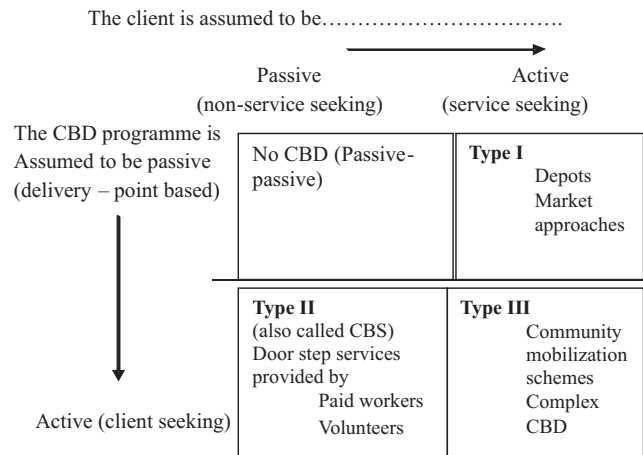
All but one of these successful CBD experiments took place in West Africa, in areas with extremely low contraceptive prevalence. The impact of CBD may be greatest in such areas. A CBD approach may be particularly good for introducing a new service because of its suitability for diffusion⁽²⁷⁾. Experimental studies demonstrating CBD effects have been conducted in settings of low contraceptive prevalence. Statistics from Kenya and Zimbabwe suggest that rigorous national CBD efforts have provided substantial proportions of the contraceptive supplies and services that are furnished to couples in those countries⁽²⁸⁾. The

timing of the CBD effort in Kenya was associated with subsequent increases in method use ⁽²⁹⁾. Whether CBD is necessary to sustain demographic change in Kenya is unknown, however, and is widely debated. Once contraceptive prevalence increases, CBD may not be as important to family planning programmes as it is in settings where prevalence is low.

Types of CBD

The typology in the Figure below illustrates assumptions about CBD that characterize the intersection of demand for contraception and its supply.

A Typology for CBD Models in Sub-Saharan Africa



The typology implies three contrasting models for the intersection of supply of services and demand for care. A totally clinical programme for passive clients defines an interface between supply and demand that will not work (the passive-passive condition). The passive-passive situation in Africa explains why CBD is needed as a policy option. Type I CBD programmes emphasize fostering demand through information, education, and communication, and through other strategies that motivate clients to adopt services at convenient fixed delivery points such as village health posts, satellite clinics, kiosks, and traditional markets ⁽³⁰⁾.

This approach is based on the assumption that the costs of contraceptive supply at fixed facilities are not unacceptably high ⁽³¹⁾. Alternatively, CBD can be

offered as a doorstep service (Type II), with the assumption that demand for services is insufficient to motivate people to use fixed facilities ⁽³²⁾. Doorstep services involve household visitation by voluntary or paid CBD agents. Where demand for family planning is fragile and new, comprehensive programmes are required that involve combinations of Type I and Type II approaches. Not only are services offered at fixed service points in convenient village locations, but doorstep and other outreach activities are also pursued. With this approach, programmes not only provide convenient access to supplies but they also attempt to foster changes in beliefs and behaviours and to encourage social change by combining elements of Type I and II programmes with strategies for achieving comprehensive community involvement. This approach is employed on the project titled “Increasing Access to Quality Reproductive Health/Family Planning Services at the Grassroots in Five Nigerian States” being implemented by ARFH with support from UNFPA – Nigeria.

Comprehensive Type III CBD that effectively develops demand in the context of offering convenient contraceptive supplies may be crucial to the success of family planning in the sub-Saharan region. Each type has a unique set of organisational requirements.

LESSONS FROM FOUR NATIONAL CBD PROGRAMMES

Evidence concerning the determinants of CBD success or failure emerges from a variety of sources including case studies of large-scale activities, operations research pilot studies and field projects, and specific studies of management issues in CBD. CBD programmes in Africa provide strategic contrasts that merit review.

