SWEDD

AUTONOMISATION DES FEMMES ET DIVIDENDE DÉMOGRAPHIQUE AU SAHEL

SAHEL WOMEN'S EMPOWERMENT AND DEMOGRAPHIC DIVIDEND

9

SWEDD SERIES: BEST PRACTICE GUIDE

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

The research informing this Guide 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+

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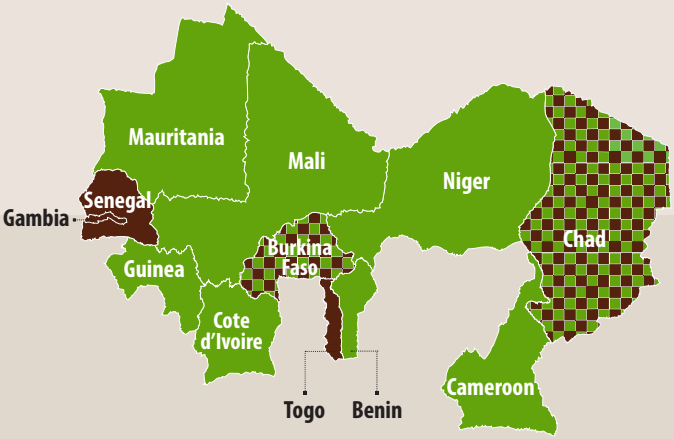

The project covers countries in West and Central Africa

SWEDD (2015–2024) SWEDD+ (2024–2028) SWEDD & SWEDD+

CBD (Community-Based Distribution), as part of the SWEDD project, is an intervention that aims to improve the supply of reproductive, maternal, newborn, and child and adolesecent health and nutrition (RMNCAH) services and products to the population by bringing them closer to the communities through various strategies.

The purpose of this Guide is to document the experience of implementing CBD in three countries (Côte d'Ivoire, Mali and Niger) in order to draw out the successes and challenges encountered and the lessons learned. It should be noted that in Niger the SWEDD project did not implement CBD

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pilots, although strategies conducted by other projects do exist. Nevertheless, we include Niger's experience because it offers relevant lessons for other countries planning to introduce or improve CBD activities.

Implementation in the various countries was integrated into national community health strategies and followed the following phases: estimating the need for RMNCAH products, communicating with and raising awareness among beneficiaries, recruiting and training CBD agents, deploying RMNCAH products, offering services, collecting and managing data, and supervising and monitoring activities.

Sample: CBD actors (a representative of the Project Coordination Unit (SWEDD-PCU), a representative of UNFPA, a representative of the local authorities, a group of four CBD agents and a group of three community members) in three SWEDD countries: Côte d'Ivoire, Mali and Niger.

Main data sources:

- Documents such as national community health strategy documents, national supply chain strategic plans, and interview reports with CBD stakeholders.

Date: December 2022 - January 2023

See the annexes for more details on methodology and sampling.

PHASE 1

ESTIMATION OF REQUIREMENTS FOR RMNCAH PRODUCTS

Estimation of RMNCAH product requirements is an important phase that takes place before services are offered to beneficiaries. It aims to ensure that RMNCAH products for CBD are available and, if necessary, that gaps can be covered before CBD starts. This stage involves several parties: Project Coordination Units SWEDD-PCU, UNFPA, and stakeholders from the Ministries of Health at different levels of the health pyramid.

In Côte d'Ivoire, the National Mother and Child Health programme (PNSME) coordinates the procurement of RMNCAH products stored at the Côte d'Ivoire New Public Health Pharmacy (NPSPCI). Through its logistics department and in collaboration with the Pharmaceutical Affairs Department (DAP), it is responsible for quantifying the RMNCNH products needed for activities[1] (including mobile clinics) and authorising their distribution by the NPSPCI. UNFPA provides substantial technical and financial support through the purchase of RMNCNH products (almost 85% of family planning (FP) products) and technical support for the SWEDD project.

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In Mali, the Department of Pharmacy and Medicines (DPM) oversees the supply chain through a pharmaceutical master plan and an operational plan for all projects, including the SWEDD project. The DPM coordinates the technical group responsible for quantifying requirements. As such, it organised meetings to quantify the need for contraceptive products and placed orders with the Pharmacie Populaire du Mali (PPM).

