



Family Planning Case Study



Uganda Family Planning Programs: Lessons from the Field

*Partnering with Communities
and District Health Teams*

October 2004



**Minnesota
International
Health Volunteers**

*in collaboration with
Adventist Development and
Relief Agency International*



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Minnesota International Health Volunteers (MIHV) is an international and domestic non-profit organization founded in 1979 whose mission is to improve the health of women, children, and their communities around the world. Its core competencies are: community mobilization, community health partnerships, research, evaluation, education, and training. MIHV has over 25 years' experience designing and implementing large-scale maternal and child health programs in Kenya, Nicaragua, Tanzania, Thailand, Haiti, and Uganda. MIHV is a member of the CORE Group.

The Child Survival Collaborations and Resources Group (**CORE Group**) is a membership association of more than 35 U.S. NGOs working together to measurably improve the health and well being of children and women in developing countries through collaborative NGO action and learning. Collectively, its member organizations work in over 140 countries supporting health and development programs.

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The CORE Group
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Acronyms

| | |
|--------|---|
| ADRA | Adventist Development and Relief Agency International |
| AIDS | Acquired Immune Deficiency Syndrome |
| AMREF | African Medical Research Foundation |
| BIHP | Bunya Integrated Health Project |
| CBO | community-based organization |
| CORE | Child Survival Collaborations and Resources Group |
| DHS | Demographic and Health Survey |
| DISH | Delivery of Improved Services for Health |
| FP | family planning |
| HIV | Human Immunodeficiency Virus |
| IEC | information, education, and communication |
| IUD | intra-uterine device |
| KPC | Knowledge, Practice and Coverage Survey |
| LAM | lactational amenorrhea method |
| MIHV | Minnesota International Health Volunteers |
| MOH | Ministry of Health |
| NGO | nongovernmental organization |
| PATH | Program for Appropriate Technology in Health |
| PVO | private voluntary organization |
| TASO | The AIDS Support Organisation |
| TBA | traditional birth attendant |
| UDHS | Uganda Demographic and Health Survey |
| USAID | U.S. Agency for International Development |
| UNICEF | United Nations Children's Fund |

Contents

| | |
|--|----|
| Executive Summary | 1 |
| Project Context: Uganda | 4 |
| MIHV Project: Ssembabule District | 6 |
| MIHV: Approaches | 7 |
| MIHV: Results | 11 |
| MIHV: Lessons Learned | 12 |
| ADRA Project: Iganga District | 17 |
| ADRA: Approaches | 17 |
| ADRA: Results | 20 |
| ADRA: Lessons Learned | 20 |
| Conclusion | 22 |
| References and Key Documents | 23 |
| Tables | |
| Table 1: Community Health Volunteers and Health Unit Staff Trained by MIHV in Ssembabule District | 9 |
| Table 2: Health Unit Staff Trained by ADRA Staff to Address Family Planning Issues | 18 |
| Table 3: MIHV and ADRA Projects: Results Summary | 21 |

Executive Summary

This case study focuses on the family planning (child spacing) efforts of two U.S. private voluntary organizations (PVOs), each of which doubled modern contraceptive use in rural areas of Uganda. Minnesota International Health Volunteers (MIHV) implemented family planning activities in Ssembabule District, a rural southwestern district in Uganda, during the second phase of a U.S. Agency for International Development (USAID)-funded Child Survival Project (1993–2000). The Adventist Development and Relief Agency's (ADRA) Bunya Integrated Health Project (BIHP) implemented activities in two predominantly Muslim sub-counties of Bunya county during a Danish International Development Agency-funded Child Survival Project, ongoing in the Iganga District in southeast Uganda (1998-2006).

Both the MIHV and ADRA projects addressed family planning within the larger context of reproductive and maternal health using a multisectoral community/participatory approach. Both organizations used a variety of strategies to educate women of reproductive age, adolescents, and sexually active men with the objective of increasing the use of modern contraceptives in their designated districts. Working with a variety of stakeholders including communities, district health units, local officials, community volunteers, and at times medical and nursing students (in the case of MIHV), both organizations forged partnerships and used *five principal strategies* to increase family planning use and to lower rates of infant, child, and maternal mortality and morbidity. MIHV and ADRA:

1. **Expanded service delivery** by enabling a range of providers (public sector, private sector, community volunteers, and medical/nursing students) to deliver family planning information, referrals, and services;
2. **Educated and mobilized communities** to increase demand for, and use of, family planning services;



Both MIHV and ADRA mobilized rural communities to increase demand for, and use of, family planning services.

3. **Built the capacity of health unit staff** to mobilize communities, supervise health workers, establish systems, create realistic budgets and plans, and (in the case of ADRA) assist with clinic rehabilitation and equipping;
4. **Collaborated with other PVOs**, agencies, and stakeholders to leverage resources and increase access to family planning services; and
5. **Developed innovative information, education, and communication methods** to deliver family planning messages to low literate populations and assisted with material support such as bicycles and provision of handbags.

As a result, mothers' knowledge of modern family planning increased significantly. For **MIHV**, project interventions contributed to the following changes, as noted by Knowledge, Practice and Coverage (KPC) Survey results between 1996 and 2000 for women of childbearing age with a child under 24 months, in Ssembabule District [sample size=300]:

- Modern contraceptive use among women of reproductive age increased from 6% to 14%.
- Use of any family planning method more than doubled, from 10% to 22%.
- Contraceptive use among women who did not want a child in the next two years doubled, from 24% to 47%.
- Reported pregnancies declined by more than one-third (from 16% to 10%).
- The number of non-pregnant women wanting a child within the next two years fell by 9%.
- Condom use by male partners increased from 0% to 11%.

