ECSA-HC

East, Central and Southern Africa Health Community

EXPANDING ACCESS TO FAMILY PLANNING SERVICES AT THE COMMUNITY LEVEL:

UGANDA ASSESSMENT

EAST, CENTRAL AND SOUTHERN AFRICAN HEALTH COMMUNITY

AND

UGANDA MINISTRY OF HEALTH

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LIST OF ABBREVIATIONS AND ACRONYMS

AOGU	**THE ASSOCIATION OF OBSTETRICIANS AND GYNAECOLOGISTS OF UGANDA**
CBFP	**COMMUNITY-BASED FAMILY PLANNING**
CHW	**COMMUNITY HEALTH WORKER**
CPR	**CONTRACEPTIVE PREVALENCE RATE**
DHMT	**DISTRICT HEALTH MANAGEMENT TEAM**
DHS	**DEMOGRAPHIC AND HEALTH SURVEY**
ECSA	**EAST, CENTRAL, AND SOUTHERN AFRICA**
FP	**FAMILY PLANNING**
GHI	**GLOBAL HEALTH INITIATIVE**
HSSP	**THE HEALTH SECTOR STRATEGIC PLAN**
HTSP	**HEALTHY TIMING AND SPACING OF PREGNANCY**
MDG	**MILLENNIUM DEVELOPMENT GOALS**
MOH	**MINISTRY OF HEALTH**
MPS	**MEMBERS OF PARLIAMENT**
TFR	**TOTAL FERTILITY RATE**
UNFPA	**UNITED NATIONS POPULATION FUND**
VHT	**VILLAGE HEALTH TEAM**
VHTM	**VILLAGE HEALTH TEAM MEMBER**

EXECUTIVE SUMMARY

Expanding access to family planning (FP) at the community level is a priority strategy for accelerating progress toward achieving Millennium Development Goals (MDGs), particularly goal 5b, universal access to reproductive health, including family planning (FP). Emphasis on community access to FP has emerged as a major goal in sub-Saharan Africa specifically, most recently in the March 2010 meeting among 12 African nations at Kigali. At the Kigali meeting, participating countries reached consensus that community FP should be the priority strategy for expanding access to FP to address unmet need and accelerate progress toward the MDGs. This strategy resonates with earlier calls for action in the region, including the Maputo Plan of Action and the 2009 International Family Planning Conference held in Uganda.

The East, Central, and Southern African Health Community (ECSA-HC) has been working with its member states, including Uganda, to address issues related to expanding access to family planning. ECSA led this assessment, using a desk review, key informant assessments, and focus group discussions. Similar assessments were conducted in four other ECSA member states (Kenya, Lesotho, Malawi, and Zimbabwe).

In Uganda, the key informant interviews were conducted in November 2011 with 13 individuals and two focus groups (see Appendix 1). The interviews were conducted with Ministry of Health (MOH) policy-makers and managers, professional health associations, regulatory boards and councils, community-based FP (CBFP) implementing agencies, donors, members of Parliament, district level providers, and community health workers.

Nearly nine of every 10 Ugandans live in rural areas, where more than two of every five women of reproductive age (43%) report unmet need for FP. Moreover, unmet need nationally, rose from 30% in 1995 to 41% in 2006. While the overall contraceptive prevalence rate has more than doubled since 1995, the rate remains far lower in rural areas (15%) than in urban areas (37%).

To address such challenges, in 2009 the MOH launched a coordinated Village Health Team approach where village level health workers can provide multiple health care services, including basic FP information and some services, including referrals. Then, in December 2010, the MOH amended its national health policy to enable community health workers (CHWs) to provide injectable contraceptives.

Section 3 of this report provides more information on policies, guidelines, and strategies about community-based FP services. Section 4 synthesizes findings from the key informants and focus groups, and Section 5 provides first person perspectives from the CHWs on key issues. This information combined with the desk review led to the six recommendations discussed in Section 6 and listed below.

1. Build and sustain awareness for community FP services at national and local levels.
2. Continue to build a supportive policy environment.
3. Strengthen service delivery systems.

4. Enhance motivation, retention, and capacity of VHTs.
5. Integrate FP with MCH services and with non-health sectors, and explore the potential of integrating FP services with drug shops.
6. Address financing issues to enhance FP services in underserved communities.

Both key informants and the CHWs themselves expressed concern about the issues listed here and had ideas about addressing them. This assessment shows that CBFP has clear benefits in improving access to family planning information and services. Therefore CBFP is a powerful tool for social transformation towards improved quality of life at the community level, including improvement in the contraceptive prevalence rate and the resulting impact on maternal and child health.

1.0 INTRODUCTION

1.1 Background

Expanding access to family planning (FP) at the community level is a priority strategy for accelerating progress toward achieving Millennium Development Goals (MDGs), particularly goal 5b, which emphasizes the universal access to reproductive health (RH), including FP services. Most of the populations in sub-Saharan Africa (SSA) live in rural communities, where the demographic determinants including health infrastructure, human resource, and financial support for health are very poor. The achievement of universal access to FP and RH services remains a major challenge. Expanding access of FP to the community has gained recognition as a promising practice for the majority of the populations in SSA, who live in the rural areas.

Expanding access to FP at the community level has been emphasized by resolutions from the East, Central and South African (ECSA) Health Minister's Conference of 2008 and 2009; from the 2010 FP conference in Kigali, Rwanda; the 2009 International FP Conference held in Kampala, Uganda; and the Maputo Plan of Action of 2006. The 12 African nations attending the 2010 Kigali meeting built a consensus to prioritize expanded FP access at the community level as a strategy for addressing the unmet need for FP and accelerating progress toward the MDGs.