Estimating the need for RMNCAH products is an important phase prior to services being offered to beneficiaries

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[1] Broadly speaking, there are three methods of estimation: (a) use of morbidity data (objectives in terms of target and by projecting consumption in relation to the expected number of users over the period); (b) use of historical consumption data and projection of the evolution of this consumption over the coming period; and (c) combining methods (a) and (b).

The documents consulted for this Guide identified, among other promising practices, the coordination of needs-estimation activities by an agency (PNSME in Côte d'Ivoire and DPM in Mali) which provides leadership: *"Coordination of needs-estimation activities helps to ensure that RMNCAH products are available on time".* (National actor, Mali). The documents also identified challenges that are essentially linked to poor estimation of needs which, depending on the level of the health pyramid at which it occurs, can result in CBD disruptions ranging from insufficient products (CBD interruption) to the absence of products (CBD delay or postponement). In Côte d'Ivoire, discussions with representatives of the UCP-SWEDD highlighted supply-related difficulties, ranging from a shortage of certain products to the total absence of RMNCAH products in some districts. These challenges are mainly due to problems with estimating needs, stock management and storage capacity at district and health centre level.

Lessons learned

LESSON 1: Effective coordination of needs-estimation activities and involving 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

Communicating with beneficiaries to raise awareness is a key stage in mobilising them around CBD and explaining the advantages of the FP methods on offer. This phase involves a number of parties, including non-governmental organisations (NGOs), community health workers (CHWs), traditional and religious leaders, and health workers.

In Côte d'Ivoire, for example, within the SWEDD project, NGOs use CHWs for outreach communication at community level. The remit of CHWs includes home visits, interpersonal communication and screening, community mobilisation and group facilitation and different intervention areas including the promotion of Essential Family Practices (EFPs), the fight against maternal mortality (obstetric fistulas, the promotion of prenatal and post-natal consultations), and family planning. The CHWs go on home visits, lead group talks and communicate with the population at mobile clinics. These activities are essential in the promotion of CBD.

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The communication strategy adopted by the SWEDD project is one that focuses on youth and that involves young people taking the message to other young people. CHWs have several ways of reaching young people. Firstly, the CHWs are identified by the community, and CHWs are selected such that that 60 percent of them are youth between 18-35 years of age and at least 50 percent are adolescent girls, who would work on a daily basis in their area throughout the year. CHW services are entirely free for beneficiaries, including modern contraceptive products (condoms, pills and injectables). In addition, CHWs also act as coaches for clubs for husbands and future husbands, thus creating an interpersonal connection with the young men and boys in these clubs.[2]

To improve the support for the activities of the CHWs and the delivery points, mobile clinics are organised in localities throughout the intervention zone, prioritising the most remote villages and schools, followed by the towns. The aim of these mobile clinics is to inform adolescents and young people about sexual and reproductive health (SRH) services and the prevention of the human immunodeficiency virus (HIV), while raising awareness among the general population about the importance of using these services. These initiatives are also opportunities to offer immediate SRH/HIV clinical advice and services, such as family planning, HIV testing, pregnancy screening, and diagnosis and management of sexually transmitted infections (STIs). It is also an opportunity to build the capacity of local providers in long-acting contraception, implant insertion and removal, intra-uterine devices (IUDs) and HIV counselling and testing. CHWs and local radio stations disseminate information and mobilise the community for each activity. The messages are broadcast two days before a mobile clinic's activities and on the first day of the activity, thus giving young people and other members of the community time to organise themselves to take advantage of the clinic's presence.

In Mali, a platform of religious leaders (Muslims, Christians, animists and others) was established and funded through SWEDD to raise community acceptance of modern contraceptive products. At national and regional levels, the Islamic Population et Development Network (RIPoD), an umbrella organisation cooperating with the SWEDD Mali project, received training on project themes such as reproductive health, prevention of and response to gender-based violence, women's empowerment, girls' education, etc.. To this end, specific awareness-raising materials have been developed and made available to the umbrella organisation. These leaders deliver advocacy sessions, preaching and broadcasts on these

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Firstly, the CHWs are identified by the community, and the selection of CHWs is planned to give a proportion of 60 per cent to young people aged 18 to 35 and at least 50 per cent to young girls, who would work on a daily basis in their area throughout the year.

[2] See Best Practice Guide number 5 for more information on clubs for husbands/clubs for future husbands.