Similarly, project interventions by **ADRA** resulted in the following results, for a population of 100,000:

- Among women of childbearing age, awareness of family planning more than doubled, from 30% in 1999 to 73% in 2004.
- The contraceptive prevalence rate increased from 11% in 1999 to 23% in 2003;
- There was increased demand on the part of the community for outreach, parish health days, and health talks.
- Twice as many patients sought information about family planning at sub-county health units.

As a result of direct community-based involvement using an integrated approach, each organization learned many important lessons. **MIHV's** lessons learned include:

- Project activities sparked positive social change, which in turn facilitated family planning uptake.
- The Catholic Church provided strong support for natural family planning methods.
- Natural family planning can offer an effective entry to other short-term and long-term family planning methods.
- There is a strong unmet demand for the female condom.
- Traditional birth attendants (TBAs) are an essential family planning resource.

- TBA performance in relation to family planning can be enhanced with strong support.
- TBAs can be trained to include family planning in postpartum care.
- Private outlets can be quickly mobilized to become major suppliers of condoms.
- Nursing and medical students can contribute to community health programs and to family planning activities in particular.
- Decentralization offers both opportunities and constraints for community-based public health programming.
- A comprehensive, integrated approach can improve individual child survival interventions.

ADRA's lessons learned include:

- The public sector cannot meet the demand for contraceptives.
- Per diems can contribute to the cooperation of extension staff.
- Joint planning and budgeting between a PVO and local authorities can improve resource utilization.
- Community volunteers should be certified.
- Community groups can greatly aid project implementation.

This study presents strategies, approaches, activities, and lessons learned as a learning model for other PVOs, government entities, and community members as they work to develop successful family planning projects in similar resource-poor environments.

Project Context: Uganda

In Uganda, women have shown a high level of awareness regarding family planning options. In the 1995 Uganda Demographic and Health Survey (DHS), virtually all women (92%) could name at least one family planning method, and a large proportion (79%) reported that they approved of contraceptive use. More than two-thirds of women (69%) wanted to either space their next birth or end childbearing altogether. Despite this interest, only 15% of married women were using a contraceptive method, and only 8% used modern methods (as low as 5% in rural areas).

Periodic abstinence, the pill, and injectables were the most common modern methods used, with condom use at less than 1% in rural areas. In 1995, MIHV found that only 10% of women in Ssembabule District were using any contraceptive method, and only 6% were using modern methods. The most common methods in the district were the lactational amenorrhea method (LAM)¹; injectables, and periodic abstinence. There was almost no reported condom use.

According to the 1995 DHS, Uganda's total fertility rate was 6.9 (7.2 in rural areas), and the desired number of children in rural areas was 5.5 for women and 5.8 for men. Frequent and closely spaced childbearing is associated in Uganda, as elsewhere, with increased mortality and morbidity for both mothers and their children, a circumstance compounded in Uganda by inadequate maternal care. In 1995, Uganda's maternal mortality rate was reported at 527 deaths per 100,000 live births. The 2000 UDHS lists an under-5 infant mortality rate of 152, an increase over the 1995 under-5 rate of 147.

Teenage girls and their children are at special risk of mortality and morbidity. Women in Uganda on average begin sexual activity by the age of 16, and 43% of women aged 15–19 are already mothers or are pregnant with their first child (45% in rural areas) (UDHS 1995).

Given such statistics, family planning professionals often struggle to bring family planning services to rural women and couples who want to space or limit childbearing. There are numerous social, institutional, and logistical factors that inhibit women's access to and use of modern contraceptive methods including:

- Family planning is rarely at the top of a community's list of priority issues given economic realities and educational levels;
- Women, their partners, and other family members often have misconceptions about the safety and efficacy of modern methods²;

The available methods of family planning in Ntusi are visible (condoms, pills), so women find it problematic to hide them from their husbands.

— *Ntusi Focus Group*

1. The 1995 UDHS did not ask women about LAM use.

- Those who wish to use a modern method may believe that family or community members would oppose contraceptive use;
- Those who decide to use family planning often find services difficult to access;
- Health centers are few and far between, and health professionals are overstretched and often unable to focus adequate effort on family planning;
- Logistics systems are underdeveloped, leading to frequent contraceptive shortages, and the private sector often has no incentive to invest in the provision of contraceptives;
- When women ask men to use condoms, the women are often viewed as promiscuous, or the men perceive that the women think they are “dirty” (from MIHV key informant interview); and
- Local women do not like to use foam or cervical caps as they are unaccustomed to inserting things inside themselves (tampon use is nonexistent) (from MIHV key informant interview).

When projects manage to increase contraceptive use in rural Uganda, it is essential that they document their efforts and disseminate both lessons learned and data-based results. This case study was commissioned by the CORE Group to provide such information.

2. It should be noted that the term “child spacing” was used by MIHV in Uganda rather than the term “family planning” since some community members interpret the term family planning to mean preventing the population from having children. In Uganda “Entegeka ya maka” literally translates as a plan for the home, which has a more positive connotation for rural Ugandans.

MIHV Project: Ssembabule District

Ssembabule is an underserved, rural district approximately 170 kilometers southwest of the capital city, Kampala. The district's 2,500 square kilometers are home to approximately 160,000 people (including 30,900 women of reproductive age) living in 270 villages. At the time of the MIHV project (1996-2000), the district had limited infrastructure, no telecommunications system, no electricity, poor roads, and poor water supply. Nomadic pastoralists inhabit the low-lying grasslands of Ssembabule's northwest, while agriculturalists dominate in the southeast. The languages most commonly spoken are Luganda and Runyankole. The literacy rate for women at the time was 57% (MIHV KPC 1996).

