



Uganda Protestant Medical Bureau increases contraceptive method choice and uptake of family planning services

Program Brief

November 2016

About E2A

The Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls Project (E2A) is USAID’s global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and facilitating the scale-up of best practices that improve family planning services.

Awarded in September 2011, this project will continue for eight years, until September 2019. The project is led by Pathfinder International, in partnership with ExpandNet, IntraHealth International, Management Sciences for Health, and PATH.

Background

Strengthening the reproductive health and family planning services offered and supported by faith-based organizations in Africa—which deliver 40 percent of all health services on the continent—is an essential strategy for increasing the availability and uptake of contraceptives, curbing unintended pregnancies, and improving maternal and child health among the most underserved populations.

The Evidence to Action Project (E2A) provided grants and technical assistance to faith-based organizations in Ethiopia, Kenya, and Uganda that are members of the African Christian Health Association Platform (ACHAP).¹ The three grants supported faith-based organizations to mobilize religious leaders in support of family planning, improve the quality of community- and facility-based family planning services and referral networks, and connect service providers with religious

leaders and other stakeholders in a collective effort to accelerate the uptake of contraceptives.

This program brief describes work conducted by E2A’s grantee organization in Uganda—the Uganda Protestant Medical Bureau (UPMB)—which took place from September 2014 to June 2016.

Introduction to UPMB

With this grant from E2A, UPMB built on its ongoing work in the North and East Central regions of Uganda to improve the delivery of family planning services, including expanding contraceptive method choice in target health facilities, and enhancing demand for contraceptive methods. In both regions, most people have heard of family planning, but face persistent cultural and religious issues that impede the uptake of family planning ser-

¹ ACHAP, with 26 member organizations in 21 countries, is a regional platform, well known for its advocacy and dissemination efforts in Africa. E2A partners with ACHAP to share learning from the grantees with its other member organizations in an effort to encourage adoption of successful approaches implemented by the grantees.

Oromia state indicators*

Total fertility rate

- East Central: 6.1
- North: 6.4

Contraceptive prevalence

- East Central: 26.1%
- North: 23.4%

Unmet need for family planning

- East Central: 42%
- North: 43%

*Uganda Demographic Health Survey 2011

vices—such as polygamy, desire for large families, and aversion to contraception, especially among Catholics. On average, women across Uganda have more than 6 children in their lifetimes. Over 40 percent of married women in these two regions have expressed an unmet need for family planning services, which is higher than the national average of 34 percent.

Over the course of this 21-month grant, UPMB strengthened the delivery of family planning services at nine of its health facili-

ties and among community health workers who work on Village Health Teams² in the areas surrounding those health facilities. In those same areas, UPMB mobilized religious leaders to speak with their communities and congregations about family planning, thereby generating demand for services. The religious leaders also made referrals to Village Health Teams and facilities for family planning services. UPMB joined these three cadres—family planning providers from the facilities, community health workers, and religious leaders—to form quality-improvement teams, which met monthly to share progress and address challenges related to promotion and delivery of family planning services.

Activities supported by the grant intended to:

- Improve clients' access to family planning and reproductive health information and counseling to help them to make voluntary, informed decisions about contraceptive methods.

- Improve access to a broad contraceptive method mix that includes short- and long-acting methods offered through both community- and facility-based services.
- Build networks of religious leaders, and community- and facility-based service providers to increase demand for and improve the delivery of family planning and reproductive health services.
- Engage men in family planning counseling and education sessions, and encourage their participation in decision-making about reproductive health and family planning.

