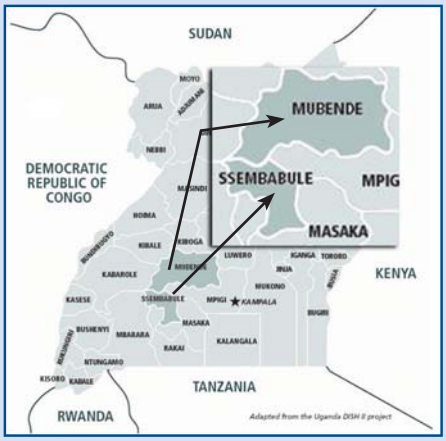
USAID FROM THE AMERICAN PEOPLE | Uganda

FAMILY PLANNING IMPLEMENTATION TEAMS:
Building Sustainable Community Ownership in Rural Uganda

Though women and men in rural Uganda know of family planning and many express a desire to control their fertility, few use modern contraception. Reasons for not using modern contraception range from lack of access to health services, to misperceptions about side effects.

Minnesota International Health Volunteers (MIHV) manages a project in the Ssembabule and Mubende districts of central Uganda that increases people's knowledge and use of and access to family planning.



Two districts in Southwest Uganda where the MIHV Child Spacing Program is located.

Their approach is squarely based in the community and a centerpiece of their work is the Family Planning Implementation Team (FPIT). Each FPIT brings together representatives from various levels and positions—from village to district, from private

INTRODUCTION

Uganda is home to nearly 30 million people. It has the third-highest population growth rate in the world at 3.57 percent per annum. Its fertility rates are also among the world's highest. On average, a Ugandan woman bears 6.7 children in her lifetime, and data indicate that fertility rates are even higher in rural areas (7.1) and among women who are poor and who have little or no education.[i] The link between high fertility and limited social and economic growth is well established.[ii] Most worrisome is that high fertility contributes to high infant, child, and maternal mortality (see table below).

In Uganda, 97 percent of women and 98 percent of men (15–49 years) *know* of at least one method of family planning. Despite this, only 24 percent of married couples *use* any method of contraception and only 18 percent use a modern method.[iii] Rural, married women are less likely to use a modern method than their urban counterparts (15 and 37 percent, respectively). Not unexpectedly, women with no education and women who rank in the lowest wealth quintile are the least likely to use modern contraception (just nine and seven percent, respectively). Unmet need for family planning services—that is, the percentage of currently married women who wish to space their next birth or

A typical family in Uganda.

CSTS+ | CORE Group

citizen to government health representative—who have a stake in helping women and men learn about and gain access to modern contraceptive methods. The FPITs meet regularly to develop plans and monitor progress. Far from being mere regulatory bodies, the teams are creative, active groups that generate new ideas and foster changes. Such changes have contributed not only to an uptake of family planning but to sustained community support for the mechanisms that ensure contraceptive acceptability and availability.

This case study examines the contributions that FPITs are making to the success of the MIHV project in Uganda. It also explores how the diverse teams' ideas, actions, and energies may have led to deeper and more sustainable changes than if MIHV had implemented its project solely via the formal health system.

stop childbearing entirely but who are not using contraception—is 41 percent nationally. These findings point to the compelling need to provide women and men with the family planning options and services they need to voluntarily limit the size of their families.

Minnesota International Health Volunteers (MIHV) is improving family planning knowledge, access, and use in Ssembabule and Mubende, two rural districts of central Uganda. MIHV's *Uganda Child Spacing Program* (UCSP, 2006-2009) is funded by the U.S. Agency for International Development and supported by the Uganda Ministry of Health.

Ssembabule is home to about 208,344 people, and Mubende is a much larger district with some 706,000 residents. The religious affiliations of residents are primarily Catholic or Protestant, with some Muslims. Both districts are rural, with extremely limited infrastructure and services. Their local economies center upon agriculture and animal husbandry.