Formerly a sub-district of Masaka District, Ssembabule became its own district in 1997, shortly after the second phase of MIHV's project began. Little capacity building had taken place to prepare Ssembabule, or its new district officials, for decentralization. Because of Ssembabule's remote location and undeveloped infrastructure, officials had great difficulty filling critical staff positions. This, in turn, adversely affected the district's ability to formulate plans, establish systems, provide services, and supervise workers.

*Ssembabule District,
Uganda, is located
170 km southwest
of Kampala.*



The central government did not have sufficient funds to help the fledgling district build its capacity or develop its physical infrastructure. With decentralization, Ssembabule was expected to generate its own revenue, but the new district had little tax base.

In 1996, the health system, though progressing, needed much improvement in terms of service availability and quality of care. The population was served by one government health center staffed mainly by midwives and nurse aides; five sub dispensaries (including two nongovernmental facilities run by the Catholic Church); and numerous TBAs, traditional healers, community-based distributors, and drug vendors. Altogether, only 25 trained health care staff cared for approximately 160,000 people without the assistance of an emergency room or hospital. As noted above, family planning use in Ssembabule was low—lower even than in the country as a whole.

MIHV: Approaches

Expand Service Delivery

At the time of the family planning project, MIHV was the only international PVO in Ssembabule District. At the project's onset, public and private sector health workers were woefully overstretched since there was only one health center serving a population of approximately 160,000 people. The ratio of health care workers to district residents was estimated at 1:1,644. To increase client access to family planning information and services, it was necessary to upgrade health worker skills, and to train an additional group of volunteer community workers to provide family planning counseling, referral, and in some cases, methods.



Traditional birth attendants in Ssembabule use picture cards to discuss possible complications of labor.

To accomplish this, MIHV created six Family Planning Implementation Teams (which consisted of a health unit staff member, MIHV's Maternal Health Coordinator, the MIHV Health Educator, and a community volunteer, such as a TBA). After receiving training from MIHV's Country Director and select family planning experts, the family planning teams were responsible for training, raising awareness, mobilizing communities, and imparting leadership skills.

The teams involved community leaders in all local advocacy activities. They used participatory rural appraisal methods to identify community health programs and to begin family planning program planning. The result of these advocacy efforts was a marked decline in opposition to modern family planning by religious and political leaders. Table 1 (page 9) lists the community health volunteers and health unit staff trained by MIHV project workers to address family planning issues in Ssembabule District.

To improve both access to and quality of family planning services, it was important to build service capacity and develop systems to support the delivery of those services. Consequently, each training included a section on tracking referrals, recording supplies, basic recordkeeping, and reporting.

Educate and mobilize communities

MIHV involved communities in program design, implementation, and evaluation, always using a grassroots, rather than a top-down approach to ensure that communities “owned” family planning project objectives, processes, and outcomes. By involving the communities in all aspects of the projects (project needs assessments, planning, monitoring and evaluation, leadership sensitization, educational events, interpersonal communication and counseling), as well as through increased service availability and visibility, the project team raised community awareness of the importance of spacing children. In Bunya District, parish development committees shared information collected through village record books and on large hanging boards, so communities could use these data for decision-making in community meetings.

Build the capacity of health unit staff

MIHV focused on building capacity of health unit staff to mobilize communities, supervise health workers, establish systems, and create responsive budgets and plans. Activities included hands-on technical assistance and incorporating district health staff in family planning project trainings.

Because Ssembabule was unprepared for the redistricting that took place during the child survival project, MIHV was called upon to provide critical support beyond what otherwise might have been required. MIHV staff offered continuous technical assistance and support to the newly formed five-person District Health Management Team, which was never fully staffed during the project period.

The MIHV project team:

- *provided technical assistance and training to district and clinic staff in health topics including primary health care and family planning, and in community mobilization and adult training methods;*
- *linked district staff to communities, community providers, and nongovernmental health units (for example, arranging introductory visits to key community partners, bringing district staff to meet TBAs in their homes or drug vendors in their shops, including district staff in teams that supervised community volunteers, and bringing volunteers to visit clinics);*
- *provided essential logistical support for district management and health service provision such as the use of MIHV’s vehicles for mobilization efforts; and*

Traditionally, men believe that if you have more children, you are considered an important person in the society.

— *Lwebitakuli*
Focus Group

- *contributed as members of the district planning team* to the creation of District Health Plans and annual budgets, as well as to proposals submitted to the central ministry. In this final capacity, MIHV helped gather data, facilitated meetings, contributed expertise and its knowledge of community needs and priorities, and assisted in the production of plans and proposals.

Table 1. Community Health Volunteers and Health Unit Staff Trained by MIHV in Ssembabule District

| Community volunteers trained through the project | Total trained |
|---|--------------------------|
| Traditional birth attendants: TBAs were trained by the project primarily on family planning, safe motherhood, nutrition, breastfeeding, immunization, STDs/HIV/AIDS, but also on malaria during pregnancy (risks and treatment). | 200 |
| Drug vendors: The project's training curriculum for drug vendors focused primarily on family planning methods and malaria, and provided stocks of condoms for these private sector providers. | 167 |
| Health unit staff: The project worked in close collaboration with government and non-governmental health unit staff to strengthen family planning services, providing yearly skill upgrades and involving health unit staff in supervision and monitoring of TBAs, drug vendors, and community-based distributors. Skill areas included modern methods, community mobilization, and condom negotiation. | 25 |
| Student doctors and nurses: The MIHV project was a field site for nursing students from the Comprehensive Nursing Training Center in Masaka and for young physicians from the University of Science and Technology in Mbarara. They obtained a practical introduction to village-level primary health care through the project. Nursing students joined family planning teams contributing their skills when possible. Medical students also provided their skills. Each medical student was assigned to work with a community to identify and address a major health problem. | 200 nurses 75 doctors |
| Community-based distributors: The project identified and trained community members to distribute condoms to bar and lodge attendants as well as to set up kiosks in all major markets throughout the district. These kiosks sold condoms and could sell oral contraceptives provided by MIHV/DISH (Piplan), if customer had already been seen by a clinical health provider. | 90 |
| Nun/Natural Family Planning Specialist: Worked with MIHV project staff and discussed natural family planning methods with interested community members and conducted referrals. | 1 natural FP specialist |
| Peer educators: Volunteers based in primary and secondary schools counseled peers about family planning, and HIV/AIDS and sexually transmitted infection prevention through dramas, music and poetry. Peer educators were part of 95 school health clubs established by the project. | 280 |
| Members of women's groups: About 40 women's groups were formed and trained mainly on income generation activities (e.g., goat rearing, book keeping, management), but also on basic home health education. | 400 |
| Professional Associations: MIHV project staff nurtured the development of professional associations, one for TBAs and one for drug vendors. | 2 CBO organizations |