Implementation of the Grant

The foundation of interventions conducted under the E2A grant rests on mechanisms for connecting all entities that are essential to the promotion and delivery of family planning services. Through this grant, UPMB worked with its faith-based



Community health workers involved in the UPMB program, located at the Bugeywa health center

²Village Health Teams are elected by villages to manage all matters related to health and other cross-cutting issues. They are composed of community health workers, which are tasked with community information management, health promotion and education, mobilization of communities for utilization of health services and health action, simple community case management and follow-up of major killer diseases (malaria, diarrhea, pneumonia and emergencies), newborn care, and distribution of health commodities.

networks in nine locations—including 18 service providers, 54 community health workers, and 45 religious leaders—to broaden community awareness and use of family planning. In each facility and catchment area, religious leaders developed messages about family planning in their sermons, counseled their followers on family planning, with a focus on reaching men, and referred followers to facility-based providers and community health workers for family planning methods. Community health workers provided family planning counseling, condoms, and oral contraceptive pills, and referred their clients to health facilities for long-acting and permanent family planning methods. A focal point at each facility—the midwife in charge of the maternity ward who is appointed by facility management—reported monthly to UPMB on the collective activities of the community health workers, facility-based providers, and religious leaders. UPMB provided technical and administrative oversight across the nine sites and also coordinated with the Ministry of Health to provide monthly reports and to participate in the Ministry’s Maternal and Child Health Technical Working Group, which brings together all partners that work on reproductive health in Uganda.

Selecting implementation sites: UPMB conducted an assessment at 13 UPMB health facilities to discern the readiness of each facility to implement family planning, reproductive health, and related activities under the grant. UPMB selected 9 of the 13 health facilities for the grant-supported interventions that had sufficient availability of midwives, religious leaders, and

community health workers working in the catchment areas around the health facilities, and other implementing partners working on family planning services in the surrounding area. At the 9 facilities, UPMB found that while some facilities were offering family planning services, method choice was limited to short-term and traditional methods. Community health workers at health posts near the facilities had also been offering family planning counseling, condoms, and oral contraceptive pills, but UPMB identified some pervasive knowledge gaps in terms of family planning service delivery. Most of the community health workers only had sufficient knowledge about condoms and therefore could not offer high-quality family planning counseling and services.

Building clinical and technical capacities in family planning: UPMB trained 18 facility-based providers (2 at each of the 9 facilities) in family planning service delivery, which included enhancing capacities to offer long-acting reversible contraceptives. The Ugandan Ministry of Health assessed the skills of facility-based provider after the trainings. UPMB also trained the 18 providers, 54 community health workers, and 45 religious leaders, on family planning knowledge, counseling, and environmental compliance. UPMB focused particularly on informed, voluntary choice during family planning counseling sessions, including ensuring full, voluntary, informed consent for the administration of permanent methods. UPMB continued to provide on-the-job mentorship through quarterly technical visits and remote support via phone/email, including forecasting and

monitoring stocks of contraceptives and related commodities.

Mobilizing religious leaders: Before the grant, religious leaders did not address family planning within their congregations or communities. UPMB engaged and trained 45 religious leaders, from Protestant, Catholic, Seventh Day Adventist, Muslim, and Orthodox faiths, to identify appropriate faith-based messages and channels to encourage family planning. Religious leaders emphasized the benefits of family planning, and made a special effort to engage with men to build awareness and support.

Developing quality-improvement teams: An important aspect of this grant was to bring together religious leaders, facility-based providers, community health workers, and UPMB staff in a joint effort to review performance and identify ways to improve and expand the delivery of family planning services. Each facility formed a quality improvement team, involving all participating providers and religious leaders. Facility teams were led by a three-person team of one religious leader, one community health worker, and one midwife (who also served as the overall focal point for the activity). Teams met monthly to discuss progress, challenges, and next steps for their family planning promotion and services in communities and facilities. In addition, UPMB convened larger quarterly ‘learning sessions,’ where team leaders from all nine sites shared their experience and jointly strategized on how to improve implementation and results.

Integrating family planning: Although services were integrated in the past, the integration element was weak and clients were not receiving family planning services at opportune times—during HIV services and antenatal care (ANC), for instance. Through the E2A grant, facility and community teams focused on improving opportunities for integration of family planning. As a result, mothers now visiting a facility for ANC also receive information on family planning, and contraceptive service delivery has also been integrated in the outreach activities of community health workers who are part of Village Health Teams.