Women in rural areas have a particularly high unmet need for FP services, especially during the postpartum period. A review of data from 27 Demographic and Health Surveys (DHS) found that 67 percent of women who gave birth within the previous year had an unmet need for family planning. One way to address this is by strengthening systems that can make FP services more available to the communities. Some approaches have worked successfully to address the critical shortage of medical professionals and to expand access to a range of health services, such as empowering cadres of health workers who have not undergone the regular medical training programmes to provide FP services at the community level. In this concept of skills transfer (known as task sharing or task shifting), which has been endorsed by WHO, providers with less medical or paramedical training can deliver some of the same services with the same quality as providers with more training.

The ECSA-Health Community has addressed issues related to expanding access to FP services at the community level. In 2008, the 46th ECSA Health Ministers Conference (HMC) adopted resolution HMC46/R4, which urged member states to allocate/increase financial resources for FP and to reduce unmet needs by 10% by 2010. The resolution also urged member states to develop and implement policies, guidelines, and training curricula on task shifting among health care providers by 2011 that allow mid-level cadres to carry out specifically identified activities that shift non/less technical duties from mid-level to lower-level cadre staff, such as community based distributors of contraceptives. In the same resolution the ECSA secretariat was directed to support countries to develop and implement policies and guidelines on task shifting among health care providers by 2010.

In 2009, the HMC in ECSA/HMC 48/R5 urged member states by December 2011 to advocate for increased political and financial commitment to FP, ensure the full integration of FP into national development plans and poverty reduction strategies, and develop costed implementation plans for sexual and reproductive health (SRH) services informed by the Maputo Plan of Action. It also called on the member states to develop country-specific policies and guidelines on task shifting by December 2012 for the delivery of SRH and FP services to ensure access to FP services for the poor, marginalized, and underserved communities. The resolution also directed the secretariat to support member states to develop and/or adopt advocacy, costing, and modeling tools; document and disseminate promising and best practices in FP with links to proven effective change practices; and assist member states to implement various international instruments such as the Maputo Plan of Action and the African charter on the rights of the woman. All signature countries to such documents are required to report against the indicators and targets in these documents.

To address these resolutions, ECSA-HC has conducted an assessment on policies, guidelines, and financing of expanding access to FP services at the community level in five member states (Kenya, Lesotho, Malawi, Uganda, and Zimbabwe) to determine the current status of these three areas, and to recommend the best way to implement a strategy to expand services. The assessments took place between November 2010 and April 2011. The Uganda assessment was conducted in November 2010.

1.2 Objectives

The objectives of the assessment were:

- To describe the degree to which national level policy and service delivery guidelines/standards facilitate the provision of quality FP at the community level.
- To determine the level and modalities of funding of FP services in the region.
- To describe the challenges and opportunities in current community-level FP service delivery systems and how they could be improved to better serve the FP needs of underserved populations.
- To synthesize commonalities with regional application and identify opportunities for improved approaches to FP services at the community level, in order to inform the development of recommendations on country and regional priorities for the improvement of expanded services to FP programs.

1.3 Methodology

The report of each country's assessment includes material from two primary sources:

1) Desk review of related literature, including DHS data, policy documents, national guidelines, research studies, and program reports; and

2) Qualitative input from key informant interviews and focus group discussions. The interviews and focus group discussions followed interview guides.

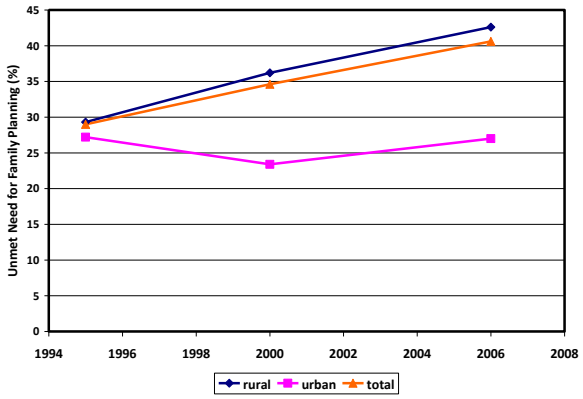
In Uganda, the interviews and discussions were digitally recorded and transcribed. The key informant interviews were conducted with 13 individuals and two focus groups in Nakasongola district. The interviews were conducted with Ministry of Health staff, professional health associations, regulatory boards/councils, CBFP implementing agencies, donors, Members of Parliament (MPs), and district level providers (see Appendix 1).

2.0 RATIONALE

Why Expand Access to Family Planning at the Community Level

Uganda faces a major challenge in making FP services accessible at the community level. Nearly nine of every 10 Ugandans live in rural areas, where more than two of every five women of reproductive age (43%) report unmet need for FP. Moreover, unmet need nationally, rose from 30% in 1995 to 41% in 2006 (see Figure 1).[1] Meanwhile, the number of women of reproductive age will more than double in the coming years – from 7 million (those currently ages 15 to 49) to some 15 million, as females younger than age 15 enter their reproductive years.[2] Currently, about half of the country's 31 million residents are under age 15, a demographic bulge that will result in the large increase in women in their fertile years.

Figure 1: Trends in Unmet Need for Family Planning



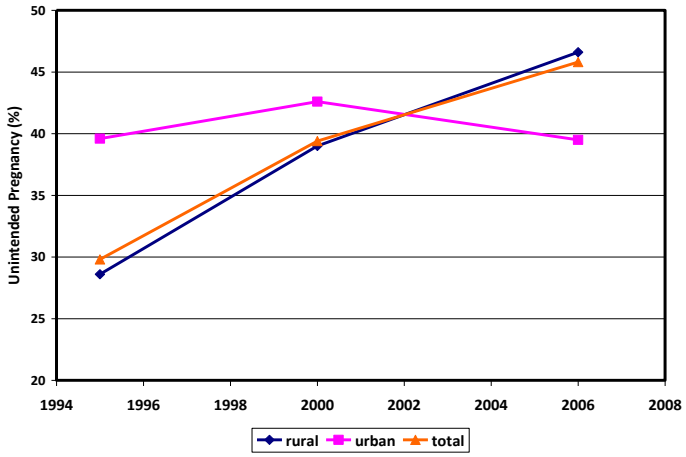
The rural living patterns and demographic bulge together represent a major challenge for the Uganda Ministry of Health (MOH). To address this challenge, in 2009 the MOH launched a coordinated Village Health Team approach where village level health workers can provide multiple health care services, including basic FP information and some services, including referrals. Then, in December 2010, the MOH amended its national health policy to enable community health workers (CHWs) to provide injectable contraceptives.