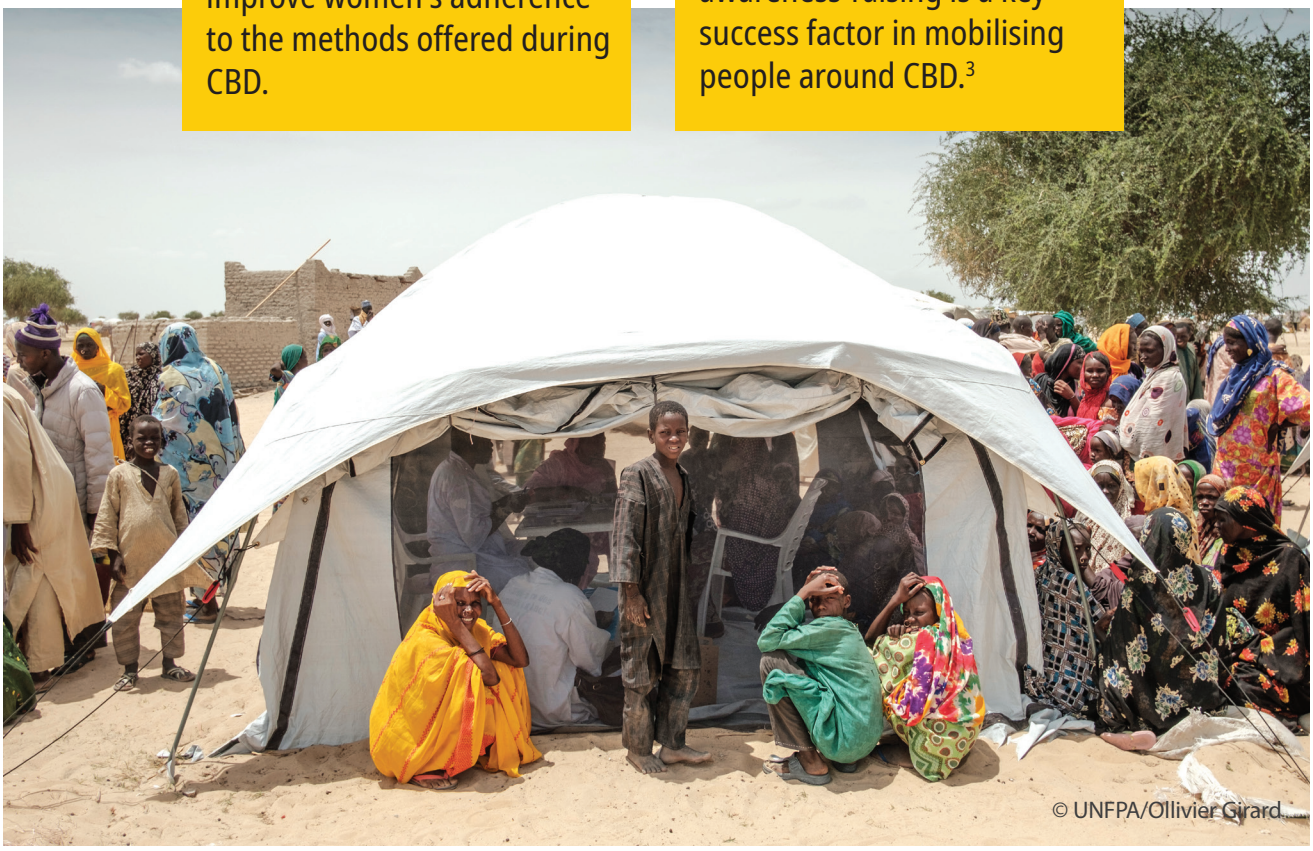
different themes. In addition, at village level, the NGOs working with the village assemblies identified five to seven leaders per village: a man and a woman from the Muslim and Christian religions, a representative of the traditional chieftaincy, a youth representative and a representative of the women's organisations. They have all been trained and equipped to raise awareness of the same issues and play an important role in raising awareness and mobilising people around CBD.

The data collected for this Guide has enabled us to identify, among other promising practices, the involvement of key groups such as religious leaders, traditional chiefs and young people in communicating about and raising awareness of CBD. However, a number of challenges remain, in particular the low level of involvement of men (husbands) as beneficiaries and to raise awareness. As cultural norms dictate that women need their husband's permission to use contraception, the lack of men's involvement has limited women's use of contraceptive methods.