Supporting commodity security: Although the nine health facilities were ready to administer long-acting reversible contraceptives (implants and intrauterine devices (IUDs)), the necessary supplies and equipment were not been readily available. UPMB conducted advocacy with Uganda's Ministry of Health to ensure that all nine health facilities have implant and IUD insertion kits. UPMB's close working relationship with the Ministry of Health and social marketing groups ensured that UPMB's private not-for-profit health centers had family planning commodities that clients could access for free. The midwife in charge of family planning, who served as the point person for the

quality improvement team, checked family planning stock cards every quarter for the facility and community health workers and reported to UPMB. UPMB then reported to the Ministry of Health each month to ensure that adequate stocks of family planning commodities continued to be available and that any stock-outs were addressed as quickly as possible.

Implementation Challenges

Delayed reporting: The midwife focal persons at each of the nine health facilities were responsible for reporting on the activities of facility-based providers, community health workers, and religious leaders in the area. However, as they were also responsible for providing clinical services, the midwives struggled to find time for compiling and sending reports. UPMB worked with each quality improvement team to ensure data collection and reporting systems were streamlined and then worked with the focal midwives to balance reports with other responsibilities.

Stock-outs and non-accessibility of permanent methods: Facilities faced periodic stock-outs of both short- and long-term contraceptive methods. Although

UPMB was largely able to resolve these issues in collaboration with the Ministry of Health, there were a few more persistent stock-outs (e.g., cycle beads, oral contraceptive pills), reflecting the overall supply situation in the country. In addition, uptake of permanent methods was limited, as clients often could not afford these procedures, despite now having access at nearby facilities. With no financial support from the Ministry of Health for the provision of permanent methods, UPMB was unable to offer these methods.

Reluctance to engage from some men: Religious leaders made a special effort to talk with men in their congregations about family planning. Some leaders, however, found that men were slow to engage in these activities. Strong gender norms, along with a culture of drinking alcohol in some communities, impeded participation in discussions related to family health. A final constraint was that couples' counseling sessions was generally not common in Uganda. UPMB worked with quality improvement teams to find solutions to these challenges and were successful in increasing male involvement. Some developed interactive drama sessions, which were more effective in engaging men. Other facilities created counseling spaces, where couples could receive information and services in private.



Handover of job aids at Bugeywa Health Center in Uganda

Results (September 2014 – June 2016)

Chart I. People reached with family planning messages through community meetings organized by religious leaders



*From July-September 2015, communities' involvement in political elections resulted in a decline in the number of sensitization meetings held by religious leaders.

Chart I: Over the course of the grant, there was a steady growth in the number of men and women reached by religious leaders through various family planning promotional activities. By June 30, 2016, religious leaders had completed over 102,000 person contacts, with roughly 39 percent of these involving men. They addressed healthy timing and spacing of pregnancies, benefits of family planning, and clarified rumors and myths about family planning. They also discussed the dangers of not having family planning that are particularly relevant in the local context, such as challenges in providing sufficient food and healthcare for all family members, and challenges in dividing family land holdings between multiple children. UPMB results reinforce the importance of religious leaders being able to reach and influence critical groups, especially men.

Chart 2. Number of clients counseled by facility- and community-based health workers by gender