Collaborate with other PVOs, agencies, and stakeholders

MIHV collaborated with the Uganda National Family Planning Association, the Ministry of Health (MOH), the African Medical Research Foundation (AMREF), UNICEF, the World Health Organization (WHO), the Ministry of Education, local government units, Lions Aid/Norway, Marie Stopes International, The AIDS Services Organization (TASO), and the USAID-funded DISH project. It also collaborated closely with all local groups including farmers, women's groups, TBAs, school and youth groups, and the Catholic Church. In addition, MIHV provided more than a dozen student field placements for Master's degree students from the United States.

One collaborative effort between MIHV and DISH II made high-quality condoms and pills more available in the district. DISH II did not have the resources to establish an office in Ssembabule, so did much of their work in the district through MIHV. DISH II used MIHV's office as a base and relied on MIHV's vehicles, logistical support, training site, and sometimes staff to conduct trainings or upgrade health units. MIHV served as a storage and distribution point for community-based distribution agents and drug vendors in the district, reporting to DISH II on commodities distributed.

Another major MIHV collaborative partner was the Catholic Church, which was highly influential in the district. At the time, the Church supported condom use for disease prevention but not for child spacing. MIHV had an excellent relationship with a nun well-trained in natural family planning, who advocated for project objectives, designed and taught a natural family planning component that was included in all family planning trainings, and referred clients, when appropriate, for modern methods.

Collaboration also occurred upon completion of the child survival project. MIHV raised additional funds from donors including the Government of Uganda, the World Bank, World Vision and the CORE Group (for polio eradication efforts), the Scandia Foundation, and PATH/Canada (for micronutrient education).

Develop innovative information, education, and communication methods

MIHV developed a number of communications strategies to deliver family planning messages to low literate populations. Community volunteers counseled clients on key **messages** including: (1) *child spacing is important for the health of the mother and well-being of the family*; (2) *family planning decisions should be made by both partners together*; (3) *fewer children means more resources for the family*; and (4) *family planning methods are safe and effective*.

MIHV family planning teams held **special events** (e.g. Child Health Days, World Health Days) in conjunction with local clinics. Events used games, dramas, songs, and contests to raise awareness. One drama featured a man whose wife spaced her children, explaining to the husband of a woman who did not space her children, how they had discovered the benefits of modern methods, how modern methods allowed them to choose when to have children, and how happy their family was as a result. Because caretakers were busy and often traveled great distances to attend, the project ensured that even "single-issue" events always provided information and services for other health issues, including family planning. As a result, these events were extremely popular.



MIHV helped establish 95 school health clubs to inform the community about family planning, HIV/AIDS, and sexually transmitted infections.

The MIHV family planning team also utilized and adapted **educational materials** to increase awareness of family planning (e.g., calendars, posters, pamphlets, songs, dramas, and flipcharts). When appropriate, it also made use of materials developed by the MOH and other USAID-funded projects.

In developing materials, the project used traditional folklore and local knowledge to ensure relevant messages. One poster (adapted from existing educational materials) reminded farmers that to have a healthy banana plantation they needed to limit the number of sprouts; to have a healthy family, they needed to space their children. As virtually everyone grew bananas, the message was immediately understood and widely accepted. Referral information was printed on the bottom of the poster; and materials were distributed at events, to community volunteers, in drug shops, in clinics, and directly to clients.

MIHV: Results

Family planning activities were monitored and evaluated through baseline (1996) and end-of-project (2000) KPC surveys implemented with 300 women, service provider records, and clinic service statistics. Major family planning results included the following:

- The use of modern contraceptives (pills, injectables, IUDs) among women of reproductive age increased from 6% in 1996 to 14% in 2000.³
- Use of any family planning method more than doubled, from 10% to 22%.
- Contraceptive use among women who did not want a child in the next two years doubled, from 24% to 47%.
- The increase in overall family planning method use could be entirely attributed to increased use of modern methods. The overall use of traditional and natural methods remained constant among women surveyed, while the use of a particularly ineffective method—periodic abstinence—decreased from 23% to 0% of all family planning users.

3. Modern methods here include injectables, pills, condoms, tubal ligation, and the IUD. None of the women surveyed currently used vasectomy, diaphragm, female condom, or foam/gel to prevent pregnancy. LAM was not considered a modern method by the 1995 UDHS or by MIHV's KPC survey. MIHV later conducted a pilot project with the female condom.).

- Reported pregnancies declined by more than one-third (from 16% to 10%).
- The number of non-pregnant women wanting a child within the next two years fell by 9%.
- Condom use by male partners increased from 0% to 11%.

The most popular modern method was the injectable, in part because women could use it without their husbands' knowledge, followed by pills and condoms. Condom use may be underestimated, however, as women who used condoms for disease prevention may not have reported using them for family planning purposes. Still, more than half of those pregnant in 2000 had not planned their pregnancies. In citing reasons for not using family planning methods, one-third of women cited husband refusal, one-third said they "did not know" about family planning, and one-third cited "other" reasons. Religious belief was not a significant factor in non-use.