Lessons learned

LESSON 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.

LESSON 3: The involvement of religious leaders, traditional chiefs and young people in communication and awareness-raising is a key success factor in mobilising people around CBD.[3]



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[3] See Best Practice Guide 1 for more information on engaging religious and traditional leaders.

PHASE 3 RECRUITMENT, TRAINING AND REMUNERATION OF CBD STAFF

The quality of staff engaged for CBD is essential to its success. CBD Agents (CBDAs) are an essential link, given the role they play in raising awareness among beneficiaries, collecting and reporting data and, depending on the country, offering certain contraceptive methods.

In Côte d'Ivoire, CHWs involved in CBD are recruited by the community on the basis of several criteria (living in the community, speaking the local language, knowing how to read and write, aged 18 to 50, etc.), listed in the Community Health Strategic Plan (CHSP). Even though women are encouraged to apply, there is low representation of women among the CHWs/CBDAs. The CBDAs interviewed said: "*There are certainly women CHW/CBDAs, but they are very few in number compared with the men, who are by far the most numerous*". According to the interviews carried out for this Guide, the number of women working as CHWs is still low due to the influence of customs, the challenges faced by women in rural areas in reconciling their work as civil servants with the needs of their families, and illiteracy, which is still 47%, of which two-thirds are women[4] despite the efforts made by the government to get girls into school. The SWEDD project also prioritises the age criterion as a key factor in the project's communication strategy in awareness-raising activities: "young people for young people".

The candidates selected by the communities are then validated through a process documented in the CHW statutes, which culminates in a decree appointing the CHWs. Once appointed, the CHWs all received training in behaviour change communication (BCC) and knowledge of contraceptive methods. The training modules and communication materials for CHWs were developed by Cote d'Ivoire's Ministry of Health, Public Hygiene and Universal Health Coverage (MSHPCMU). These are cascading training courses. They last five days and are based on training documents drawn up in a workshop with all the stakeholders, covering concepts of gender, women's rights, SRH/HIV for adolescents and young people, including unmarried people, and the introduction of short-acting contraception, including injectables.[5]


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[4] https://www.gouv.ci/_actualite-article.php?recordID=15651.

Two examples of CBD experiences around the world:

A number of CBD experiences worldwide have demonstrated 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".* A document published by Family Health International (FHI) demonstrates successful models in Turkey, Mali and Bangladesh, with prevalence rates that can triple following these interventions (Best, 1999).

Moreover, community distribution initiatives for injectable contraceptives and their introduction strategies in four sub-Saharan African countries (Uganda, Madagascar, Nigeria and Kenya), documented in the Special Report on "International Perspectives on Sexual and Reproductive Health", have achieved interesting results including reinjection rates after three months, user satisfaction, client knowledge of the essential characteristics of the injectable and comparisons of the incidence of morbidity between injections administered by community health workers and in clinics. For example, 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).

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


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During the supervision of CHW activities in the field, additional training needs are identified by the NGOs recruited by the SWEDD project and lead to capacity building, particularly on how to complete the data collection tools. This supervision is carried out jointly on a monthly basis with the health centre manager. In addition to the various non-financial incentives (easier access to care, community support, honorary recognition), a subsidy of 20,000 F/CFA is granted through partner NGOs and paid quarterly on submission of reports validated by the supervising health worker.

In Mali, CHWs and community relays are recruited according to criteria listed in the PSNSEC[6]. In the SWEDD project, CHWs and community relays present in villages are identified (one man and one woman) by village chiefs and religious leaders to become CBDAs. In addition to their initial training, the CBDAs we met had received training in family planning. These agents do not receive fixed remuneration, but do receive income from the sale of products to beneficiaries (equivalent to 50% of the sale price).

[5] Documentation is available on the DSCPS website: www.dsccom-ci.org.

In Niger,[7] the CBDAs are selected with the involvement of all sections of the community in collaboration with the authorities and health workers. This process generally results in the recruitment of one man and one woman for each village. They are paid 5,000 CFA francs through NGOs recruited by UNFPA or other partners. They also benefit from other types of motivation, such as cash donations and testimonials.