Mortality	*Uganda*	*Ssembabule*	*Mubende*
Infant (per 1,000 live births)	76	122	119
Child (per 1,000 live births)	137	—	—
Maternal (per 100,000 live births)	435	500	600

MIHV conducted a survey in Ssembabule in 2006. This occurred before the launch of the current project but after they had already done some family planning work in the area. The MIHV survey revealed the following:

- 99 percent of respondents knew of at least *three* methods of family planning.
- Unmet need for spacing and limiting births in Ssembabule is 56 percent (±15 percent), which is higher than the national average of 41%.

The UCSP uses a community-based strategy to increase demand for family planning services *and* to increase supply of family planning methods to women and men who choose to use them. As mentioned previously, a critical component to this strategy is the Family Planning Implementation Team (FPIT), established in both districts to facilitate and coordinate MIHV's community-based work.

The purpose of this case study is to describe how the Family Planning Implementation Teams have contributed to the successful implementation of the UCSP. The document also briefly highlights the FPIT members and how they work together, as well as the challenges of using FPITs. It closes with a handful of lessons that MIHV has learned which may be useful to other groups that are implementing community-based family planning programs.

PROJECT APPROACHES

Community-Based Distribution

The majority of health facilities in rural Uganda are not providing adequate access to family planning methods nor meeting the need for clinical services. In the Ssembabule district of 35 parishes, 22 health centers exist for 208,344 residents. Mubende's 92 parishes have only 52 centers for the district's 706,000 residents. Under such conditions, increasing service delivery points through *community-based distribution* is a vital mechanism for providing family planning information and methods to women and men of child-bearing age.

In rural Uganda as elsewhere, community-based distribution is a complement to contraceptive distribution at health centers. Family Planning Community Health Workers, or FP-CHWs as they are called by the UCSP, are one such community-based distributor. FP-CHWs help fill a gap between people's need for family planning information and methods, and their ability to access health centers to obtain these contraceptives. They distribute certain family planning methods within communities and they increase referrals for methods that can only be provided at health facilities. Such referral services include surgical procedures, IUDs, and implants. MIHV and two other NGOs are currently providing injectables through pilot community-based distribution programs because it is the preferred family planning method by women in Uganda and make up the largest portion of referrals.

Good working relationships between FP-CHWs and clinical staff are crucial for the success of this community-based approach to improving family planning. FPITs provide a useful forum for forging and sustaining these solid, respectful relationships.