"We believe community based delivery of injectable contraception is the best avenue to increase access to the most popular family planning method in Uganda, particularly for women living in hard-to-reach areas," said Dr. Nathan Kenya Mugisha, Director General of Health Services in the MOH, announcing the changes in March 2011. This announcement came after a number of steps in the last seven years that had gradually increased access to injectables, the most popular method in sub-Saharan Africa.

While these are significant steps, much remains to be done. Almost half of all pregnancies in Uganda (46%) are unintended, a jump from just under 30% in 1995 (see Figure 2).[3] An unintended pregnancy is a pregnancy reported as either wanted later or not at all. If women who desired to space or limit their births had access to FP, 25% to 35% of maternal deaths could be avoided, including abortion-related mortality.[4] Although

Uganda's maternal mortality rate has decreased by 36% since 1990, it remains high at 430 deaths per 100,000 live births.[5]

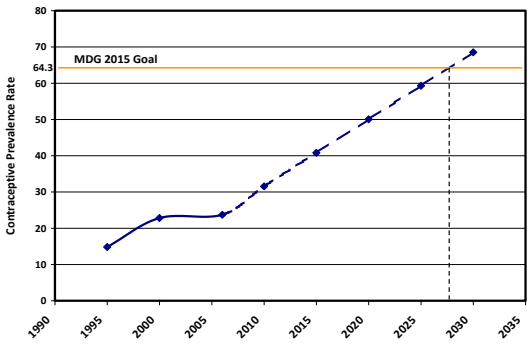
Figure 2: Unintended Pregnancy Trends in Uganda



The latest DHS (2006) shows 18% contraceptive prevalence rate (CPR) for modern methods (including condoms) among married women of reproductive age. While the overall rate has more than doubled since 1995, CPR remains far lower in rural areas (15%) than in urban areas (37%).[6] Notably, the use of a modern contraceptive method by non-married sexually active women is much higher at 47 percent.

To achieve the Millennium Development Goal (MDG) 5b for family planning by 2015, Uganda's CPR needs to rise to 64 percent. This will require far more dedicated attention working within many constraints, including limited national resources, a population concentrated in rural areas, and a growing number of women moving into their sexually active years. Figure 3 indicates that a sharp increase in CPR is needed to meet this goal, even by 2027, which is 12 years after the MDG target year. The solid line (through year 2006) is based on DHS data; the dotted line for subsequent years comes from a recent modeling study.[7]

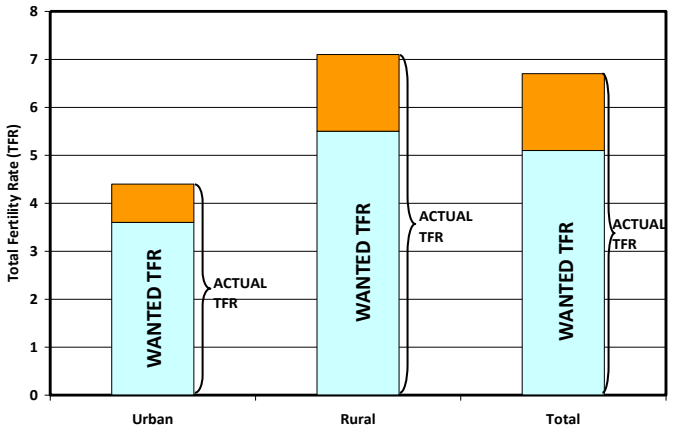
Figure 3: Trends in Contraceptive Prevalence Rate (Married Women, All Methods)



The total fertility rate (TFR) has remained nearly unchanged between 1995 (6.9) and 2006 (6.7), the latest available data. The divide between the urban TFR (4.4) and the rural

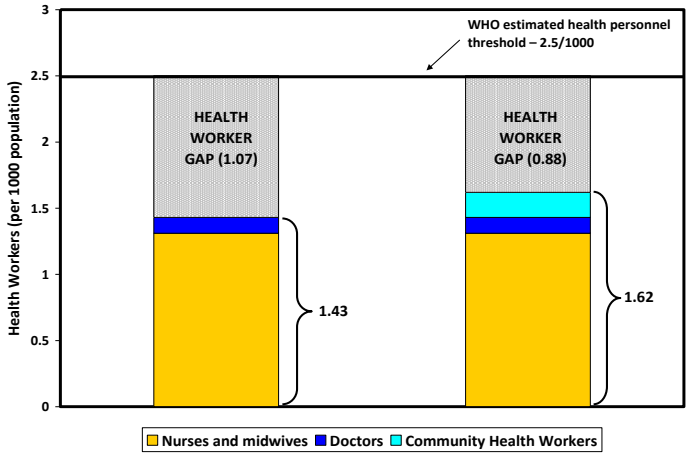
TFR (7.1) is large and demonstrates the need for greater access to services in rural areas (see Figure 4).[8]

Figure 4: Total Fertility Rate, Wanted versus Actual, Uganda 2006



Most women in Uganda access FP from a private source (69%), including shops and friends or relatives. About three of every four people (78%) access FP from hospitals, health centers, or clinics; 14% do so from a pharmacy, drug shop, or shop. Only 1% of women access FP services from community based distributors. Women face problems accessing health care in general. Nearly nine of ten women (86%) report at least one problem accessing health care; lack of money for treatment ranks first and distance to the health facility was second most mentioned problem. Rural women are more likely to report problems in accessing health care, citing the distance to the health facility and having to take transport as key issues.[9] More than half of the population (51%) lives more than five kilometers from the nearest health facility. Uganda has 1.43 health workers per 1,000 people, well below the WHO recommendation of 2.5. The ratio increases marginally to 1.62 per 1,000 people when CHWs are included.[10]