However, difficulties linked to remuneration and lack of means of transport can undermine the motivation and commitment of these actors. In Côte d'Ivoire, the set monthly remuneration is linked to a target of awareness raising for 75 women and 20 new acceptors per month. The CHWs interviewed considered this objective to be "challenging" because the products are not free: "*It is very difficult to achieve this target, especially the 20 new acceptors per month, because the FP products are not free. They have to be paid for and this discourages the women somewhat*". Also, in contexts where countries are increasingly moving towards reducing the costs associated with RMNCAH (often towards free provision), remuneration based on the number of beneficiaries to whom products are supplied does not offer CBDAs a stable and sustainable income. There is the additional risk of bias in the methods offered to users. In Mali, the CBDAs interviewed think that "*the sale of contraceptive products is not going well because the women [beneficiaries] tend to go for long-term contraceptive methods*" before adding: "*Women claim to forget daily doses, which is why they prefer long-term methods*".

The mobility of those involved in (and during) CBD is an essential factor in its success. The use of appropriate transport to aid accessibility in certain areas will enable all populations to benefit from CBD and improve the project's indicators. In Côte d'Ivoire, the CBDAs interviewed referred to mobility difficulties resulting from inadequate means of transport, particularly in the rainy season when some roads become impassable (bicycle distribution is planned but has not yet implemented). In the absence of rolling budget, it is difficult to sustain a transport allowance. A similar situation is described in Mali, where the CBDAs interviewed, although they carry out their work using their own means of transport, state that their travel expenses are not reimbursed.

> *Achieving this target is challenging, especially for the 20 new acceptors per month, because FP products are not free. They have to be paid for, which is something of a disincentive for women.*

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[6] PSNSEC: National Strategic Plan for Essential Community Care (Mali).

[7] Although not implemented under the SWEDD project, there are CBDs in Niger implemented by NGOs with UNFPA support.

Lessons learned

LESSON 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.

LESSON 5: The lack of suitable means of transport limits the ability of CBDAs to carry out their activities in certain areas that are challenging to access.

LESSON 6: The remuneration arrangements for CBDAs influence the ability of countries to retain them.

PHASE 4 DEPLOYMENT OF RMNCAH PRODUCTS AND FAMILY PLANNING SERVICES

In addition to accurately estimating needs, the deployment of products to distribution sites is an essential link in making products available and accessible to beneficiaries. This deployment precedes the active phase of CBD, during which the various parties reach out to communities to raise awareness and offer them contraceptive methods. In general, the existence of a master plan and distribution network, compliance with these plans and networks, and monitoring of distribution help to improve availability at the peripheral level of the health pyramid and to facilitate rapid resupply as needed during CBD.

In Côte d'Ivoire, products are deployed through a distribution network established in the country. Specifically, essential medicines are distributed by the NPSPCI, which supplies health districts, referral hospitals and health establishments in Abidjan based on a pre-established schedule. Supply for community-based distribution begins in the health districts. Despite the availability of means of transport in all health districts, there are no deliveries to peripheral sites in the majority of districts. Information on the distribution of medicines gathered from districts benefiting from vehicles provided to boost the medicines supply chain demonstrates that distribution plans exist for the 21 beneficiary districts and that distribution is up and running in 18 districts.

In order to improve distribution performance, the Pharmaceutical Affairs Department (DAP) experimented with two pilot models for last-mile distribution in the SWEDD project, with a view to selecting the most advantageous and sustainable model. These were the public model or district approach (based on the district's logistical distribution capabilities) and the public-private partnership (PPP) model (experimenting with outsourcing distribution to a private service provider). Each of these models was tested in five different districts, and the district approach was found to be the most advantageous and sustainable. Under this approach, districts are exempt from transport costs. Thus, FP services are mainly provided through mobile clinics run by midwives and nurses, while the activities of the CBDAs are limited to raising awareness, providing guidance and following up beneficiaries after the mobile clinics.

In Mali, once orders have been placed with the PPM, procurement follows the master plan for the supply and distribution of essential medicines. The Pharmacy and Medicines Department (DPM) supervises the distribution of CBD products to ensure that the distribution plan is fully implemented. The CHWs receive an initial allocation from the Community Health Association (ASACO) after training and sell the products in accordance with the provisions in force (the prices charged must not exceed those of the Community Health Centre (CSCom)).