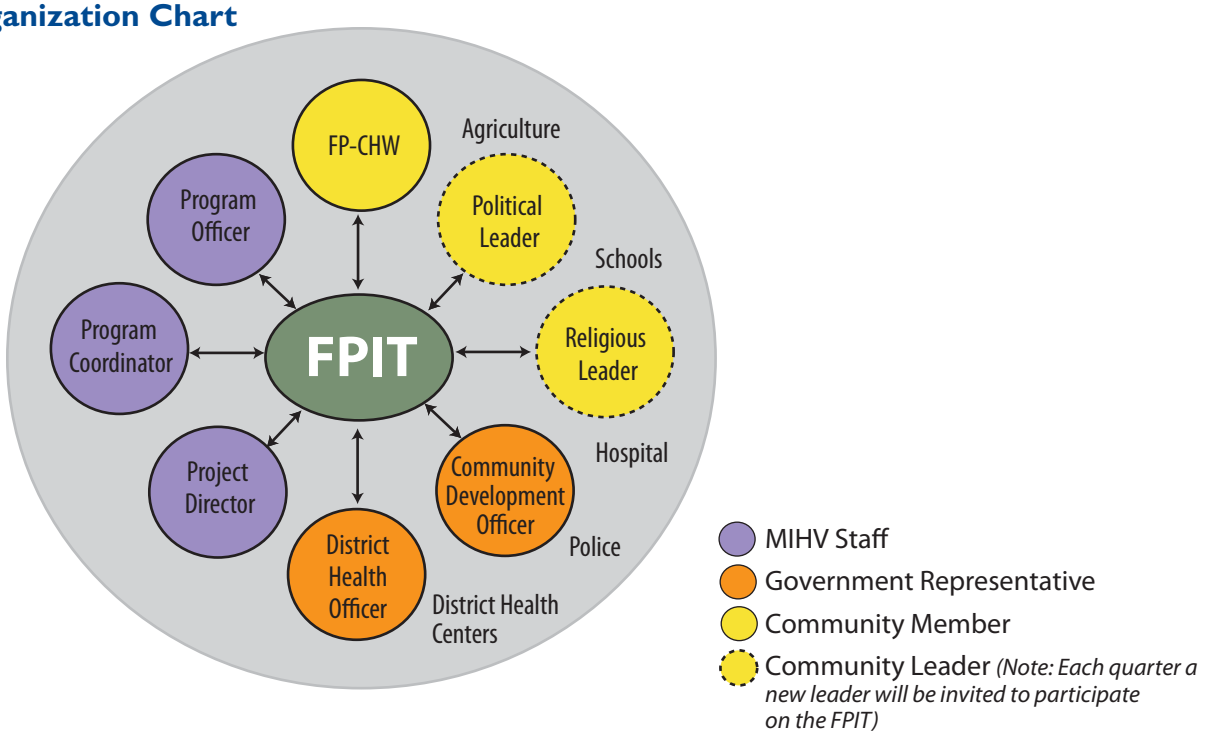
Community Empowerment and Leadership

FPITs are based on principles of multi-sector team building, community empowerment, and leadership. In conjuction with the efforts of FP-CHWs, FPITs foster community ownership of family planning promotion and services. MIHV and its UCSP partners anticipate that such ownership will contribute to sustainability when external funding ends.

Formation of FPITs was unique in each of the two districts, although some members were constant on each team. These were—

- The District Health Officer (DHO) or his/her representatives. The DHO is responsible for the operation and oversight of district health centers.

FPIT Organization Chart



Moonbeads

As is common in areas where modern contraception is not widely known or used, many women and men in the UCSP districts expressed concern that contraceptive use was "unnatural" and had harmful side effects. FPITs agreed that offering a natural method of family planning could help overcome this problem.

Thus FP-CHWs learned to teach couples to use MoonBeads (the Ugandan name for the string of beads that helps couples practice the Standard Days Method).

The beads were included with condoms and oral contraceptives in the FP-CHWs' distribution kits.

- The Community Development Officer (CDO), the local representative of the Ministry of Gender, Labor, and Social Development, which deals with youth and children's affairs, the elderly, the disabled, and cultural and gender issues.
- The Program Coordinator who is an enrolled nurse/midwife and a Program Officer who functions as a community health educator. These individuals are MIHV staff.
- A representative of the FP-CHWs selected by his/her peers and by MIHV staff.

Significantly, the DHO representatives of the Mubende FPIT are also key family planning staff in the district health centers. This provides a distinct advantage for sustaining project activities as the health educator and nurse-midwife also assist with monthly supervision of the FP-CHWs and conduct outreach activities with the project.

Recognizing their influence on local attitudes and behavior, others considered for FPIT membership include political and religious leaders. FPIT members have opted to invite religious and political leaders to gather consensus and engage as many groups as possible. Each quarter a new leader will be invited to participate on the FPIT.

One noteworthy aspect of FPITs is that members of different status—such as an FP-CHW and a DHO—can sit at the same table and learn from one another. While the Mubende FPIT has been considering a larger membership, there is consensus across both teams that the size should not exceed 10 people lest members feel constrained in expressing their views.