Figure 5: Uganda Heath Work Force



The health sector budget as a percentage of the national budget has been increased continuously from 7.5 percent in 2001 to 9.7 percent in 2005. However, the rate is still well below the Abuja target of 15 percent by 2010.[11] Despite the gains up to 2005, in

2010/2011 (current fiscal year) the health sector was allocated 8.7 percent of the national budget, down from 10.4 percent in 2009/10.[12] The total health expenditure in Uganda for 2007 (latest data available) is 750 million US dollars (1.7 trillion Uganda shillings).[13] This amounts to approximately US$28 per capita expenditures on health, which is below the WHO Commission on Macroeconomics and Health recommendation of US$34 per capita.[14]

With such a large rural population, high unmet need for FP, and demographic bulge among young people entering their reproductive years, Uganda needs to seek ways to expand access to contraception. Approaches to greater access in rural areas in particular provide an important way to help women achieve their own pregnancy goals and to help the country meet its MDG goals.

3.0 FINDINGS: POLICIES, GUIDELINES, STRATEGIES

All current reproductive health policies support the use of FP in general. Of particular relevance to CBFP is the 2010 addendum to the *2006 National Policy Guidelines and Service Delivery Standards for Sexual and Reproductive Health and Rights*. The addendum allows VHTs to provide injectable contraception. Community health workers had been providing Depo-Provera in select sites in Uganda since 2004, and a growing body of global evidence had led to an international consensus endorsing this approach through the World Health Organization. Even so, Uganda joins only a few countries in sub-Saharan Africa that allow this service (including Madagascar and Malawi in East Africa). For the full range of FP services provided by each cadre in Uganda's health system, see Appendix 2.

3.1 The Village Health Team Strategy

Around 2003, the Ministry of Health began developing the Village Health Team (VHT) Strategy with Operational Guidelines for the national structure for health service delivery and primary health care at the lowest level coming later. This approach has the potential to facilitate expanded access to FP significantly. Under the VHT strategy, individuals previously known as community health workers (CHWs) or community reproductive health workers (CRHWs) are in the process of becoming members of VHTs and known as Village Health Team Members (VHTMs). Some programs and health workers still use the terms CHW and CRHW in part because all community-level health workers have not yet been absorbed into the VHT system.[15] At the time the Health Sector Strategic Plan (HSSP) III (2010-2015) was released in 2010, VHTs had been established in 75 percent of the districts, but only 31% of those districts had trained VHTs in all villages.[16] HSSP III set the target to establish, sustain, and train VHTs in all villages in Uganda.

The main purpose of VHTs is to increase access to health services among people who cannot readily reach health facilities. VHTs provide services within their communities, serving as the first point of contact for community members. VHTs serve as a link between health facilities and communities, performing a variety of tasks in health promotion, service delivery, and encouraging community participation and empowerment in the utilization of health services.[17] VHTs are recognized providers of FP services in Uganda, including select methods approved for provision at the community level and referrals for higher level care.

Criteria for Selection. Individuals are chosen to become VHTMs by their own communities. Following a village sensitization meeting, community members select one VHTM for every 25-30 households in the village by a popular vote. Female VHTMs must comprise at least one-third of the VHT. Criteria for selection include:

- Must be resident of the village
- Should be exemplary, honest, trustworthy, respected
- Should be available to perform specified VHT tasks
- Should be a good mobilizer and communicator
- Should be able to read and write at least the local language
- Should be 18 years and above

The roles and responsibilities of a VHT include:

- Home visiting
- Mobilization of communities for utilization of health services
- Health promotion and education
- Community-based case management of common ill health conditions
- Follow-up of mothers during pregnancy and after birth, and newborns for provision of advice, recognition of danger signs, and referral
- Follow-up of people who have been discharged from health facility and those on long-term treatment
- Distribution of health commodities
- Community information management
- Disease surveillance

Regarding FP methods, VHTMs can provide condoms, combined oral contraceptives, progesterone only contraceptive pills, and injectable contraception. VHTs also create awareness of and counsel clients on long acting and permanent methods, and refer clients for these methods and other services requiring higher level care. There is no system of hierarchy among VHTMs.

VHTMs are volunteers. However, the VHT Strategy and Operational Guidelines stipulate that a minimum monthly stipend of 10,000 Uganda shillings (5US$) should be budgeted for the VHTMs. This is not currently being practiced. VHTMs do receive incentives, which vary by program. The Strategy suggests that initial incentives include certificates, a commissioning ceremony, badges, t-shirts, bags, job aides, IEC materials, and registers.[18] Some programs also provide umbrellas, gumboots, and bicycles. When they are required to travel outside of their communities, they may be provided with a transport refund and lunch allowance. According to the strategy, VHTMs shall also be given preferential treatment at health facilities and may participate in study tours within and outside their own districts. These tours are organized by the MOH and partners.

VHT services, including FP methods, are provided free of charge to clients in accordance with MOH policy. VHTs providing injectable contraception should all have the minimum package of materials for this service, according to MOH standards; this package includes a lockable contraceptive storage box, waterproof bags, calendars, registers, tally sheets, contraceptives, and a sharps disposal container.[19]

Training and Supervision. Most individuals chosen to be VHTMs have already undergone two to three weeks of training in FP provided by implementing partners, in some cases using different training manuals.[20] Once chosen, VHTMs participate in a MOH-approved, two-week basic training on topics such as healthy timing and spacing of pregnancy (HTSP), FP basics, infection prevention, malaria, hygiene, sanitation, childhood illnesses, and record-keeping. Following this training, implementing partners are expected to provide specialized training, which can last one to three weeks. The Depo-Provera curriculum is MOH-approved, and according to the 2010 policy addendum, VHTs should be trained in injectable contraception, only by MOH-approved

FP trainers. VHTs receive periodic refresher training and may occasionally be invited to assist with health activities at health centers for apprenticeship training.