The Kenya Experience

Kenya has the greatest diversity in CBD programmes and activities of any country in the world. In the 1980s, CBD initiatives proliferated with the encouragement and support of the National Council for Population and Development and financial support from the Kenya USAID Mission. Rather than standardising a centrally planned initiative, official policy has encouraged action in diverse private- and public-sector organizations.

In some agencies, coverage is achieved by

canvassing, in others by community depots, and in others by distribution through village women's groups. In some programmes, workers are volunteers; in others, paid personnel; and in others, compensated volunteers. The level of compensation also differs considerably by agency. Recruitment and training schemes differ, and administration, logistics, supervision, and management information systems follow no set scheme or unified design. In a genuine sense, Kenya represents a laboratory of CBD diversity in that nearly every type of CBD approach that has been tried anywhere is represented in some fashion in the Kenyan setting⁽³³⁾.

Type I CBD in Nigeria

Nigeria provides lessons from market-trader examples of Type I CBD effort. In 1985, the Fertility Research Unit, University College Hospital, Ibadan launched a feasibility study to test the acceptability of training and equipping traditional market vendors to sell contraceptives in 39 markets of Ibadan City⁽³⁴⁾. This approach to family planning service delivery has since proliferated in Nigeria and now encompasses several distinctly different schemes for training and equipping traditional market traders to add contraceptive commodities to the items that they sell^(35,36,37). The commercial sale of contraceptives in market locations is based on the premise that making services available in markets will increase contraceptive awareness and use⁽³⁶⁾.

Considerable international attention has been directed to this initiative, in part because it uses the traditional African institutional arrangements of the market to foster family planning, and in part because it is potentially a self-sustaining, low-cost mechanism for reaching a large segment of society⁽³⁸⁾.

The underlying hypothesis of the approach can be stated as follows:

Shoppers who are exposed to accessible, low cost family planning supplies in markets are more likely to use a method than are shoppers who are not exposed to convenient supplies.

Type II CBD in Zimbabwe

Zimbabwe provides an example of Type II public-sector programme implementation and sustainability with a national community-based distribution programme that has been in operation since 1983. The programme is administered by the

Zimbabwean National Family Planning Council, a parastatal agency, and its objectives are to make modern contraceptives available to people through household distribution, educate them about family planning, recruit new acceptors, follow up on dropouts, and make referrals to health centers when necessary.

Zimbabwean distributors are selected by the communities served, receive government salaries and benefits, and are assigned a defined catchment area in which they are expected to complete rounds of household visits in three-week cycles^(39,40). A large national information campaign promotes family planning with messages targeted to various population subgroups, most prominently to men⁽⁴¹⁾.

Also, CBD may not be as effective in increasing contraceptive use as in expanding clinical services. The assumption that CBD has been a factor in the Zimbabwe story is a reasonable one, but beyond anecdotal evidence, little can be said about the demographic role of CBD in Zimbabwe⁽⁴²⁾. Reports advocating this view attribute success to selecting workers from the villages they serve, paying them a regular wage, assigning them clearly defined tasks, and holding them accountable for performing a basic work regimen that is easy to understand and feasible to carry out^(43,44,45).

Type III CBD in Ghana

CBD programmes in Ghana illustrate the benefits of using social research findings to guide programme priorities. In 1969, Ghana became the second country in Africa (after Kenya) to promulgate an official population policy. Failed effort in Ghana illustrates the value of evidence-based policy planning. Early in the Ghana programme, organisers assumed that accessibility to services would be the crucial problem to solve in developing CBD. Because midwives and traditional birth attendants (TBAs) are accessible to women throughout the country, the Ghana Registered Midwives Association (GRMA) Family Planning Programme was assigned the task of midwife training and field coordination of a family planning initiative. This initiative was subsequently expanded by training TBAs to provide family planning services as a CBD programme.

A national CBD project was constituted to identify TBAs, upgrade their delivery skills, and train them

in the sale and distribution of pills and condoms. In terms of numbers of people trained and volume of contraceptive sales, the midwife-TBA approach appeared to be successful⁽⁴⁶⁾. However, survey data eventually revealed that the volume of contraceptive distribution among midwives and TBAs remained low. The Ministry of Health estimated that a TBA, on average, supplies fewer than ten clients a year with contraceptives.