KEY FPIT CONTRIBUTIONS

FPITs have provided important contributions to the UCSP, from program planning through implementation. Their knowledge of community norms and beliefs has shaped project approaches, and has increased community acceptance and ownership of family planning activities. The following are a few examples that illustrate FPIT contributions:

- *Defining the profile and role of the FP-CHW.* FPITs identified villagers to be trained as FP-CHWs and suggested that two FP-CHWs—one man and one woman—be trained from each parish. This was an increase from original plans but has proven effective in ensuring that contraceptive information and methods reach men and women. FPITs also reviewed and approved the 5-day curriculum used to train FP-CHWs.
- *Recommending that traditional birth attendants (TBAs) and traditional healers not be trained as FP-CHWs.* FPITs noted that some TBAs who receive even a little training begin to use their newly acquired skills in other key health interventions such as complicated pregnancies. This has led a few TBAs to not refer complicated pregnancies to the health center. This can actually increase infant

Family Planning Community Health Workers show the variety of family planning methods distributed locally.

and maternal mortality. The present concern was that TBAs may demonstrate similar overconfidence with contraceptives. It is also expected that Ministry of Health policy will recommend that TBAs be phased out over the coming decade. However, because TBAs are in contact with postpartum women, they are being trained for a more limited role as advocates of family planning. FPIT members also felt that training traditional healers as FP-CHWs might diminish the UCSP's credibility in the eyes of some community members.

- *Proposing that family planning and child health outreach be integrated.* FPITs suggested that family planning outreach be merged with the other health activities brought to communities or lower-level health facilities. For example, health center staff might travel to a health post of a village to provide child health services, such as immunizations, not normally offered outside the center. Thanks to FPIT input, now such outreach also includes family planning education and interventions. Women and men may be more likely to attend such an event if it focuses on their children's health, and now they also gain family planning information and services.
- *Suggesting Family Planning Days to improve UCSP's outreach to youth and men.* These large community events include drumming to convene community members. They also include dramas, quizzes, and contests as a means of delivering family planning information; sports matches to attract youth; speeches by politicians; and outreach to religious leaders to attend and invite their church members. FP-CHWs and district health center staff offer family planning counseling and distribute contraceptives. In 2007, UCSP reached more than 500 people at each Family Planning Day.
- *Determining the acceptable limits of FP-CHWs' work.* Initially, FPIT members debated which contraceptive methods FP-CHWs should be allowed to distribute. Should they, for example, prescribe oral

MIHV will evaluate the UCSP and measure its outcomes in mid-2009. FPITs' active involvement has contributed to the following outputs to date—

- **Training:** *UCSP has trained 265 FP-CHWs, 108 private providers, 45 health facility staff, and 46 TBAs.*
- **Increasing Knowledge:** *More than 146,000 community members have been reached with education activities, including 19,341 who have received individual family planning counseling.*
- **Increasing Family Planning Use:** *Project data show 17,477 new users of family planning methods and 851 additional couple years of protection through community-based distribution of condoms, MoonBeads, and oral contraceptives.*


Family Planning Implementation Team support MIHV's community family planning education.

Family Planning Community Health Workers.

contraceptives or only resupply clients who had been screened at a health facility? Similarly, was it safe for FP-CHWs to administer injectables? The DHO ultimately decided which methods the FP-CHWs could handle in his/her district, based on government policy, but FPITs provided recommendations on practical implementation.

- *Uncovering violations of the free contraceptives distribution policy.* FP-CHWs notified FPITs that some health centers were charging clients for family planning methods that are in fact free per government policy. The DHO investigated these complaints on behalf of FPITs and thus ensured that all health staff will remain in compliance with government policy.
- *Reversing negative attitudes and beliefs about family planning.* The varied members of FPITs, such as influential political and traditional leaders, FP-CHW, and various government representatives, have proved ideally situated to counter ignorance and misperceptions about contraceptives at all levels.
- *Combining efforts to increase demand for and supply of contraceptives.* Some family planning programs have encountered difficulty when supply of and demand for contraceptives are treated as disconnected activities or concerns. FPITs brought together individuals whose major responsibilities were represented at all points along the supply-demand continuum. By integrating supply *and* demand, they were able to provide opportunities for collaboration on such events as Family Planning Days where activities to increase demand were reliant upon a ready supply of methods. Similarly, ensuring supplies at recent family planning film shows enabled distribution of 22,488 condoms.