As part of the SWEDD project, several CBD strategies were deployed. Initially, CBD relied on the traditional strategy of distribution through community relays and CHWs in the CSCom. Women who visit health centres for treatment or to accompany their children (for vaccination or when sick) are invited to take part in discussion groups in the course of which contraceptive methods are discussed and offered. Secondly, in addition to the traditional strategy, two new strategies were implemented: a) distribution of these contraceptive methods in hairdressing salons frequented by women and in the twice-weekly tontines established by the NGO AMPPF (Malian Association for the Promotion and Protection of Families). The Relays and CHW package includes both Social Behaviour Change Communication (SBCC) activities and promotion of essential family practices adopted at national level, and CBD of non-medical and/or approved products including contraceptives (condoms, coil, pills, spermicides);[8] and b) the use of mobile platforms (medically equipped vehicles) that can provide services to three people at a time and offer health services ranging from medical consultations to rapid screening tests for certain diseases (diabetes, HIV) and FP services.

The deployment of products to distribution sites is an essential link in making products available and accessible to beneficiaries.

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The discussions with the various stakeholders and the literature review conducted for the preparation of this document identified promising practices in the implementation of a pilot phase of last-mile distribution in Côte d'Ivoire and the evaluation of the distribution models deployed during this pilot phase in order to select the most appropriate for the country's context. However, until it is scaled up, difficulties in delivering the products to the communities (impassable roads in the rainy season, isolated sites, security problems) and inadequate means of transport are hampering the continued availability of the products to the communities and hence the smooth running of CBD. The upkeep and maintenance of logistical resources also remains a challenge, given the need to deploy RMNCAH products from central to community level. In Mali, the national authorities mention "*major difficulties in the upkeep and maintenance of the rolling stock made available to the health districts under the project*".

Lessons learned

LESSON 7: Deploying products according to an established master plan and distribution channels helps to improve their traceability and timely availability at community level.

LESSON 8: In addition to the availability of logistical resources, effective fleet management (servicing, maintenance, fuelling, etc.) ensures the effective deployment of RMNCAH products.

LESSON 9: The diversification of CBD strategies enables it to offer a wider range of FP services.

PHASE 5 CBD DATA MANAGEMENT, SUPERVISION AND MONITORING

In Côte d'Ivoire, leadership in data management for RMNCAH is provided by the National Mother and Child Health programme (PNSME). The CBDAs recruited are trained in data collection and their equipment contains tools for data collection in the community. Thus, through its NGO partners, the SWEDD PCU collects data to provide information for the project indicators on supply disruptions, the number of new users and the number of women reached. CBDAs have data collection forms that they must complete to support their activities.

It is important that the activity of CBDAs is monitored so that they are motivated, and coached, if necessary. This monitoring is carried out by the nearest healthcare provider (nurse or midwife). Supervision is based on the principle of graduated supervisory level. At the national level in Côte d'Ivoire, CBDAs are supervised by the centre's nurse or midwife, known as the supervising nurse or midwife. Monitoring is also provided at the district-level, by the coordinator of community-based activities (CAC), and by the NGOs recruited by the SWEDD project, through the supervisor of this NGO, and by the National Mother and Child Health programme (PNSME), through the supervision of mobile consultations.

[8] In Mali, in addition to the products distributed by community relays, CHWs are able to administer the injectable method (Depo Provera).

In Mali, CBDAs are monitored through supervision or training/retraining missions by AMPPF (Malian Association for the Promotion and Protection of Families) and CSCom. This monthly supervision covers, among other things, the availability of supplies and the completion of forms. The Regional Health Department (DRS) and the Circle Distribution Depot (DRC) are also involved in supervision missions including by telephone.

In Niger, CBDAs are regularly monitored according to a clearly defined schedule depending on the level: monthly monitoring by the head of the CSI (health centre) to which they are attached, quarterly monitoring by the district and half-yearly monitoring by the regional level and joint monitoring by the central level with a sample of CBD sites in collaboration with certain NGOs.