In response to this finding, investigations were made in a series of focus group studies on how to improve CBD acceptability. Results of this investigation showed that accessibility was not the primary concern of villagers. Uneasiness about lack of privacy and confidentiality led to objections about the choice of midwives and TBAs as contraceptive distributors. TBAs were viewed as socially gregarious individuals who talk openly about who is using family planning. This finding suggests that such pre-selection of agents is not acceptable in Ghana, because the persons chosen do not have the ability to keep secrets or other personal qualities that engender trust.

In summary, the experience of CBD in Kenya, Nigeria, Zimbabwe, and Ghana has revealed three themes that may have relevance to other countries in Africa:

1. Predetermined CBD strategies typically are feasible to implement, but often are not the most appropriate approaches for a particular setting. As the Ghana experience demonstrates, CBD strategies should be tested and adjusted to local conditions before large-scale operations are implemented. Strategies for managing CBD in one type of institutional environment may not be appropriate for another organisational environment. For this reason, systems for CBD must be assessed in the broader organisational setting where outreach services are based. If these precautions are taken, and if programmes are pursued with political resolve and ample resources, imported CBD models like that used in Zimbabwe may be made to work.

2. No single model emerges as the optimal universal approach to CBD. The Kenyan decentralized strategy has encouraged diverse approaches through a variety of institutions. By fostering the proliferation of NGOs, the Kenyan programme established de facto centralisation and marshaled

resources for the programme that would not have emerged otherwise.

3. Mixed models do not work. In Zimbabwe, a bureaucratic, top-down CBD programme was successfully implemented. As demonstrated by the Kenyan Ministry of Health, however, bureaucratic, top-down models should not be used with attempts to provide CBD services through volunteers. African organizational approaches can work well, but not as appendages to artificial public bureaucracies. If a programme is organized on African institutional principles, the logic of indigenous networks, structures, and systems of interchange must be thoroughly understood and fully employed.

LESSONS LEARNED FROM CBD SUCCESS AND FAILURE

In general, the CBD literature is diffuse and atheoretical, complicating the task of deriving cross-cultural themes or generic lessons. Research findings and management reviews of CBD programmes and pilot projects throughout the sub-Saharan region suggest certain general conclusions about basic management, however, that can improve service delivery and ultimately lead to greater impact on contraceptive prevalence or total fertility.

Elements of Successful CBD Management

Operational diversity in CBD activities derives from alternative approaches to the CBD service regimen; to community involvement; to agent selection, training, compensation, and supervision; to the manner of deployment; to the resource base for salaries and operational costs; to management information systems; and to political support. Experience with CBD in Africa has provided information about which approaches and combinations of approaches are most successful

Mixed Methods

The service regimen of CBD programmes is sometimes highly focused on family planning and sometimes integrated with primary-health-care outreach. Ever since the 1994 International Conference on Population and Development in Cairo, increasing attention has been directed to integrating reproductive health activities into CBD schemes. Extending multiple service options is

generally believed to improve service quality and acceptability, and offering contraceptive methods and services in conjunction with other health services tends to enhance the credibility of family planning. The ARFH experience combined treatment of minor ailment and pregnancy monitoring with the provision of non-prescriptive FP methods to the community members. Broadening the service regimen adds management challenges that must be addressed in careful strategic planning, however.

Training

Broadening CBD programmes to include reproductive health requires extensive training programmes. For example, experience of ARFH in the implementation of the UNFPA supported CBD project in Five Nigerian States; Community leaders can be involved in CBD as the collective recipients of information, the coordinators of information and educational activities, or as direct managers of CBD operations. All stakeholders on the project were trained and these included, Managers of CBOs/NGOs, PHC service providers, Volunteer community members, Community leaders and Religious leaders that functioned in the capacity of Project Advisory Committee members. Alternatively, traditional leaders and social groups can be involved in all aspects of CBD planning, management, and implementation. Models for community involvement are thus highly varied. Community involvement is crucial at the strategic planning stage. Leaders can participate effectively in the design of operations, but are less effective in implementation or routine management.