CHALLENGES

The FPITs have made many positive contributions to the UCSP, but using this multi-sectoral team approach has also posed some challenges. Foremost among them was ensuring that the project budget was sufficiently flexible to incorporate the new ideas that FPITs generated. If a community-based leadership approach is to succeed, financial constraints cannot be allowed to derail the community's best ideas and recommendations. As the UCSP project director noted, "You need to be careful what you ask for. When the community comes up with an idea, you want to follow through with it, but there may not be enough money."

The most dramatic instance in the UCSP occurred when the FPITs recommended that two FP-CHWs be trained in each parish, more than in UCSP's original plan and budget. Because both FPITs so strongly favored this idea, MIHV made budget reallocations to implement it.

LESSONS LEARNED

- *Multi-sectoral teams boost creativity, idea generation, community ownership, and advocacy power.* In combination, FPIT members representing different sectors of the community and district offer greater problem-solving abilities than they could individually. As one FPIT member said, "It's the ideas. More heads are better than one." Team members feel a sense of solidarity and community ownership. They expect that the positive experience of working together will be sustained over time to enhance family planning and perhaps address other health challenges in their district. The FPITs have also discovered that they are more likely to succeed when they advocate as a group to the district health office for more resources or adherence to a policy than if one member advocates alone.

- *A system for following up on recommendations should be established within the team.* An FPIT's good ideas are only valuable if someone is responsible for ensuring that they are implemented. For example, when some members argued for inviting a politician and a religious leader to join the Mubende FPIT, no one took responsibility to follow through. The invitations were delayed for months.

- *FPIT membership must be balanced between stable, long-term members and emerging community leaders.* Membership in Ssembabule's FPIT has remained the same for a long time. While this contributes to stability it can also lead to complacency and a lack of new ideas. In contrast, Mubende is still deliberating on its FPIT's final membership roster. Therefore, the group is working to create a more coherent sense of its direction. One way to balance long-term and new members, as suggested by an FPIT member, is to base membership on one's position in the community rather than on personality. This would ensure some stability and some turnover as new individuals assume new roles in community sectors.

- *FPITs contribute to the formative evaluation at each step of the project.* The project director's meeting notes and quarterly reports contain a record of the FPITs' continuous learning: their successes and challenges, and how they have adjusted project activities and strategies accordingly. This record offers an initially unforeseen yet valuable contribution to the formative evaluation of implementation steps within the UCSP. For example, Family Planning Days were implemented after the Ssembabule CDO recommended that the UCSP reach more youth and men. Their success led MIHV to rework its project budget to allow for more Family Planning Days in more villages throughout the districts.

FPIT Stakeholders

RECOMMENDATIONS

MIHV's evidence to date strongly suggests that building sustainable community support for family planning is enhanced through use of FPITs and community ownership of the FPIT process. While team memberships and duties should be tailored according to each location and its situation, each FPIT should include a cross-section of stakeholders and should meet regularly. Flexibility and follow up are vital to maintaining interest and enthusiasm.

[i] Uganda Bureau of Statistics (UBOS) and Macro International Inc. (2007). *Uganda Demographic and Health Survey 2006*. Kampala, Uganda and Calverton, MD: UBOS and Macro International Inc.

[ii] Disease Control Priorities Project. (2007). *Why contraception is a best buy: Family planning saves lives and spurs development.* Accessed March 2008 at www.dcp2.org/.

[iii] All data in this paragraph from UBOS's *Uganda Demographic and Health Survey 2006*.

Written by:
Joän Patterson and
Minnesota International
Health Volunteers Uganda

Edited by:
Catherine Toth and
Macro International Inc.

Photos by:
Philip Bowen, Sarah Schewe
and Minnesota International
Health Volunteers Uganda

Design by:
Macro International Inc.