The discussions with the various stakeholders for this Guide identified a promising practice in the establishment of a system for collecting data on community-based distribution activities, the involvement of all levels of the health pyramid in monitoring CBD, and the commitment of NGOs whose experience in interventions at community level and/or in sexual and reproductive health boosts the supervision of CBDAs. However, the mere existence of data collection tools is no guarantee of high-quality data. The failure of CHWs to use data collection tools and/or the failure of CHWs to transmit quality data undermines the reporting of CBD data. This observation is also shared by the UCP-SWEDD in Côte d'Ivoire, which states that "*although CHWs are trained to use the tools, they are not always able to transmit quality data. This is why the SWEDD project, through monitoring and evaluation and the recruited NGOs, is training them in this area.*" In Mali, one of the recommendations to emerge from the various interviews was to "*improve data collection forms by using new information technologies with applications on tablets and smartphones to allow instant remote access to databases.*" Training CBDAs in the correct use and validation of the data they collect and transmit helps to improve quality.

Lessons learned

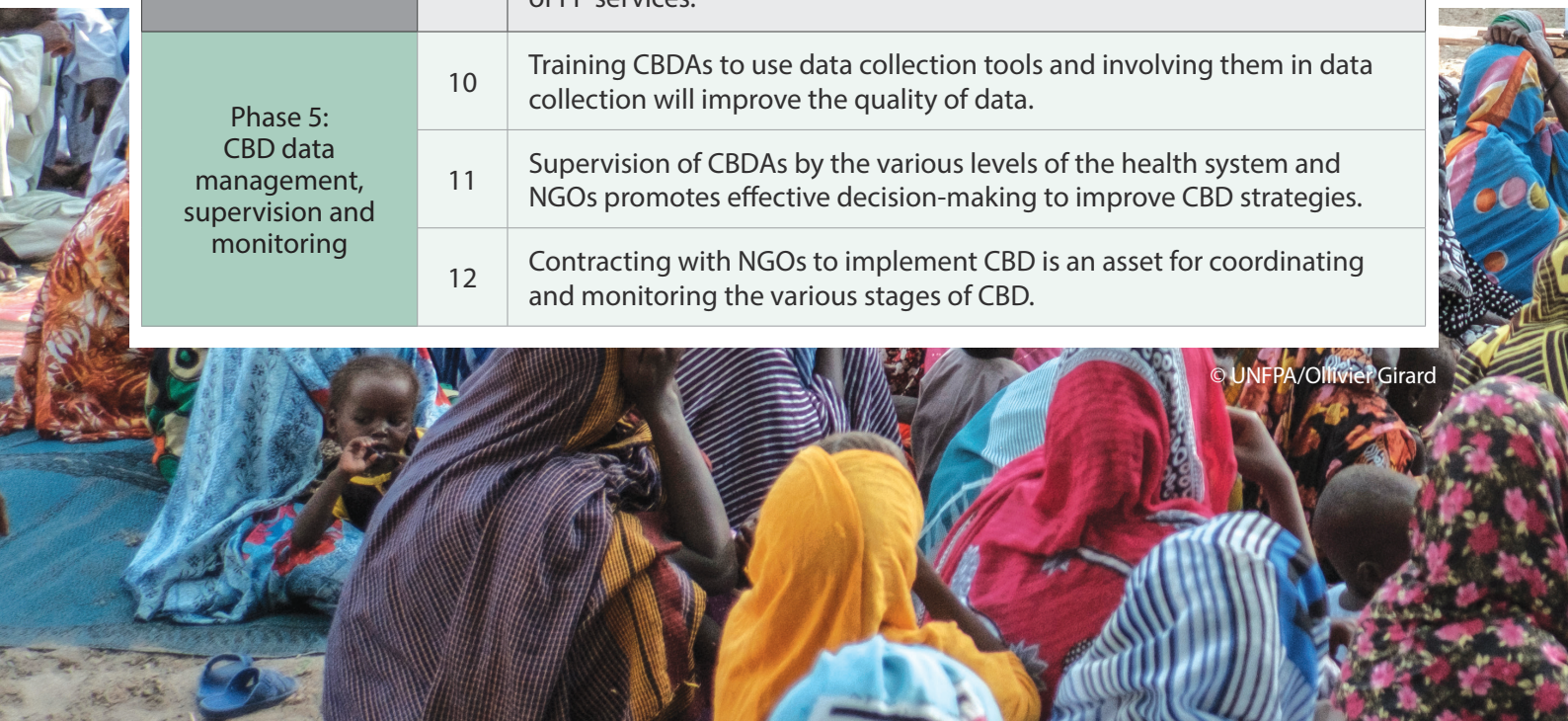
LESSON 10: Training CBDAs to use data collection tools and involving them in data collection will improve the quality of data.