In Africa, experience shows that broad-based social and technical training is preferable to narrow technical design. The frequency of in-service training varies widely among projects, although most observers agree that the quality and intensity of agents' training is the most important single determinant of programme quality and impact. Training of CBD agents should be based on competence and be incremental and practical.

Selection of CBD Agents

CBD agent selection is a key variable in programme design. Agents can be selected by the community. Experience generally shows that community selection of agents is more effective than is setting predetermined criteria for agents. Seeking an

internationally optimal type of agent is fruitless. Operations research can demonstrate practical means for identifying the appropriate type of agent, but they should not be used to test the efficacy of some predetermined category of service worker.

Compensation for CBD Agents

CBD agents can be uncompensated or compensated for their work. Paid distributors, in turn, are sometimes compensated in cash or with other forms of reward. Rewards in cash can derive from user fees, or direct payments as transport allowances. The research record generally shows that paid workers perform better than volunteers. When agents are paid, rigorous supervision can be exercised, programmes can be implemented rapidly, work routines can be standardized and designed to cover populations, and service quality can be maintained. ARFH pay stipend as transport allowance for both the CBD Agents and their supervisors.

Research also shows that when workers are unpaid volunteers, the deployment scheme should not be demanding and that some other motivational scheme is required to substitute for the absence of wages. Voluntary CBD programmes are more complex to manage than are programmes that rely upon paid agents.

Service Provision and Cost

CBD agents may be deployed to places where men or women congregate for nonfamily planning purposes (for example in the ARFH-UNFPA supported CBD project, to markets, women's associations, religious gathering in Churches and Mosques or other village social functions) as well as to people's homes. As noted above, the common assumption that accessibility is the primary constraint to contraceptive use has not been demonstrated by research. Social costs represent the most important set of constraints, and some evidence suggests that social discord may arise from failing to address social impact issues. UNFPA is giving the FP commodities to the States and they in turn give the LGAs at a subsidized rate.

Male Involvement

Men's fears and concerns that lead to social costs for women can be addressed with appropriate male mobilization strategies. Example from the ARFH-UNFPA supported CBD projects, Male agents were

trained as Male Advocates to reach out to their male counterparts on issues relating to Family Planning.

Agents' Supervision

Models for agents' supervision vary considerably. In some programmes, supervisors are paid professionals, whereas others use volunteers. In general, effective supervision requires professional staff and ARFH is working with the PHC Staff of the individual LGA. When village workers are volunteers, supervising challenges increase, because community activities must be designed to motivate workers and clients alike. Styles of supervision differ therefore, according to the field strategy used and the institutional culture of the CBD agency. Whatever the approach, supervision should be supportive rather than directive. Supervisors recruited from the ranks of Junior CHEWs are more effective than are hired supervisors who have no service-delivery experience as seen in the ARFH implemented CBD project.

Management Information System

Ever since family planning programmes were first organized, information systems have been designed to provide indicators on performance. CBD represents a unique challenge to management information systems design, because systems must be simple to use and yet informative. Information systems should support the quality-of-care information needs of CBD agents as a first priority. Information for senior management can be aggregated as needed. Systems designed to extract information solely for senior management do not work. ARFH designed data collecting tools with pictographs that are user friendly for the project. The semiliterate and the illiterate CBD Agents can conveniently fill the data collecting tools using the tally method.

From ARFH's experience, data are generated by the CBD Agents and are collated by the LGA supervisors who hand these over to the NGO who perform the oversight function for onward delivery to ARFH on a monthly basis. This has not been easy though, but follow up by phone and email is sent to the NGOs to remind them to send the collated data and ARFH staff collects any outstanding data when they go on quarterly monitoring visit.

Cost Recovery

In Africa, considerable emphasis has been placed on

developing cost recovery schemes for CBD. The typical scheme charges commodity fees to users and awards a percentage of this fee to agents as commission. In some projects, however, community health-service systems have been developed with cost-recovery mechanisms for primary-health-care services. Health-service fees can generate revenue to subsidize family planning CBD indirectly. When demand for family planning is fragile, cost-recovery schemes often face fundamental organisational challenges.

