implementation story:

Ensuring Access: How RHITES-E Improves Uptake of Voluntary Family Planning in Rural Eastern Uganda Through Partnerships and Collaboration

PHOTO CREDIT: IntraHealth International

A community mobilizer discussing voluntary family planning with a couple.

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Background and Context

Uganda has one of the highest fertility rates in the world, at five children per woman (World Bank, 2018). This can be attributed to several factors, including low awareness of and demand for voluntary family planning among women of reproductive age across Ugandan rural communities. Although Uganda has seen a significant increase in its overall modern contraceptive prevalence rate in the last two decades, it is still relatively low, at 35 percent—and is higher in urban areas (41 percent) than rural areas (33 percent) (Demographic and Health Survey [DHS] Uganda, 2016).

> "As a responsible father, I always escort my wife to hospital for family planning and together we decide on the method of choice after adequate information has been given to us by a midwife."
>
> Kissa Joseph, husband and father

The Sebei Cluster in mid-Eastern Uganda contains three districts: Kapchorwa, Kween, and Bukwo. The Kalenjin are the main inhabitants and the dominant ethic group in the three cluster districts. In May 2017, the U.S. Agency for International Development (USAID) Regional Health Integration to Enhance Services in Eastern Uganda (RHITES-E) project, implemented by IntraHealth International, became the main implementing partner for both family health and HIV in this region. Overall, this region has had relatively low contraceptive uptake compared with the rest of Uganda. At the start of the project, the modern contraceptive prevalence rate for the Sebei Cluster was 13 percent overall (16 percent in Kapchorwa, 15 percent in Kween, and 7 percent in Bukwo) (District Health Information Software [DHIS2 FY 2016/2017]). The use of long-acting reversible contraceptives (LARCs)—specifically, implants, and intrauterine devices—was 7 percent in Kapchorwa, 4 percent in Kween, and 9 percent in Bukwo (DHIS2 FY 2016/2017). Baseline survey findings conducted by RHITES-E in June 2017 indicated that the low use was due to several factors: low demand for voluntary family planning and reproductive health care; influence of cultural

beliefs, such as the association of bearing children with wealth; myths about family planning (for example, that it causes cervical cancer, infertility, or high blood pressure); frequent stockouts of family planning commodities; and inadequate skills among health workers.

THE HIGH IMPACT PRACTICE

To address the issue of low contraceptive use and voluntary family planning access barriers in the Sebei Cluster, the RHITES-E team spearheaded a collaborative using principles of community group engagement, a high-impact practice (High-Impact Practices in Family Planning, 2016). This approach was adopted to foster intentional and continuous learning to ensure access to voluntary family planning through partnerships of stakeholders such as health facility leads, cultural leaders, government leaders, and other implementing partners. The purpose of the collaborative was to build health workers' capacity to deliver unbiased and integrated health care and increase voluntary access to a full range of contraceptive methods—with a focus on LARCs— among rural and underserved populations in the Sebei Cluster. Collaborative partners, along with government agencies, implemented the activities.

PHOTO CREDIT: IntraHealth International

A health facility lead counseling a couple about voluntary family planning

The collaborative focused on women of reproductive age, particularly young women. In the Sebei Cluster, there is a high rate of adolescent pregnancy. Increasing youth-friendly reproductive health care—particularly LARCs—among this group has great potential to improve the health and well-being of families in the three cluster districts.

Implementation Story

The collaborative began during a coordination meeting with partners across the three cluster districts, hosted by RHITES-E. Such coordination meetings had not been previously held among implementing partners in the region. In addition to RHITES-E, participants included representatives from key local nongovernmental organizations. During the meeting, participants identified the following key challenges: inadequate funding, contraceptive stockouts, insufficient skills among health workers, and the need for more community mobilization and sensitization around voluntary family planning issues. To respond to these challenges, the RHITES-E team proposed ongoing partner collaboration as a means of pooling resources, combining geographic coverage, increasing the involvement of local governments, and striving for sustainability.

The partners agreed to start a collaborative, and shortly after the initial meeting, co-developed an operational plan and work plan. To prevent duplication of effort and promote efficient use of resources, the work plan indicated each partner's activities, marked those in need of partner co-funding, and highlighted activities already supported by local governments. We planned a range of interventions, including integration of voluntary family planning information with community dialogues, family planning access camps (community events where clients can receive contraceptive methods and counseling of their choice outside the health facility setting), radio talk shows, mentorships, and facility-based trainings. The collaborative also conducted activities in schools—for example, drama, poems, riddles, and music performances—to counter myths and misconceptions around voluntary family planning.