The VHT strategy stipulates that quarterly supervision meetings should be held between VHTs, health facility staff including trainers or supervisors, LC I and II chairpersons, and parish chiefs. VHTs will have the opportunity at these meetings to share experience and reports, and receive feedback. All those attending these meetings receive a transport refund. VHTs are expected to report monthly to Health Center IIs for supervision, resupply, and to submit reports. The monthly reports contain a summary of activities and referrals. This information is used to determine the quantity of resupply. Data from VHTs should be submitted to the health facility which is then entered into the district HMIS system.[21] VHTs are also to receive supportive supervision in their communities at least once every year.

VHT's Relationship to Health Facilities. According to the VHT strategy, health facilities are responsible for coordinating, implementing, monitoring, and evaluating VHT activities. Specifically, facilities are to conduct training, supervision, resupply VHTs, and receive and utilize VHT records. Health facilities are to honor referrals from VHTs and refer clients for follow-up in the community when appropriate. According to the 2010 policy addendum, the District Health Office has a critical role in the coordination and implementation of the VHT strategy. Key responsibilities include organizing and training the teams in collaboration with implementing partners, selecting VHTs with implementing partners, conducting supportive supervision, coordinating logistics management, and ensuring effective monitoring.[22]

3.2 Service Delivery Strategies

A number of service delivery mechanisms are used to implement CBFP in Uganda. A 2007 mapping exercise obtained detailed information on the major programs offering CBFP programs in Uganda at the time. These included Save the Children, the Family Planning Association of Uganda, Plan International, Pathfinder International, Marie Stopes Uganda, Christian Children's Fund, and the Adventist Development and Relief Agenda of Uganda. Currently, the USAID-funded STRIDES for Family Planning project, a bi-lateral project (2009-14) implemented by Management Sciences for Health, is working with the MOH, districts, communities, local private organizations, and individual private providers in 15 districts to increase contraceptive use and promote healthy timing and spacing of pregnancy, decrease maternal and child mortality, and create a scalable nationwide intervention by the year 2014. Strong emphasis is being placed on the long-term impact and sustainability of activities well beyond the project end date.

Regarding injectable contraception, in 2007 three districts (Luwero, Nakasongola, and Nakaseke) were providing Depo-Provera at the community level. Six more districts have since begun implementing this service in selected villages, for a total of nine as of February 2011. The STRIDES project is supporting some of this implementation, working with FHI as a subcontractor.

3.3 Financing FP services

Financing of FP services remains a challenge for Uganda in the future. For example, in 2011, following its announcement of the formal policy change to allow nationwide coverage of DMPA by the VHTMs, the MOH asked FHI to develop a national scale-up plan for this service in rural areas. However, the MOH has not yet developed a funding plan to sustain such a service. Meanwhile, the STRIDES project is emphasizing issues related to sustainability of its services beyond 2014, when this bi-lateral project ends. But more attention is needed to such issues as line-item budgeting for community FP services at the national level and a costed implementation plan that can plan for the financing needed in future years.

4.0 ASSESSMENT SYNTHESIS

This section synthesizes information obtained during the key informant interviews and focus group discussions. The material is grouped according to general barriers to family planning that arose, barriers specific to CBFP programs, and facilitating factors and opportunities. The general barriers include social-cultural barriers, as well as specific resistance to provision of FP by lower level of cadres. Regulatory boards have questions, as do others. Operational barriers also exist, including linkages of CHWs to facilities, retention of these workers, and some policy-level barriers.

4.1 General Barriers to Family Planning

Socio-Cultural Barriers. Larger families are desirable in some areas, especially where livestock are central to communities. "People still believe that their children are supposed to provide labor, especially in cattle producing areas," mentioned one district-level respondent. Child survival is also a factor. As one MP said, "I asked a certain gentleman in the village that why do you have so many children like this? And he said that you see I produce so many children so that when some die, I still have some to stay with me."

Another factor is polygamy. According to the 2006 DHS, 28% of married women were in a polygamous union. According to respondents, where polygamy is practiced, wives may compete with each other to have more children. One district-level respondent said, "If a man marries three wives, the first wife will not say that she is going to space her children. She will say let's compete with the younger one. So at the end of the day they produce more children than they are able to manage." District-level respondents also mentioned that competition between clans to grow larger encourages high fertility.

Other factors mentioned by respondents as a barrier to FP use were religion, stigmatization of contraceptives, and women's empowerment. An MP believed that stigmatization is especially important in rural areas, "where people think that using contraceptive pills or condoms is for people who are prostitutes."

Respondents pointed out that many men reject family planning because larger families are associated with prestige. Men also view FP as a woman's issue, even though women may not be able to act on their own fertility preferences. A growing body of evidence shows that constructive male involvement can indeed lead to improved reproductive health outcomes, including FP use.[23] A member of the Ugandan Parliament echoed these findings: "In matters of reproductive health, I consider both partners to be stakeholders."

Lack of Knowledge. All respondent groups mentioned lack of knowledge and misinformation about FP as a barrier. The lack of knowledge about FP particularly in rural settings and its relationship to low literacy levels are challenges. A commonly cited misconception about FP was that it will permanently prevent women from having children. A possible cause of the association between FP and sterility may relate to messaging around FP. Several respondents felt that FP messages focus too much on limiting family size, thereby missing the broader objective of healthy timing and spacing of pregnancies (HTSP). Messages related to HTSP emphasize the importance of the

timing and spacing of pregnancies to avoid problems with the mother and baby, including higher risks of mortality. Fear of side effects was also mentioned by several, pointing to the need for improved counseling. The District Health Management Team (DHMT) and MPs mentioned the common misconception that FP causes cervical cancer. Health workers themselves may also be a barrier. In one instance, during a time with shortages of DMPA, clients were told that the government had banned the drug, so it may only be provided illegally for a high fee. The respondent said, "Some people who own the clinics started telling these clients that, you see, [the] government has stopped the usage of injectables and we are also bringing it illegally, so when we give Depo-Provera, we shall be committing a crime, so we shall do it behind the counter. So ladies started paying very high treatment fees for that Depo-Provera."