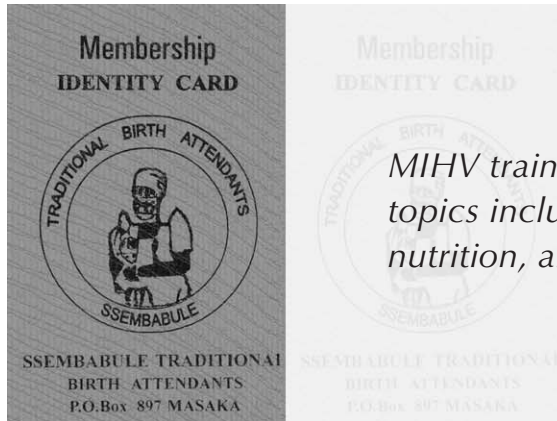


MIHV team members interviewed village mothers as part of the project's data collection efforts.

MIHV: Lessons Learned

- **Decentralization offers both opportunities and constraints.** Redistricting in Ssembabule happened quickly and without adequate training, staffing, or infrastructure development. In a very real sense and for a substantial period of time, the provision of basic health services was threatened. But decentralization also brought unexpected opportunities. Because MIHV was the first and only international PVO in the district, and had built trust during the four years of the project's first phase, communities were receptive to project messages and activities. Also, because the area was unaccustomed to the exercise of power, its emerging leaders, many with ties to the project, had not yet been jaded by it: they were often enthusiastic and idealistic. The project had an opportunity, therefore, to influence both communities and their leaders just as they were beginning to assume greater responsibilities.
- **A comprehensive, integrated approach can improve individual child survival interventions.** To address Ssembabule's many needs, the project focused on multiple child survival interventions (maternal health/family planning, diarrhea, immunization, breastfeeding, nutrition, malaria, and HIV/AIDS). This comprehensive approach allowed interventions to be linked in an efficient and responsive way. For example, a TBA trained in postpartum care could also discuss family planning and immunization

with a new mother. Preparing community volunteers to respond to the broader health care needs of their communities improved the project's success with individual child survival interventions and may also have yielded greater openness to interventions seen as lower priority, such as family planning.



MIHV trained 200 traditional birth attendants in topics including family planning methods, nutrition, and immunization.

- **Project activities sparked positive social change which in turn facilitated family planning uptake.** According to focus group discussions, project activities contributed to increased communication about sexuality between men and women. This type of dialogue was critical. As the DHS 1996 Negotiating Reproductive Outcomes study noted, only about one-third of men and women in 1995 reported having discussed family size or child spacing with their partners, even though more than 90% of rural respondents knew of at least one modern contraceptive method. DHS and MIHV researchers learned that both men and women assumed their partners wanted more children than they actually did. In a culture where large families are the norm and couples do not traditionally talk about such matters, lack of communication is an important family health problem. MIHV found that providing couples with a forum for discussing family size quickly dissipated this culture of silence. Conventionally excluded from the process, the men appreciated being part of the family planning conversation, learning how an entire family's well-being might improve with better spaced children, and discussing options with their wives.

Project activities also contributed to greater empowerment of women. Women joined project-supported women's groups, assumed leadership positions as project-trained community volunteers, contributed cash income to their families earned through project-supported garden and goat projects, and with their new prestige, ran successfully for political office. With this new confidence, financial independence, and access to resources, many women felt increasingly empowered to learn about family planning and spacing their children.

- **It is possible to gain support for natural family planning methods from the Catholic Church.** The project gained credibility and responded to client needs by working with the Church at the district and local level. A nun specializing in natural family planning was heavily involved in

family planning training and advocating for the project. Building this relationship took time, but as a result, the Church did not obstruct project activities, and clients in every parish had access to modern and more effective natural family planning methods.

- **Natural family planning can offer an effective entry to modern family planning.** There is an unmet demand for natural family planning in the Ssembabule District as demonstrated by low modern family planning use, significant use of less effective traditional methods (e.g., periodic abstinence), negative attitudes toward family planning,⁴ and strong Church influence. To meet this unmet demand and to correspond with the guidelines on the rhythm method and LAM being issued by family planning and maternal/child health donors (e.g., the Uganda National Family Association, UNICEF, and USAID), MIHV included natural family planning in community volunteer and health worker trainings. Natural family planning education was provided by an expert representative of the Catholic Church. This program addition enabled couples with reservations about modern methods to still attempt to space their children, and the overall concept of child spacing became more acceptable.

One unexpected outcome of this activity was that men were competently educated by an unimpeachable source (the Church representative) on the complicated nature of natural family planning, as opposed to the perceived “easiness” of merely counting days. Stymied by the difficult and uncomfortable demands of natural family planning (e.g., intimate knowledge of woman’s body, tracking menstrual cycle, postponing desire until a “safe” day) men attending training sessions would often instruct their wives to find a more convenient, less meddlesome modern method to use instead. Unexpectedly, the introduction of natural family planning often led project participants to embrace modern family planning methods.

- **TBAs are an essential family planning resource.** Given proper training and support, TBAs greatly expand the accessibility of family planning information by providing referrals and services, and reinforce key family planning messages. To address the unmet need for family planning, TBAs provide antenatal care, perform deliveries, provide clinical postpartum care, and advise on natural family planning. Importantly, as trusted members of the communities, TBAs can efficiently carry out educational activities. MIHV discovered that both young and old TBAs were eager and able to learn new knowledge and skills.
- **TBA performance can be enhanced with strong support.** The family planning team educated TBAs in family planning, maternal health, safe delivery, HIV / AIDS prevention, immunization, nutrition and breastfeeding, malaria and diarrheal disease control, the objectives of community-based health care, community mobilization, and how to

Men should also be trained on family planning, because they are the very people who are polygamous.