Collaborative meetings are now held every quarter, and we bring together partners to share and learn from each other on expanding not only voluntary family planning and reproductive health programs, but those in other health areas as well. During these quarterly partner review meetings, we review work plan progress and deliverables, reflect on areas needing improvement, identify best practices to consider for scale-up, and discuss priority donor interests. We continuously use data to inform decision making and enhance accountability.

Based on data, we implement additional activities in certain sub-counties, such as intensified community mobilization and engagement of facility-based health workers (including clinical officers, medical officers, midwives, nurses, health inspectors, and records assistants)

"We worked with districts and facilities to implement planned activities as well as agreed action plans. We also reached health workers [with additional skills and capacity] to close access and utilization gaps."—Dr. Siraji Masai District Health Officer, Kapchorwa District

CHALLENGES

During implementation, we have encountered a number of challenges, including gaps in health workers' capacity, lack of systems linking communities and health facilities, inadequate resources, and resistance from some community leaders. The collaborative has addressed these challenges in the following ways:

At the district level:

- We mapped out key activities per implementing partner and co-funded additional activities to reduce strain on resources.
- We held district-based advocacy meetings and budget conferences to encourage local governments to allocate voluntary family planning funding in health budgets.
- We supported districts to engage the private sector by encouraging private practitioners to provide a range of affordable contraceptive methods.
- To ensure consistent availability of methods, we are working to strengthen district logistic and information systems.

At the facility level:

- Using World Health Organization guidelines and the Training Resource Package for Family Planning, we addressed learning and performance gaps by conducting facility-based training to enhance the technical capacity of health workers to deliver high-quality care (USAID, WHO, and UNFPA, 2020).
- We adopted blended learning approaches, such as presentations on best practices during quality improvement sessions, which then connected providers to mentors and supervisors through additional peer-to-peer sessions. Mentors and mentees often communicated via WhatsApp to improve competency without disrupting health service provision.
- We conducted skills building for provider-initiated discussions about voluntary family planning—that is, asking every woman and girl about her needs for contraception to space or limit pregnancies.

At the community level:

- We developed radio talk shows and dramas and distributed educational materials to enhance mobilization among community members.
- We held dialogue meetings among selected community leaders to encourage them to advocate for voluntary family planning. We conducted a stakeholder mapping matrix to guide teams on the most influential and appropriate leaders to include.
- We engaged with satisfied family planning users to provide appropriate information to potential users (for example, information on contraceptive mechanisms of action, administration of different methods, and side effects).

Additional challenges persist, although they have been greatly reduced. These include varying donor interests, funding gaps, and slowed response among some communities in the cluster districts (especially in Kween District).

"WE HAVE RECEIVED TECHNICAL SUPPORT FROM RHITES-E TO IMPROVE AND STRENGTHEN KNOWLEDGE AND SKILLS OF HEALTH WORKERS IN FAMILY PLANNING SERVICE PROVISION. NOW WE ARE ABLE TO PROVIDE SERVICES WITH CONFIDENCE AND SKILLS UNLIKE BEFORE."

Kiti Peter, health facility lead at Terenboy Health Center III -Kween District, Uganda

A health worker from Reproductive Health Uganda attending to a young woman seeking information on voluntary family planning.

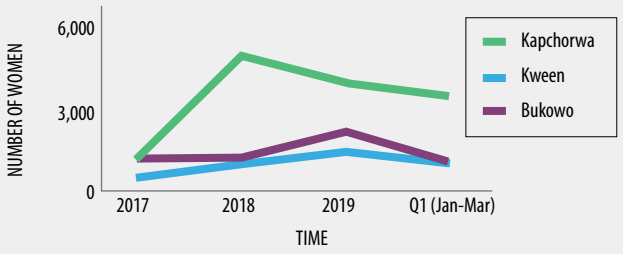
IMPACT

Overall, the collaborative allowed partners to align activities and pool resources for greater impact. The modern contraceptive prevalence rate increased from 13 percent in the Sebei Cluster in 2016–2017 to 16 percent in 2019–2020 (DHIS2 FY 2019/2020). Across the cluster districts, a total of 25,504 women voluntarily initiated LARCs from January 2017 to March 2020. By the end of 2017, 3,499 women across the three districts adopted LARCs, increasing to 7,680 in 2018, and 8,149 in 2019 (4,096 in Kapchorwa, 1,685 in Kween, and 2,368 in Bukwo). During the first quarter of 2020 (January to March), 3,608 women initiated LARCs in Kapchorwa, 1,262 in Kween, and 1,306 in Bukwo. We therefore anticipate even greater numbers by the end of 2020.