Politics. Political statements linking increased population with development also appear common. As one MP explained, some parts of the government "say that you just continue producing until when you cannot produce anymore." Some politicians also encourage high fertility at the district level, by telling their constituents that a higher population will lead to greater resource allocation and more development. Politicians may even offer incentives to women for having children. As one DHMT member said, "The politicians make statements that…the higher you deliver we shall be giving you prizes. For example, whenever a lady delivers, you come to me and you get a piglet. It became a song and people were doing it, it was something like a competition in that district."

4.2 Barriers to Expanding Access to FP Services at the Community Level

Resistance to Provision of FP by Lower Level Cadres. Some regulatory boards and other health professionals oppose the delivery of such services as Depo-Provera by lower level cadres. While some professional associations have expressed concerns about the ability of CHWs to provide quality services, respondents during the assessment supported CHW provision of injectables, given adequate training and selection criteria. Reservations were expressed by a regulatory board over the safety of the provision of Depo-Provera in the absence of sound selection criteria for lower-level cadres, but the respondent felt that community-level providers could be utilized if they were well trained and had attained at least a Senior 4 level of education. However, the new national policy allows a lower level cadre to provide DMPA, without requiring this degree of education.

The Uganda Nurses and Midwives Council does not license CHWs and considers them to be illegally operating. Respondents expressed concern that licensing CHWs could lead to some of them attempting to perform duties for which they are not qualified. There may also be resistance from higher level cadres because, as a professional association explained, the CHWs "may be seen as competition because then people are fighting for patients...they may do a bigger job than what a health care professional a hundred kilometers away may do, and accept, for example, in-kind payments which maybe a regular health care provider would not accept, and therefore the health care providers may see them as a threat."

Retention of CHWs. Retention of CHWs is a challenge to the success of expanding access to FP services at the community level, primarily because high attrition rates are

costly. One of the most commonly cited reasons for attrition is that CHWs leave if other organizations offer them a salaried position or a job with more incentives. Most respondent groups expressed concern over the lack of compensation for CHWs, particularly in light of these high attrition rates. CHWs are volunteers, although many receive incentives such as gumboots, bags, bicycles, and air-time for mobile phones. Other reasons for attrition included adding to the workload of CHWs without compensation and unfulfilled expectations of non-monetary incentives.

Policy-level Barriers. Policy barriers to expanding access to FP services include issues related to drug shops, compensation, and regulation. Regulatory boards were not supportive of drug shops as a service delivery outlet for FP due to concerns about their lack of readiness to provide quality services. Regulation of drug shops is poor. The regulatory board representatives expressed concern that services through drug shops could endanger a woman's health by improperly distributing drugs and not practicing sound storage procedures. At the time of this assessment, the lack of explicit policy support for the provision of DMPA at the community level was a barrier.

4.3 Operational Barriers to FP at the Community Level

Limited Coverage of CHWs. The DHMT explained that access to FP is still limited because there are not enough providers at the community level, where women prefer to receive services. The DHMT reported that in Nakasongola, there are only 53 CHWs who provide FP in their area, but there are 316 villages. Due to the limited availability of community-level providers, many women need to seek services from facilities. However, due to the challenges in accessing facilities, long queues, and in some cases maltreatment by health workers at the facility, women with an unmet need for FP are becoming pregnant. An implementing agency representative echoed the DHMT's concern that there are not enough providers at the community level to satisfy demand.

Contraceptive Security. Stock-outs present challenges at both the facility and community levels. Groups expressed concern about future contraceptive security in light of rising demand and increased service delivery at the community level. A donor questioned how contraceptive security could be assured at the community level when even facilities are experiencing stock-outs. During the early efforts to provide DMPA at the community level, commodity stock outs have been a problem. According to a JSI report, the most common reason for stock outs is lack of central level supplies. Supplies are often transported between health facilities when higher levels are stocked out. With DMPA, sometimes VHTMs get DMPA but no syringes. In this case, they must ask their clients to buy syringes which can create the impression that clients have to pay for the service.

Linkages between CHWs and Facilities. Weak linkages between community-level providers and health facilities were a common concern among respondents. In addition to affecting supervision, quality of services, and resupply, these linkages are critical for the successful completion of referrals to a higher level of care for clients seeking a FP methods not provided at the community level. A strong referral mechanism for ensuring access to the full range of contraceptive options, including LAPMs, is an important component in CBFP programs. Although CHWs make referrals, according to the DHMT,

women do not have regular access to long-acting methods at the district level because higher level services are not always available at health centers. In this particular district, services are provided quarterly through the mobile outreach system provided by Marie Stopes International.

Parliamentarians, implementing agencies, regulatory boards, and the DHMT all reported that shortages of health workers at the facility level, due to lack of personnel and high unemployment rate, are a barrier to service delivery in general, as well as links to community services. The lack of infrastructure, including supplies and equipment, at health facilities was also a common concern

4.4 Financial Matters/Needs that Affect FP Services at the Community Level

Commitments to supporting FP services at the community level requires advocacy at the national levels, said respondents. More attention is needed to integrating funding for VHTs into national line-item budgets and other funding issues. This includes consistent commodity supplies in rural areas as well.

4.5 Facilitating Factors and Opportunities

The findings from the assessment found opportunities to overcome the various barriers discussed above. Community engagement was widely seen as perhaps the most important overarching factor that can facilitate greater access and use of FP in local isolated areas.