— Lwemiyaga Trading Center Focus Group

4. For example, many were initially afraid that modern contraceptives would make women sterile. Some men felt that access to pills or injectables would lead their wives to become promiscuous and the husbands (particularly pastoralist husbands) might never know. The idea that Western powers were promoting modern contraceptives in order to limit Africa’s population was also not uncommon.

make referrals. Further, the Maternal Health Coordinator created simple, flexible record-keeping tools. For example, to enable older, low-literate, innumerate TBAs to track the number of deliveries and unusual delivery conditions, the project taught various counting systems. One system used colored stones, another hash marks on the wall, and another a simple pictograph-based tool. FP team members collected the data monthly.

The family planning team also fostered strong relationships between TBAs, clinic nurses, and clinic midwives. For example, MIHV involved clinic health unit staff in TBA training and quarterly supervision visits. TBAs visited clinics to check on referred clients and accompanied clients to clinics for follow-up care. Such ‘two-way’ feedback strengthened the referral system as TBAs continued to feel connected to and responsible for their clients.

- **Training TBAs in postpartum care can be an effective family planning intervention.** Based on lessons learned working with TBAs for eight years, MIHV believes that the most important responsibilities of TBAs are to provide clients with education, antenatal and postpartum care, and referral. Postpartum care is particularly important. It is through postpartum care that TBAs can most easily and effectively promote care for new mothers, postpartum family planning, breastfeeding, children’s immunization, nutrition, and appropriate care for childhood malaria and diarrhea.

At the onset of MIHV’s project, the few women who sought postpartum care sought it from trusted TBAs who lived close by. To utilize the current system, MIHV trained and supported TBAs to recognize danger signs in babies and postpartum mothers, to refer suspected problems, to promote immunization and optimal breastfeeding, and to counsel mothers about postpartum family planning options and child health. The project’s strategy of training TBAs to provide postpartum care was successful as evidenced by the large number of women who reported, in the project’s final survey, that they followed postpartum advice.

- **Private outlets can quickly be mobilized to become major suppliers of condoms.** Between 1996 and 2000, private vendors (e.g., drugstores, kiosks, bars) replaced family planning clinics as the primary supplier of condoms. Specifically, use of clinics fell by one third to one half, while use of these private sector outlets more than tripled to 50%. This shift is attributable to several factors, including: condom shortages at clinics, increased availability of condoms through project-supplied community-based distributors and drug vendors, greater convenience of private sector sources, DISH II promotion of drug vendors, and reluctance by men to buy condoms at public clinics. This transition is presumed sustainable because private-sector providers are all trained, marketing efforts popularized the product, customers are satisfied with product quality, and private sector providers recognize the incentives associated with increased demand in continuing to stock the products.
- **Nursing and medical students can offer much to community health programs.** The medical profession rarely emphasizes family planning or the development of skills in community health and outreach. Therefore, it is extremely valuable to involve nursing and medical students in

community health programs while they are still learning and receptive to new ideas. The MIHV project site served as a practicum site for 200 future nurses and 75 future doctors. These young professionals benefited from designing their own community education interventions, and their involvement greatly extended the availability of medical expertise for the underserved population of Ssembabule. Due to shortages of doctors and hospitals, the approximately 15 student doctors in the district represented the district's greatest medical expertise. The project facilitated an environment where young medical professionals could develop skills to be used in future careers as rural public health physicians and nurses. Their presence revitalized health unit staff, raising spirits and reducing overwhelming workloads. MIHV also served as the practicum field site for more than a dozen Master's degree students from the United States.



The MIHV project site served as a practicum for 75 Ugandan medical students.

Women may get worried that if they controlled child birth, their men might get other women with whom to produce.

— *Lwebitakuli*
Focus Group

- **There is a strong unmet demand for the female condom.** During the last six months of the project, Marie Stopes International asked MIHV to pilot the female condom in Ssembabule. MIHV was chosen as a partner because of its collaboration with DISH II, its status as the only PVO working in Ssembabule, its family planning experience, its reach at the community level throughout the district, and its clear commitment to improving the health of women and families in the area.

The MIHV team surveyed sexually active teenage girls in school about their needs and the potential acceptability of the female condom. Team members found surprisingly high interest and distributed approximately 2,000 female condoms. In a two-day training session, the family planning team introduced selected TBAs to the female condom and trained them in its cultural, physical, and financial aspects. The trained TBAs then distributed female condoms and educational materials (free of cost) to interested postpartum clients. Finally, the family planning team educated women leaders (e.g., women council members and members of Parliament) to advocate for the female condom. Through these activities, MIHV and Marie Stopes International discovered a strong interest in the female condom, as well as strong support for the condom among female leaders.

ADRA Project: Iganga District

In 1998, ADRA/Uganda partnered with the World Health Organization (WHO) and the Ministry of Health (MOH) to implement selective activities in Bunya County, Iganga District, in southeastern Uganda. The project, titled the Bunya Integrated Health Project (BIHP), targeted two sub-counties: Malongo and Kityerera. The target population included the total population in these two sub-counties, approximately 85,000 people. The project was planned in three phases over 8 years (1998 to 2001; 2001 to 2004; and 2004 to 2006) and is ongoing.

The project area is predominantly Muslim, and 92% of the households are polygamous. A baseline survey revealed that the number of people using family planning methods was small (10.7% compared to the national figure of 15.2%). The survey also found that the average household size was eight people. Sexual debut was found to be early (at 6–10 years old)⁵. Population growth was 3.5% (UDHS, 1995). Very few women (6%) who received antenatal care had their baby delivered by a health worker. As a result, morbidity and mortality both for women and children was very high.