This increase in the number of women using LARCs indicates that awareness creation has really taken root. Some cultural leaders are now advocating for the uptake of voluntary family planning. This approach also helped foster sustainability—family planning funding within district budgets increased every year, while donors gradually reduced their funding. And Kween and Kapchorwa districts have already allocated 5 million and 4.5 million Uganda shillings each, respectively—to support implementation of voluntary family planning related activities by district health offices of both districts—while donor funding decreased during the same period.

Figure 1 shows that all three districts are increasing LARC use, particularly Kapchorwa. The focus of program implementation is now concentrated in Kween and Bukwo, where we are applying key learnings for scale-up from Kapchorwa.

Figure 1. Women Who Voluntarily Initiated LARCS Across Sebei Cluster, 2017–2020



LESSONS LEARNED

Collaboration with implementing partners and other stakeholders is efficient. Stakeholders are able to leverage funding, share donor interests, and divide responsibilities. This helped avoid duplication and maximize funding.

The collaborative provided a conducive environment for stakeholders to nurture relationships, share experiences, and improve voluntary family planning outcomes.

Quarterly meetings provide important moments to pause and reflect, where all stakeholders can come together to share progress and challenges.

Consistent data review guides decision making among implementing partners and stakeholders. It allows them to focus activities in areas that may be lagging, offering extra support as needed—for example, mentorships on high-quality, voluntary family planning counseling, ensuring family planning stock availability, or intensified community mobilization.

Focused community-based interventions play key roles in challenging cultural practices and addressing myths and misconceptions—for example, rumors about contraceptives causing infertility or high blood pressure or about bleeding while using contraception causing bad luck.

Including health information in school-based activities—such as drama, poems, riddles, and music—is an effective way of reaching youth with information about reproductive health care, human papillomavirus vaccination, and other health topics.

recommendations

01 **Hold regular (monthly or quarterly) collaborative meetings to discuss the scope of implementation, and the activities and progress of each partner**. This helps identify opportunities for synergy and enables the collaborative to adapt as needed.

02 **Define expectations and roles for each partner**. This encourages proper coordination and accountability for each activity.

03 **Review donor interests consistently and keep scouting for partnerships with other implementing partners who have similar donor interests**. This ensures leveraging and building on other's activities, reducing duplication of effort, and spending funds more efficiently.

04 **Use stakeholder mapping to identify and prioritize which stakeholders and cultural leaders to engage**. Especially in areas where cultural values and practices have a huge influence on health-seeking behavior, stakeholder analysis helps mobilization efforts and increases the chance that leaders will become family planning champions.

05 **Integrate voluntary family planning with other health areas within the community**. This enhances voluntary family planning uptake, especially in communities where access to family planning is limited.

06 **Advocate for district leaders to be accountable for specific family planning activities and programs**. This goes a long way to ensure sustainability of programs after the collaborative has ended.

REFERENCES

High-Impact Practices in Family Planning (HIPs). (2016). Community Group Engagement: Changing Norms to Improve Sexual and Reproductive Health. USAID. https://www.fphighimpactpractices.org/briefs/community-group-engagement/

Uganda Bureau of Statistics - UBOS, & Icf. (2018, January 01). Uganda DHS, 2016 - Final Report (English). Retrieved November 04, 2020, from https://dhsprogram.com/publications/publication-FR333-DHS-Final-Reports.cfm

Uganda's Electronic Health Information System. (n.d.). Retrieved December, 2019, from https://hmis2.health.go.ug/hmis2/dhis-web-dashboard/#/

Uganda's Electronic Health Information System. (n.d.). Retrieved October 27, 2020, from https://hmis.health.go.ug/dhis-web-commons/security/login.action

A midwife counseling a couple on various methods to enable them to make informed choice.

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