LESSON 11: Supervision of CBDAs by the various levels of the health system and NGOs promotes effective decision-making to improve CBD strategies.

LESSON 12: Contracting with NGOs to implement CBD is an asset for coordinating and monitoring the various stages of CBD.

SUMMARY OF KEY LESSONS

Phase 1: Estimation of RMNCAH product requirements.	1	Effective coordination of needs-estimation activities and involving 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 mobilising 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 challenging to access.
	6	The remuneration arrangements for CBDAs influence the ability of countries to retain them.
Phase 4: Deployment of RMNCAH products and the offer of the family planning service	7	Deploying products according to an established master plan and distribution networks 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 data collection tools and involving them in data collection will improve the quality of data.
	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.



ANNEX 1: Methodology and sampling

I. Data collection methodology

The information included in this Guide was gathered during interviews organised by the Centre Hospitalier des Métiers de la Pharmacie (CHMP), with respondents selected to undertake the retrospective documentation of the design and implementation of CBD activities. The SWEDD countries that opted to take part in the interviews on this theme were Côte d'Ivoire, Niger and Mali. The information was collected through interviews with key CBD agents in these three countries, and a review of documents such as national community health strategy documents and national supply chain strategic plans. The respondents from each country were proposed by the technical partner and the consultants, liaising with the members of the PMUs of each participating country.

Conversations were organised face-to-face, or virtually in circumstances where face-to-face was not possible. The facilitators were given a conversation guide - developed by the technical partner - which included questions on the design and implementation of CBD activities. During the conversations, the facilitators used personal recording devices (phones, tablets, etc.) to record the conversations and then transcribed them later before consolidating them into a summary.

II. Data sources

The information was gathered through key informant interviews with individuals engaged in the design and implementation of CBD activities in the three SWEDD countries listed above. These informants do not represent a systematic sample, "but, rather, a convenience sample of those with experience in the theme of this Guide across these countries" that makes it possible to leverage existing SWEDD capacity. The country informants are listed in Annex 2.

For overall data on RMNCAH in the three countries, the information comes from: the DHS (Demographic and Health Surveys) of the three countries involved in this Guide, the countries' National and Strategic Plans, and censuses, all dating back several years. Some other information comes from additional documents listed in the Bibliography below.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ANNEX 2: The people interviewed for the Guide

Informants interviewed	Country
In individual interviews: two representatives of the SWEDD-PCU Côte d'Ivoire, a representative of the Pharmaceutical Affairs Department (DAP), a representative of the National Mother and Child Health programme (PNSME), a representative of the Community Health Department (DSC) and two representatives of UNFPA; In focus groups: four CBDAs and three beneficiaries	**Cote d'Ivoire**
In individual interviews: a representative of the SWEDD-PMU Mali, a representative of UNFPA, a representative of the DPM; In focus groups: four CBDAs and three beneficiaries	**Mali**
In individual interviews: a representative of the SWEDD PMU, a representative of UNFPA, a representative of the Family Planning Department (DPF)	**Niger**

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This Guide is one of a series that retrospectively documents the process of implementing the interventions of the SWEDD project, and documents good practices, challenges and lessons learned. The "Sahel Women's Empowerment and Demographic Dividend" (SWEDD) project was launched in November 2015 with financial support from the World Bank, and technical support from the United Nations Population Fund (UNFPA) and the West African Health Organisation (WAHO). SWEDD aims to accelerate the demographic transition, trigger the demographic dividend and reduce gender inequalities in the Sahel. The motivation for this series is the fact that SWEDD has become a strategic framework for political decision-makers, opinion leaders (traditional and religious chiefs, and other community leaders), and the community to work together on issues considered sensitive in the region. This is why it was considered important to share the processes through which the project was developed. This includes descriptions of experiences, lessons learned and recommendations. A total of four Guides in this series, including this one, aim to document the experiences of implementation under SWEDD component 2 interventions with the objective of improving the provision of reproductive health services. These include Community-Based Distribution (CBD) interventions to bring services and products closer to communities (Guide number 9), experience in building the capacity of healthcare staff, particularly midwives through mentoring programmes (Guide number 10) and Centres of Excellence (Guide number 11) and the deployment of these midwives to make up for the shortage of staff on the ground, particularly in rural areas (Guide number 12). However, the lessons learned from this documentation do not imply that all four interventions need always be simultaneously implemented.

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