Not unexpectedly, challenges in the district were numerous and included: a high level of poverty, long walking distances to the nearest health units, inadequately trained staff in the health centers, untrained TBAs delivering most of the babies in the villages (70% of all deliveries), ill-equipped health centers providing antenatal care services, and 90% of government health units housed in temporary and substandard premises contributing to poor service delivery. Much needed to be done to sensitize and strengthen community members through the existing local community systems such as Parish Development Committees, Health Unit Management Committees, Village Development Committees, and health unit staff.

In 2000, Bunya County became an independent district called Mayuge but retained the project area under its constituency. According to the 2002 population and housing census, Mayuge District has a population of 326,839, of whom 20% are children under five and 23% are women of childbearing age. The district's fertility rate is 7.2 as compared to the national figure of 6.9. The infant mortality rate is 125/1000 (national figure 97/1000) and the maternal mortality rate is 506/100,000. The under-five mortality rate is 208/1000 compared to the national figure of 147/1000 (Mayuge District Situational Analysis Report 2001).

5. The 1998 BIHP baseline survey found that age of sexual debut was 6-10 years among both boys and girls. Reasons for early debut included: 1) a community housing structure (i.e., no separation of parents' bedroom from that of the children) that exposes young children to sexual activity and leads to imitation of parents' behavior; 2) regional cultural norms that encourage young boys to "explore and test their manhood"; and 3) high levels of school absenteeism among young girls, which contribute to vulnerability to coerced sex or sex with older boys for economic gain.

ADRA: Approaches

Educate and mobilize communities

ADRA uses a multisectoral approach in Bunya County, integrating family planning activities into a variety of other programs (nutrition, literacy, income generation, and water/sanitation). The project has sensitized and trained a variety of community members, especially women of childbearing age (estimated at 27,000) about the importance of family planning through parish development committees, functional adult literacy classes, income generation activities, and other community groups. Manuals containing these messages are used as textbooks. Educational activities are integrated with establishing community contraceptive distribution systems through 29 trained community-based reproductive health workers. All community health workers are attached to the nearest health unit, through which BIHP channels all services.

Table 2. Health Unit Staff Trained by ADRA Staff to Address Family Planning Issues

| Health Unit Staff Trained | Total Trained |
|---|--|
| Midwives trained in basic family planning clinical skills for 30 days.* | 8 midwives |
| Nursing Assistants educated as nurse-midwives for 2.5 years to improve the quality of service delivery in health units.* | 8 nursing assistants trained as nurse midwives |
| Nursing Assistants trained in comprehensive nursing skills for three months to improve the quality of service delivery.* | 6 nursing assistants |
| Community workers, district and sub county health officials, and health unit staff educated in participatory methods and community mobilization.** | 29 reproductive health workers 38 TBAs 420 Parish Development Committee members 55 functional adult literacy instructors 13 sub-county trainers 21 sub-county Enterprise Management Committee Members 100 model farmers 20 sub-county officials 28 district health staff 56 health unit management committee members for eight health units |
| Community-based reproductive health workers educated to carry out community education, home visiting, counseling, distribution of contraceptives, and referral. | 29 community-based reproductive health workers |

*Training included: rationale for family planning, correct use of family planning methods, use of family planning/maternal health service delivery guidelines, client education, anatomy/physiology, integrating reproductive health services including antenatal and post-natal care, treatment of sexually transmitted infections, client counseling on informed choices, managing family planning side effects, client screening, and using a syndromic approach to manage sexually transmitted infections/HIV/AIDS.

** TBA training included: client history-taking, physical examination, mother screening and referral to health units for family planning services and maternal health, and use of the Lactation Amenorrhoea Method. Community-based health worker training included: rationale for family planning, client counseling on informed choices, client education, home visits and follow-up, client screening and referral to health units, and anatomy/physiology. Training sessions also addressed the benefits of family planning services in relation to general community development, family development, and economic growth.

Build the capacity of health unit staff

ADRA works closely with health unit staff by funding training in basic family planning skills through the district and the MOH. Table 2 lists those staff trained by ADRA through BIHP's first two phases.

To improve support systems for family planning, ADRA trained personnel in support supervision and assisted the District Medical Office to establish a supervision system. The project team also linked community distributors with the nearest clinic for monitoring, supervision, contraceptive supply, referral, and reporting; and trained community workers and groups in monitoring and data collection. ADRA assisted health unit staff by rehabilitating and equipping eight health units for family planning service provision, and created eight bicycle stretchers or "bicycle ambulances" for transporting sick people to health units.

ADRA and health unit staff also collaborated on monitoring and evaluation. The health unit staff and the BIHP family planning coordinator use a monthly family planning appointment card and a monthly monitoring family planning client card to collect information, then present monthly monitoring and evaluation reports to BIHP and ADRA-Uganda. Community reproductive health workers present monthly reports on the number of homes visited, the number of mothers referred for antenatal care, the number of family planning and information, education and communication sessions given, and materials requested by the community. In addition, BIHP, ADRA-Uganda and ADRA-Denmark review the project annually. This is followed by an impact assessment and evaluation every three years.

In terms of supervision, the district has given health unit staff responsibility to supervise community-based health workers and traditional midwives. They hold quarterly meetings to plan and review community activities. The district pays for transport to and lunch during these meetings. In turn, health unit staff are supervised by the district and BIHP intervention coordinator.

Collaborate with other PVOs, agencies, and stakeholders

ADRA has collaborated with many community partners on its family planning initiative. These include the Government of Uganda (Ministries of Health, Gender, Labour and Social Development, and Uganda AIDS Commission), the district health office, local governments, Marie Stopes/ Uganda, the Family Life Education Project, the Program for Enhancing Adolescent Reproductive Health, local youth and women's groups, school and farmer groups, and faith-based groups. ADRA/Uganda also coordinated visits to its project site by other PVOs including Concern International, CARE Uganda, and Save the Children UK. In addition, they facilitated student placements from Busoga and Makerere Universities, as well as students from Sweden and Denmark.