LGA Support

Removing service from the confines of clinics subjects programmes to political requirements at all levels—national, state and local. CBD effort often involves careful liaison with political authorities. Launching a CBD programme does not obviate the need for political support for family planning more generally. Several important trials have demonstrated the critical role of political support for CBD.

In the ten (10) LGAs that ARFH is presently working, almost all the LGA are supporting the project in one way or the other. Some LGA are paying additional stipends, some put the CBD Agents on their pay roll, some trained more CBD Agents, some provide lunch during the monthly statutory meeting. This is because the LGAs were involved at all levels of planning and implementation of the project.

FACTORS CONTRIBUTING TO CBD FAILURE

A CBD project can be considered successful if it introduces family planning to a population and the introduction results in higher levels of contraceptive use than would be expected in the absence of CBD, or if it enables women to attain their reproductive goals more effectively. Reasons for failure typically are not discussed in reports, because projects often have the modest goal of demonstrating operational feasibility rather than of establishing that the project's strategy has worked. Several studies and large-scale programmes have clearly failed to confirm hypotheses about the role of CBD⁽¹⁹⁾.

Common reasons for CBD programme failure are discussed below:

Misplaced faith in CBD success can lead to failure if planners view CBD as something that is simple

and automatically so successful that the basic elements of service quality and sound management are neglected⁽⁴⁷⁾. Although endlessly repeated trials of CBD impact are not necessary, the process of developing large-scale optimal CBD operations is likely to require organisational research in each setting where a new CBD programme is launched. Considerable progress has been registered since techniques of evidence-based organisational development were developed in the 1960s. This approach emphasises the importance of developing strategies that fit the organisational environment, testing and developing pilot approaches on a small scale, and phasing in change in large-scale operations⁽⁴⁸⁾.

Premature implementation sometimes weakens CBD programmes because large-scale effort is inappropriate for the social environment. Mixing the elements of different CBD models sometimes weakens strategic designs. The main pitfall of premature CBD implementation is failing to use strategies that are guided by community opinion^(49,50,51). Preoccupation with a single good idea can direct attention away from developing a comprehensive service system. When CBD fails, its failure has less to do with what is being tried than with the absence of other critical elements of comprehensive service systems⁽⁵²⁾. CBD research should be driven less by discrete questions about the relative impact of contrasting operational design than by the need to adopt and develop a CBD system of care that is appropriate for a particular setting.

CBD fails, not because the specific operational ideas pursued are flawed, but because a system of care has not been developed in which the full potential of a set of good ideas can be realized. The operational design of the programme should be guided by the organisational design of social institutions⁽⁵³⁾. CBD can fail if the initiative has narrow institutional grounding. For example, **a failure to build political support** can lead to CBD failure. Local political resistance or administrative objections and lapses can arise from a weak commitment to population issues.

Premature focus on sustainability and cost recovery can weaken CBD effort. In Africa, where demand for family planning is often fragile, sustainability schemes introduce new operational complications and user constraints. Sustainability

represents a second-generation issue in the design of programmes. Expensive, heavily subsidised professional programmes may be more sustainable than alternative designs simply because they may introduce the concept of reproductive planning effectively and launch transitions that produce self-sustaining demographic change in the long run⁽⁵⁴⁾.

Failure to address quality-of-care requirements and social costs can weaken programmes. CBD is sometimes implemented quickly without adequate attention to quality of care or possible social costs⁽⁵⁵⁾. Evidence gained from pilot studies can be crucial to diagnosing quality-of-care problems before large-scale CBD operations are instituted.

CONCLUSION

The CBD approach project has demonstrated the feasibility of increasing the uptake of FP services in communities where hitherto FP was unacceptable. From anecdotal evidences, the activities of the CBD agents have also increased FP clientele in the various PHCs within the project communities as a result of referrals made by the CBD Agents.