Community engagement through sensitization is needed to address the lack of knowledge and misconceptions about FP and enhance participation in CBFP programs. An MP felt that sensitization is particularly needed around men's involvement in FP, recalling a successful national radio campaign that encouraged men to see the benefits of smaller families by using humor to compare the difficult life of one man who has not used FP and has many children, with the life of another man who has a small, manageable family. Women's groups and drama clubs could also provide an effective venue in which communities can engage in sensitization efforts.

Dr. Nathan Kenya-Mugisha, the MOH Director General of Health Services, put the issue simply, "Working with communities is the answer."

Many respondents said that providing FP services at the community level is acceptable to national and district-level stakeholders. The respondents believe that the provision of FP at the community level is beneficial and recognize the potential of utilizing this strategy to expand access to FP in underserved areas. "There are very many people who were against this community-based distribution of injectables," says Dr. Anthony Mbonye, Uganda Commissioner for Community Health. "Now they have changed their minds, having seen that it works."

Key informants identified certain characteristics of community-level FP providers and the positive effects that a CBFP program may have on the community. "[CHWs] are cheap to train, easily acceptable in the community setting; they know how to speak the local

language to convince the husbands, the youths and the wives of the need to use family planning services in the village," explained a regulatory board member who supported existing programmatic and research evidence that CBFP is acceptable to clients.

"Clients prefer to get services nearby where they can actually access them," said a member of the DHMT. Moreover, CHWs themselves explained their ability to increase community members' acceptance of FP and dispel myths, thereby helping to address some of the socio-cultural barriers to uptake.

According to the VHT Strategy and Operational Guidelines, community participation "enables communities to take responsibility for their own health and wellbeing and to participate actively in the management of their local health services."[24] Indeed, community ownership is the first of three guiding principles for the VHT strategy. Equal access and community support are the other guiding principles.

Community engagement can also be enhanced by CBFP programs. The MOH reported that community members have a sense of ownership where VHTs and CHWs are active. One MOH respondent said that community members support CHWs by organizing to help them with work on their farms.

Again and again, respondents and existing documents cited the importance of expanding access to FP at the community level and mentioned the various issues that should be addressed.

"You should always involve them [the community] in decision making," said a representative of the Uganda Nurses and Midwives Council. "You talk to them, sit with them and listen to their views…and you look around and say how will the program you are introducing help them in dealing with their problems with their resources? How will the resources be utilized to address the needs of the people? And they will be interested to see that they are part of the decision being made."

One opportunity identified during the assessment came from The Association of Obstetricians and Gynaecologists of Uganda (AOGU). They felt that they could support increasing access to FP at the community level by supporting the training of trainers of CHW and by training those who would supervise CHWs. AOGU also has the capacity to develop curricula for providers at all levels.

Additionally, there is the potential for FP methods to be available at drug shops. As of 2008, there were nearly 4,800 registered drug shops in Uganda and it is currently legal for most drug shops to sell socially marketed brands of oral contraceptive pills and condoms. It is also common for drug shop operators to sell and administer DMPA injections despite it being illegal to do so. However, a 2008 survey of drug shops found that among 124 shops that sold DMPA, many providers were nursing aides (33%) or nurses (26%), and most (77%) reported formal training in FP suggesting that drug shop operators have the qualifications to provide DMPA. Research is being undertaken to train drug shop operators to safely administer DMPA.[25] Evidence being generated by this and other activities, may lead to more opportunities to expand CBFP through this resource.

5.0 In Their Own Words: CHWs Speak

As part of the assessment, eight CHWs in Nakasongola district participated in a group discussion. VHT identification and training is ongoing, and the sub-county in which this group of CHWs worked had not yet undergone the process of formally becoming VHTMs. Some of the CHWs in the discussion were trained providers of Depo-Provera. The group included both male and female CHWs. The summary below is as close to their words as possible, given the fact that these responses were translated from Luganda, and that the remarks by individuals have been merged into one response for each question.

How do you view your role as Community Health Workers?

The community was initially skeptical about FP due to misconceptions, but we have been able to sensitize people, particularly men, to the benefits of FP. Community members began seeing the positive outcomes of FP use. Although men continue to be a barrier to FP use and more sensitization is needed, we feel that our work is contributing to the development of our community. For example, our clients have more time to engage in productive activities because they have fewer children, and they are better able to provide for the children they do have. Our clients are also saving money they may have spent accessing services elsewhere. The money they may have used for transport or the loss of productive time they experienced traveling to health facilities is now less of a concern, as the services we provided are convenient and do not require travel.

What are the benefits of being a Community Health Worker?

The main benefit of being a CHW is our self-esteem, recognition, and sense of value we feel in our own community. We value the skills we have learned and the respect we feel within the community. Sometimes, even the facility personnel will refer clients to us because they are confident in the services we provide and are overloaded with work. We feel proud of our ability to dispel myths and misconception about FP, and community members feel comfortable approaching us with questions. Some of us were skeptical about FP at first too, but we have since come to realize the benefits. Other community members look to us as examples and are encouraged to use it as well.

How do you think the community can be more involved in delivering health services to women, men, and families?

Conducting sensitization at Local Council meetings could be a way to involve communities by using existing structures and systems. Dramas and music are also an effective way to harness community interest. We could create a women's group to sing, and this could mobilize a lot of people including community leaders. The sound of music will attract them to come and see what's going on.

What do you think about the supervision and training you received?

We receive monthly supervision visits by Save the Children field extension workers, but sometimes they visit up to twice a week. We find the supervision visits motivating. We

were trained to refer for any health issue that we were not taught to address. We have received two weeks of training on general FP, including pills and condoms, plus an additional two weeks of training on Depo-Provera – one week on theory and one week practicum. We were also trained in issues of ante- and post-natal care, newborn care and nutrition, LAM, HIV, and STIs. We believe that our training adequately prepared us to perform our tasks, and welcome additional refresher trainings.

What are some of the challenges of being a community health worker?

Our workloads vary, but it is a concern for us because we are volunteers and need to engage in other income-generating activities. When our workloads are heavy, we do not have time have for other work. It is difficult volunteering our time and not being compensated. Also, the reimbursement for the transport cost to obtain re-supply is not sufficient. For those of us who have bicycles, any repairs are done at our own cost.