ADRA collaborated with Marie Stopes International to improve the method mix available in project sub-counties. The district medical office provided pills, injectables, and condoms to area health units, but prior to ADRA's activities, health units could not provide longer-term and permanent methods. Together with communities and district health officials, the project was able to arrange for Marie Stopes International to conduct monthly outreach visits to each project sub-county, providing both Norplant and

voluntary surgical contraception. Within a period of eight months, 52 clients had received Norplant inserts, 54 had received tubal ligations, and 1 had received a vasectomy.

Marie Stopes now offers two outreach sessions every month (one in each sub-county) providing permanent methods. Before Marie Stopes collaborated with the ADRA project, ADRA had transported couples interested in long-term surgical contraceptive services to Jinja Town, 80 kilometers away. This approach proved unsustainable with conflicting vehicle schedules and high transport costs.

Develop innovative information, education, and communication methods

ADRA has sensitized and mobilized the Bunya County community and conducted outreach sessions to raise awareness of family planning activities. The team has used educational dramas and videos, conducted project staff home visits, and used satisfied clients as family planning “witnesses.” Parish Health Days provided family planning referrals, and dramas, presentations, and testimonials were also used. The project team also held multisectoral “model home” competitions, which integrated education regarding hygiene, energy-saving devices, agriculture, and family planning. Family planning messages were incorporated into literacy materials and income-generation training.

ADRA provided material support to reproductive health workers and other community actors (listed in chart, page 17), who were provided with more than 100 bicycles, more than 600 handbags, family planning client cards, referral forms, report forms, communication materials, brochures, and posters. These materials successfully increased both family planning awareness and client motivation to obtain family planning information.

ADRA: Results

- Among women of childbearing age, awareness of family planning more than doubled, from 30% in 1999 to 73% in 2004.
- The contraceptive prevalence rate increased from 11% in 1999 to 23% in 2003.
- The number of family planning counseling sessions in sub-county health units doubled, showing an increased demand (from 10% in 1999 to 24% in 2003) (BIHP Quarterly Summary Report).
- There was increased community demand for outreach, parish health days, and health talks.

ADRA: Lessons Learned

- **The public sector could not meet demand for contraceptives.** Even with ADRA’s contraceptive contribution, the district did not have enough supply to meet rising demand for methods. This was due to underestimates by district staff, delay of distribution due to transport problems, and periodic shortages of supplies at national stores.
- **Per diems contribute to extension staff cooperation.** It was rather difficult to involve extension staff in the field without the provision of per diems. Such provision greatly increased cooperation.

- **Joint planning and budgeting between a PVO and local authorities can improve resource utilization.** This is especially true at the district and community levels. Since planning emphasizes community-defined needs, resources are focused on community priorities. Also, joint planning and budgeting eliminates duplication of services and allows for more rational government contributions to PVO efforts. Finally, joint planning and budgeting can familiarize local authorities with the efforts and value of community volunteers. When the PVO project phases out, governments may be more inclined to include volunteer support and incentives in their budgets.
- **Community health volunteers should be certified.** Since overburdening scarce trained health workers is a concern, PVOs should advocate for certification of community health volunteers, eventually lobbying that such workers be formally recognized by the government.
- **Establishment of community-based organizations helps break down barriers and aid in project implementation.** After training and dialogue, it is helpful to encourage communities to form associations (e.g., youth groups, income generation associations) that can register with the district to turn into community-based organization (CBOs). CBOs can (1) help maintain and consolidate project achievements; (2) be used by local governments to channel funding for community health activities; and (3) lobby with local authorities on behalf of their constituencies. These CBOs help maintain the achievements of the project after project completion and can be used by the local government as channels through which funds to run community health activities can be funneled.

Table 3. MIHV and ADRA Projects: Results Summary

| MIHV Project (1996–2000) | Result |
|--|---|
| Use of modern contraceptives, women of reproductive age | Increased from 6 % to 14 % |
| Use of any family planning method | Increased from 10% to 22% |
| Contraceptive use, women who did want children in next 2 years | Increased from 24% to 47% |
| Reported pregnancies | Declined from 16% to 10% |
| Condom use by male partners | Increased from 0% to 11% |
| ADRA Project(1999-2004) | Result |
| Awareness of family planning, women of childbearing age | Increased from 30% (1999) to 73% (2004) |
| Contraceptive prevalence rate | Increased from 11% (1999) to 23% (2003) |

Conclusion

In many resource-scarce environments, fertility is high and contraceptive use is low. There are numerous social, institutional, and logistical factors that inhibit women's access to and use of modern contraceptive methods. Given this reality, it is often necessary to involve an array of partners and expand service delivery by training and motivating not only traditional health care providers but also community workers to deliver family planning information, referrals, and services.

Both MIHV and ADRA reached project objectives by educating and mobilizing communities to increase the demand for and use of family planning services. This was accomplished by involving communities in program design, implementation, and evaluation, and by using a grassroots rather than a top-down approach. Building the capacity of health unit staff and collaborating with multiple stakeholders led to successful outcomes.

Successful replication and/or scale up to the national level will require greater coordination and partnerships among NGOs and PVOs active in Uganda, as well as close collaboration with District Health Teams and the MOH. Both MIHV and ADRA played essential roles in the provision of family planning services by bridging the gap between communities and health units, sharing their reproductive health expertise while learning from their host country partners, transferring lessons learned from other projects, and modeling best practices in community health to raise awareness about family planning and decrease unintended pregnancies.

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