REFERENCES

1. Kols AJ and Maria JW. "Community-based Health and Family Planning." *Population Reports Series L*, 1982. Number 3.
2. Phillips JF, Greene WL and Jackson E. Lessons from community-based distribution of family planning in Africa. Policy Research Division Working Paper, Population Council, New York; 1999, 121.
3. Aboderin MA. "An overview of a community-based distribution project in Oyo State of Nigeria." In *Proceedings: A Conference on Community-Based Distribution and Alternative Delivery Systems in Africa: Harare, Zimbabwe, 3-7 November, 1986*. Washington, DC: American Public Health Association
4. Adamchak DJ and Michael TM. "The relationship between fertility and contraceptive prevalence in Zimbabwe." *International Family Planning Perspectives* 1990, 16(3): 103-111.
5. Adepoju A and Wariora M. "The African family: An overview of changing forms." In *Family, Population and Development in*

- Africa*, ed. Aderanti Adepoju. London: Zed Books. 1996, 41–59.
6. African Medical and Research Foundation (AMREF) and The Population Council. *Expanding Family Planning Delivery Systems Using Traditional Health Practitioners: An Operations Research Study in Rural Kenya*. Nairobi: AMREF and The Population Council. 1993.
 7. Agyepong I and Constance M. “Is there a place for community health worker Programmes in primary health care delivery in Ghana?” Unpublished report of the Internal Evaluation of the Dangbe West District Community Health Workers Programme. Accra: District Health Management Team, Ministry of Health. 1992.
 8. Ainsworth M. “Economic Aspects of Child Fostering in Cote d'Ivoire.” *LSMS Working Paper* No. 92. 1993. Washington, DC: The World Bank.
 9. Akuetteh LSN. “The Ghana social marketing Programme (GSMP).” In *Proceedings: A Conference on Community-Based Distribution and Alternative Delivery Systems in Africa: Harare, Zimbabwe, 3–7 November, 1986*. Washington, DC: American Public Health Association. 1987.
 10. Amin R, Yiping L and Ashrad A. “Women's credit Programmes and family planning in rural Bangladesh.” *International Family Planning Perspectives* 1996, 22(4): 158–162.
 11. Amin R, Stanley B and Bayes A. “NGO-promoted microcredit Programmes and women's empowerment in rural Bangladesh: Quantitative and qualitative evidence.” *Journal of Developing Areas* 1998, 32(2): 221–236.
 12. Ross JA, Donald JL, Joseph DW and Allan GR. “Community based distribution.” In *Organizing for Effective Family Planning Programmes*, ed. Robert J. Lapham and George B. Simmons. Washington, DC: National Academy Press. 1987.
 13. Ross JA and Elizabeth F. *Findings from Two Decades of Family Planning Research*. New York: The Population Council. 1993.
 14. Wolf EC. “Beyond the Green Revolution: New Approaches for Third World Agriculture.” *Worldwatch Paper* 73. 1986. Washington, DC: Worldwatch Institute.
 15. Anonymous. *The Indonesia Family Planning Programme: Basic Strategies*. 1976.
 16. Huber SC, Phyllis TP, Malcolm Potts BC, Stephen LI and Reimert TR. “Contraceptive Distribution: Taking Supplies to Villages and Households.” *Population Reports Series J*, 1975. Number 5.
 17. Foreit JR, Martin EG, Duff GG and Merritt CG. “Community-based and commercial contraceptive distribution: An inventory and appraisal.” *Population Reports Series J*, 1978. Number 19.
 18. Gallen M and Ward R. “Operations Research: Lessons for Policy and Programmes.” *Population Reports Series J*, 1986. Number 31.
 19. Debpuur C, Alex N, James FP, Pierre N and Fred NB. “The Navrongo Community Health and Family Planning Project: Preliminary impact of project activities on reproductive behavior.” Paper prepared for the IUSSP Seminar on Reproductive Change in Sub-Saharan Africa, Nairobi, 2–4 November. 1998.
 20. Bongaarts J and Judith B. “The causes of unmet need for contraception and the social content of services.” *Studies in Family Planning* 1995, 26(2): 57–75.
 21. Katz KR, Caroline GW, Fode D and Fatoumata K. “Increasing access to family planning services in rural Mali through community-based distribution.” *International Family Planning Perspectives* 1998, 24(3): 104–110.
 22. Doucoure A, Diane D, Fanta T, Amadou T, Seydou D, Diouratie S, Dale H and Claire V. “The effect of a family planning CBD project in Mali.” In *Family Planning Operations Research: A Book of Readings*, ed. James R. Foreit and Tomas Frejka. New York: Population Council. 1998.
 23. Luck MM, Diane N, Ebrima J and Marc M. “Contributions of demand mobilization and contraceptive availability to increased contraceptive prevalence: Issues for replication.” Final report. Save the Children Federation, the Gambia Field Office. Unpublished. 1996.
 24. University of Ghana Medical School. “The Danfa Comprehensive Rural Health and