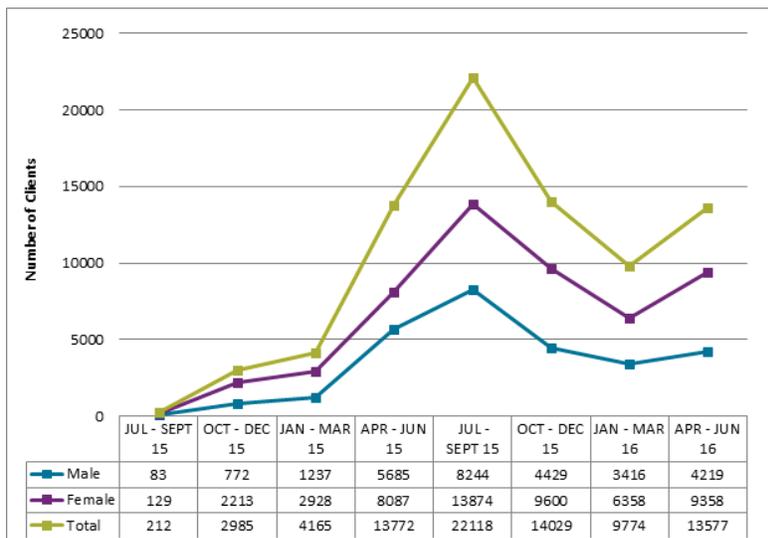


Chart 2: Overall, the number of clients counseled grew over time, reflecting both enhanced promotion and service delivery efforts. Although there was some variation across quarters, the number of women and men counseled on family planning increased in Year 2 (Jul 2015 – Jun 2016), as compared to Year 1 (Jul 2014 – Jun 2015). Importantly, 35 percent of those counseled were men, again highlighting how this initiative was able to engage with this important group on family planning.