- Family Planning Project: Summary, conclusions, and recommendations from the final report." Accra, Ghana: University of Ghana Medical School. 1979.
25. Kwansa E. "Reaching Men: The Ghanaian experience." In *Family Planning for Life: Experiences and Challenges for the 1990s* ed. Mohammed Bouzidi and Rolf Korte. London: International Planned Parenthood Federation. 1990, 129-142
 26. Apter D. "The role of traditionalism in the political modernization of Ghana and Uganda." In *Political Development and Social Change*. New York: John Wiley and Sons. 1966.
 27. Aryee AF. "Socio-cultural policies and Programmemes for efficient family planning in Africa." In *Developments in Family Planning Policies and Programmes in Africa*. Legon, Ghana: University of Ghana, Regional Institute for Population Studies. 1989.
 28. Askew I and Atigur RK. "Community participation in national family planning Programmes: Some Organisational issues." *Studies in Family Planning* 1990, 21(3): 127-142.
 29. Hammerslough CR. "Proximity to contraceptive services and fertility transition in rural Kenya." *International Family Planning Perspectives* 1992, 18(2): 54-58.
 30. Atkinson L. Robert C. Allan C and Allan GR. "Oral contraceptives: Consideration of safety in non-clinical distribution." *Studies in Family Planning* 1974, 5(8): 242-249.
 31. Awasum DN. *Situation Analysis of the Family Planning Programme in Burkina Faso*. Final report (condensed). New York: The Population Council, Africa Operations Research and Technical Assistance Project. 1992.
 32. Bakouan D. Pascaline S. Ian A. Youssouf O. Placide T and Claire V. *Situation Analysis of the Family Planning Programme in Burkina Faso*. Final report (condensed). New York: The Population Council, Africa Operations Research and Technical Assistance Project. 1992.
 33. Caldwell JC and Caldwell P. "Cultural forces tending to sustain high fertility." In *Population Growth and Reproduction in Sub-Saharan Africa*, ed. George TF. Acsadi GJ and Rodolfo AB. Washington, DC: The World Bank. 1990b.
 34. Iyun BF. Oke EA and Matanmi OO. "Analysis of a baseline survey for the Ibadan low cost market based health care delivery project." Report to the Fertility Research Unit, College of Medicine, University of Ibadan and the Center for Population and Family Health, Columbia University, New York. Unpublished. 1987.
 35. Ladipo OA. Weis E. Delano GE. Revson J. Onadeko M and Ayeni O. "Community-based distribution on low-cost family planning and maternal and child health services in rural Nigeria." In *Health and Family Planning in Community-Based Distribution Programmes*, ed. Maria Wawer, Sandra Huffman, Deborah Cebula, and Richard Osborn. Boulder, CO: Westview Press. 1986, 371-381.
 36. Ladipo OA. McNamara R. Delano GE. Weiss E and Otolorin EO. "Family planning in traditional markets in Nigeria." *Studies in Family Planning* 1990, 21(6): 311-321.
 37. Lambo ET. Adewoye KA and Okorosobo T. "Ilorin Marketbased Distribution Project Report." Report of the Department of Management Sciences, University of Ilorin, Ilorin, Nigeria to the Kwara State. 1990.
 38. Jinadu MK. James FP and Thomas TK. "Market vendor distribution of contraceptives in Nigeria: A synthesis of experience and achievements." Report prepared for the Africa Operations Research and Technical Assistance Project, The Population Council. Unpublished. 1993.
 39. Muvandi I. "Utilization of research findings for the improvement of family planning Programmemes: Implications for IE and C." Harare, Zimbabwe: Zimbabwe National Family Planning Council, Evaluation and Research Unit. 1990.
 40. Dube HMB. Caroline SM and Lewis N. "An Assessment of the Zimbabwe Family Planning Programmeme: Results from the 1996 Situation Analysis Study." Harare: Zimbabwe National Family Planning Council and Nairobi: Africa Operations Research and Technical Assistance Project II, The Population Council. 1998.
 41. Kuseka I. Terry S. Adrienne K and