Chart 3. New family planning acceptors by method type

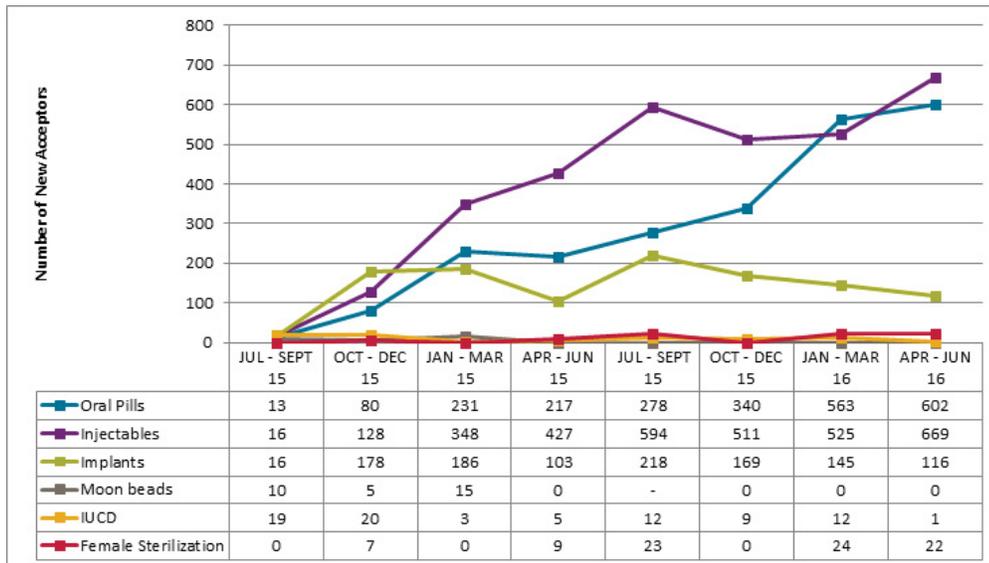


Chart 4. Repeat family planning clients by method type

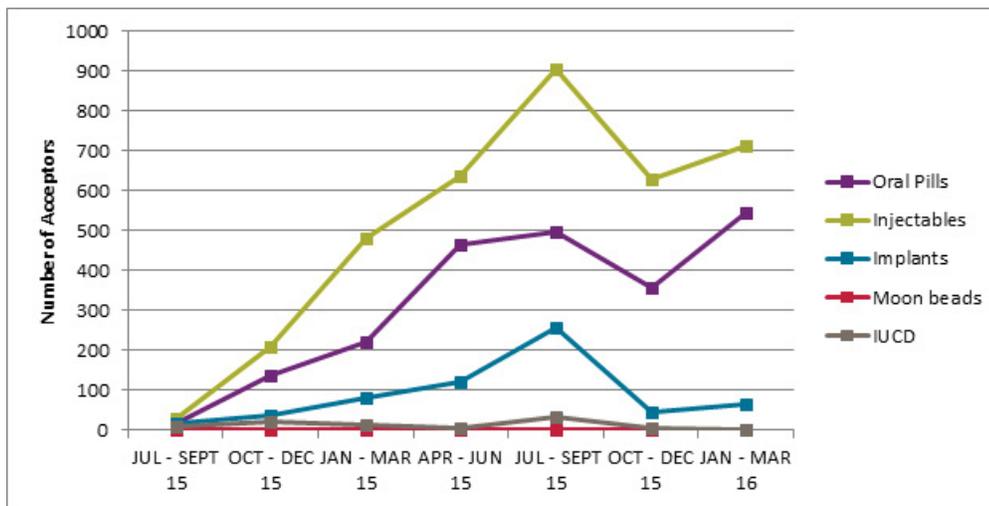
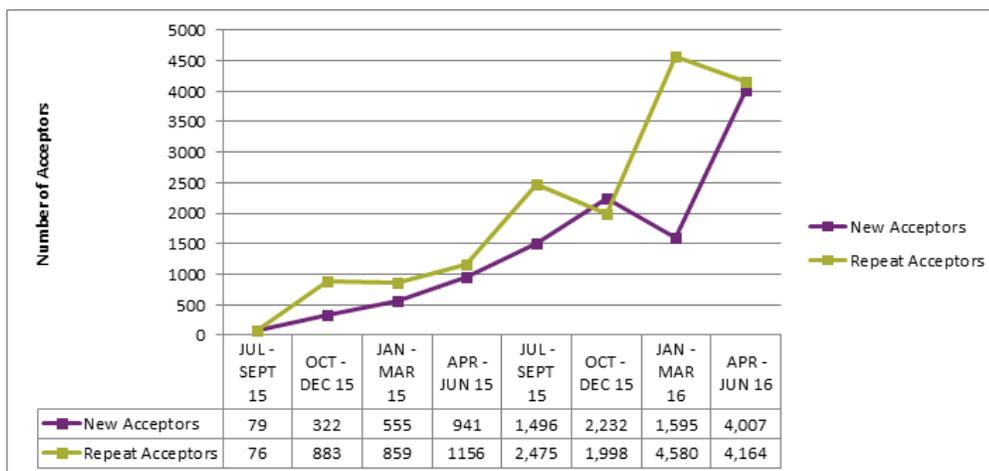


Chart 5: Condom use by new and continuing users



Charts 3, 4, and 5: Charts 3, 4, and 5 present the uptake of contraceptive methods over the life of the grant, with Chart 5 focusing on condom use and Charts 3 and 4 highlighting all methods except condoms. Each chart shows an increase in the number of people who initiated or continued using contraceptives. In general, both new and continuing users had a preference for short-term methods, particularly oral contraceptive pills and injectables, perhaps reflecting familiarity with these methods and ease of access. However, the uptake of implants by new users suggests a more promising outlook for long-acting reversible contraceptives in the future.

Condom use is examined separately in Chart 5, both to facilitate ease of understanding patterns in contraceptive use to highlight uptake of this male-controlled method. Condom use can be challenging in Ugandan contexts, with both men and women reluctant to use a method that is associated with infidelity or mistrust. Correcting myths and transforming attitudes about this method was part of the promotion and counseling offered through this grant, and the steady increase in new and continuing condom users suggests that these efforts had some effect.

Conclusions

Regular meetings among facility-based providers, community health workers, and religious leaders provided a platform for shared learning and progress. The monthly meetings among appointed leaders from the nine quality-improvement teams (one religious leader, one community health worker, and one midwife from each facility and its catchment area) were a forum where the teams could boast about their results and get feedback on unresolved challenges. After these meetings, teams often applied what they learned from others. For example, at one meeting, a representative from Kumi Hospital in Eastern Uganda explained the value of offering family planning counseling in a separate, private space from other services. After that meeting, New Life Hospital in Northern Uganda, which was previously offering counseling in the maternity ward, created a separate room for family planning to address issues of confidentiality and privacy. The meetings fostered a spirit of healthy competition between the quality-improvement teams that have encouraged positive improvements to the way family planning services were offered. In addition to the monthly meetings

among team leaders, community health workers and religious leaders met with facility-based providers and UPMB administrators to discuss progress, challenges, and ways forward. This multi-level, team-based approach ensured that all actors knew their responsibilities and worked together toward a common goal.