- Lettenmaier CL. "Male Motivation Impact Evaluation Survey." Harare, Zimbabwe: Zimbabwe National Family Planning Council, Evaluation and Research Unit. Unpublished. 1990.
42. Cleland J. James FP. Sajeda A and Golam MK. *The Determinants of Reproductive Change in Bangladesh*. Washington, DC: The World Bank. 1994.
43. Nzuma T. "Community-based distribution/alternative delivery systems Programmeme in Zimbabwe." In *Proceedings: A Conference on Community-Based Distribution and Alternative Delivery Systems in Africa: Harare, Zimbabwe, 3-7 November, 1986*. Washington, DC: American Public Health Association. 1987.
44. Mugwagwa NO. "Evolution and growth of family planning in Zimbabwe." In *Developments in Family Planning Policies and Programmemes in Africa*. Legon, Ghana: University of Ghana, Regional Institute for Population Studies. 1989, 523-47.
45. Guilkey DK and Cochrane SH. "Zimbabwe: Determinants of contraceptive use at the leading edge of fertility transition in sub-Saharan Africa." Unpublished. 1992.
46. Ghana Registered Midwives Association and Center for Population and Family Health. "Final Report—Operations Research Project, Ghana Registered Midwives Association Family Planning Programme." New York: Center for Population and Family Health, Columbia University. 1990.
47. Motlomelo S. Maliehe T. Skoane M and Lewis G. "Report on the Lesotho Planned Parenthood Association community-based distribution project evaluation." Maseru, Lesotho: S. Lesotho Distance Teaching Center, etsi Sa Tsoelopele Thutong. 1990.
48. Delano GE. "Organizing for community participation in a rural health care/family planning project: The Oyo State, Nigeria experience." In *Proceedings: A Conference on Community-Based Distribution and Alternative Delivery Systems in Africa: Harare, Zimbabwe, 3-7 November, 1986*. Washington, DC: American Public Health Association. 1987.
49. Ministry of Health, Health Research Unit. "First make sure our children won't die: An appraisal of community potential to support family planning services in Bolgatanga District." Accra, Ghana: Ministry of Health, Health Research Unit. 1991a.
50. Ministry of Health, Health Research Unit. "Won't it cause infertility?: An appraisal of community potential to support family planning services in Berekum District." Accra, Ghana: Ministry of Health, Health Research Unit. 1991b.
51. Ministry of Health, Health Research Unit. "The ability to keep secrets: An appraisal of community potential to support family planning services in Dangbe West District." Accra, Ghana: Ministry of Health, Health Research Unit. 1991c.
52. Delano GE. "Community based family planning in Africa." *Populi* 17(2): 54-Department of Community Medicine, Faculty of Medicine, University of Khartoum, and Operations Research Programme, Center for Population and Family Health, Columbia University. 1988. "The Sudan community based family health project: Final report, March 31, 1988." New York: Operations Research Programme, Center for Population and Family Health. 1990.
53. Doucoure A. Djeneba D. Toure F. Traore A. Doumbia S. Sanogo D. Huntington D and Viadro C. "The effect of a family planning CBD project in Mali." In *Family Planning Operations Research: A Book of Readings*, ed. James R. Foreit and Tomas Frejka. New York: Population Council. 1998.
54. Cleland J. Phillips JF. Amin S and Kamal GM. *The Determinants of Reproductive Change in Bangladesh*. Washington, DC: The World Bank. 1994.
- Douglas A. "A visit to the Sudan." *FPIA News* 1997. (1): 3, 7.