Religious leaders served as a powerful voice in promoting family planning with women and men. According to UPMB, most religious leaders, when they were first approached, began with a negative attitude about family planning, but changed after the training sessions. By the end of the grant period, most said that they wished they had had the information earlier. They made specific efforts to engage men in discussions about family planning and to reach youth for prevention of unintended pregnancies and prevention of sexually transmitted infections. In a country where religious beliefs drive important decisions about lifestyle and health, it was a helpful and beneficial strategy to mobilize religious leaders in support of family planning and engage them to promote healthy behaviors related to reproduction and contraception. Although the mobilization of religious leaders for improved family health is a best practice that has been applied for many years, the work accomplished under the grant reinforces the importance of engaging religious leaders to encourage use of contraceptive methods. Beyond mobilization, religious leaders needed to be trained regularly and also given time and space to find their own faith-appropriate language and forums so that they have updated knowledge on family planning and they can address family planning in a positive way with their communities and congregations.

Recommendations

The grant from E2A helped UPMB to broaden and strengthen its approach to family planning promotion and service delivery, including expanding the contraceptive method choices it offers at nine of its health facilities and surrounding communities. As a faith-based provider, the grant has helped UPMB to leverage the voice of religious leaders, a critical channel for encouraging the acceptance of family planning services in its catchment areas. UPMB, like other faith-based health service-delivery organizations in Africa, is a trusted health service provider. The following recommendations, pulled from UPMB's experience, highlight the various elements needed to sustain and expand facility- and community-based family planning promotion and service delivery to all UPMB health facilities in the future.

Develop and support quality-improvement teams: Regular meetings among midwives, community health workers, and religious leaders foster teamwork, generating demand for family planning services and ensuring the provision of quality services. The teams learn from each other about simple improvements they can make in the way they are offering services to better meet clients' needs and increase uptake of contraception. The teams clarify each team member's responsibility toward the delivery of family planning services and provide a platform for analyzing performance and planning activities. Making small investments in the continued facilitation of these meetings, either on a monthly or quarterly basis, will support continuous enhancement of family planning service delivery in Eastern and Northern Uganda.

Continue to mobilize religious leaders: UPMB's mobilization of religious leaders has largely changed their perceptions about family planning and many of them have transformed from being opposed to family planning to being advocates among their communities and congregations. UPMB will need to continue to mobilize religious leaders in order to sustain and build demand for family planning in Northern and Eastern Uganda, messages on healthy timing and spacing of pregnancy and natural family planning methods for those who remain opposed to modern contraception.

Ensure sufficient clinical capacity of quality-improvement teams: As staff are often transferred within or to other health facilities, more trainings having a system of continuing medical education and training is needed to ensure the presence of qualified health facility staff who can provide a range of family planning methods (including long-acting reversible contraceptives) and that their skills are up to date. UPMB will also need to continue in-person and remote quarterly supervision to monitor commodity security and provide capacity building and on-the-job mentorship.

Address commodity-security issues: Even when facility-based providers are

adequately trained, they cannot fully do their jobs unless they have the supplies, equipment, and commodities necessary. All facilities need a long-term commodity security plan for sustaining provision of IUD and implant insertion kits. The Government of Uganda should also consider how permanent methods can be offered at a reduced cost. Given the increasing demand for both long-acting and permanent methods, which may continue to grow as religious leaders and community health workers reach out to their communities, addressing both costs and commodities is essential for sustained service delivery.

Invest in reaching men: Men are largely absent from decisions made about family planning and reproductive health in Uganda, and may oppose family planning in favor of having large families and sometimes many wives. Working through religious leaders proved to be an effective approach in accessing many men and beginning to influence their beliefs and attitudes. Building on other innovations, including the use of drama and the creation of private counseling spaces, will be important in UPMB's efforts to transform the beliefs of men and thereby increase access to family planning among women and men in Uganda.

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