We also have challenges because of stock-outs. We are creating demand for FP but sometimes find there are no supplies at the facilities. As a result, we may disappoint our clients who are at risk of unintended pregnancy.

Completing referrals is another challenge. We have referral forms that we give to our clients to take to the health facility. At the facility, the health worker who sees the client will acknowledge it and the client is supposed to take it back to us. However, many clients lose their forms before they go to the facility.

What motivates you to perform your duties?

Overall, the love for our community motivates us to do this work. Despite our feeling that the compensation is inadequate, incentives such as bicycles and gumboots are motivating because they help us do our work better. In addition, having such items allows us to be recognized within our communities. We are also motivated by our relationship with Save the Children, and our hope that better programs and incentives will be developed and that the future is promising.

6.0 RECOMMENDATIONS

This assessment led to six key recommendations to expand access to FP through community-based services.

6.1 ***Build and sustain awareness at national and local levels*****.** A representative of the AOGU recommended community dialogues, whereby the local health management team would engage in a dialogue with their community with the goal of generating solutions to their problems. The community can also provide input into community-level FP programs, but AOGU suggests that guidelines on this process should be developed to ensure uniformity across districts. According to the Inter-Religious Council, engaging key members of the community, such as religious leaders and village-level authorities, is a critical component of any community-based program. The theme of community engagement was echoed by a regulatory board and the Ministry of Health. Other ideas include local leaders discussing FP on local radio shows, involving men and community leaders, and promoting the stature of CHWs can all promote better acceptance of FP.

Advocacy at the national and local levels can sensitize politicians to issues related to FP, including the benefits of FP in terms of MCH and development more broadly. STRIDES has taken innovative measure to address this issue by providing politicians with fact sheets that make them more comfortable talking about reproductive health issues, using accurate information. Advocacy may also be conducted by MPs to ensure funding is increased and FP remains on the national agenda. This approach was successful in 2010, when advocacy by MPs and civil society organizations resulted in a $130 million loan from the World Bank, of which $30 million was allocated to reproductive health, including FP.[26] Advocacy efforts should also be directed at professional associations and policymakers, according to the Ministry of Health.

In addition, advocacy is needed to strengthen community engagement, an issue mentioned by a number of assessment informants. The more involved the community, the more acceptance that will grow for family planning services.

6.2 ***Continue to build a supportive policy environment*****.** A national level respondent cited the need to endorse task sharing at the highest levels by identifying specifics tasks which can be shared with lower level cadres and implementing such changes. Specifically, Clinical Officers can perform vasectomies and tubal ligations, midwives can insert implants, and VHTs can administer DMPA injections. The 2010 policy addendum permitting the provision of injectables by VHTs will help to create a more supportive policy environment for CBFP. The recommendation was also made that the Ministry of Health should be engaged in discussions around how VHTs can better meet the needs of the youth.

6.3 ***Strengthen service delivery systems.*** Improvements are needed in monitoring how community FP services are operating. This includes capturing data in HMIS systems so that the impact of CBFP can be better understood and improved. When activities of CHWs are not recorded, determining the productivity of these workers or the cost-effectiveness of CBFP programs is extremely difficult.[27] Another important aspect of

service delivery is supervision. A 2007 mapping of community based distribution programs in Uganda identified supervision as one of several key practices needed for success.[28] The professional association suggested that nurses are the best resource for supervision, working from the nearest health facility. Participants also spoke of the need to strengthen health centers and increase linkages between facilities and community networks to ensure regular and constructive supervision, complete referrals, and access to services not offered by CHWs.

6.4 ***Enhance motivation, retention, and capacity of VHTs*****.** In general, respondents would like VHTs to become a paid cadre, citing improved sustainability, higher retention rates, and greater motivation of workers as key reasons. Although paying VHTs may lead to a more sustainable program, there is uncertainty about where the funding would come from. One MOH report proposed that districts fund 30% of VHTs compensation, with the donors providing the rest. Such a system, however, raises the question of sustainability, with donor dependence. Another MOH suggestion was that local governments mobilize to pay VHTs. The issue of fairness also arose as an important reason to standardized CHW compensation. As one donor stated, "How do they feel that they are wanted as service providers and therefore continue to work with the rest of the system even with minimum incentives? I mean even the health worker is working with minimum incentives but if it comes regularly, and they are recognized maybe they can work better than they are currently working."

Aside from monetary compensation, a number of recommendations emerged in the interviews to enhance CHW motivation, job satisfaction, and address concerns that CHWs are performing tasks beyond their scope of work. For example, a regulatory board member suggested CHWs be given identification such as a name tag or uniform so that they can be recognized within the community. "This is where the local councils would be prominent, so that everybody gets to know who is supposed to give them the services," the respondent said. Similarly, CHWs can be formally introduced by local councils in front of their communities. According to a regulatory board member, this would give the CHW recognition and good standing within the community, and involve community leaders.

6.5 ***Integrate FP with MCH services and with non-health sectors, and explore the potential of integrating FP services with drug shops*****.** One donor suggested the US Government's Global Health Initiative (GHI) approach to integration. The GHI is a planning framework for guiding USAID programs, designed to promote best practices at scale in the community as well as facilities. Under this approach, integration of FP and MCH will focus on key efforts, such as integrating FP into MCH services throughout the first 12 months after childbirth and providing FP information and services as essential component of post-abortion care. The DHMT and implementing agencies were supportive of integration. The Inter-Religious Council suggested that FP be integrated into non-health sectors such as agriculture and microfinance. Drug shops are active in providing some family planning services in Uganda, including injectables. While regulatory boards are nervous about these unregulated shops, research has shown that they are being used and could be made safer. Evidence may lead to more opportunities to expand CBFP through this resource.

6.6 ***Address financing issues to enhance FP services in underserved communities.*** Supporting an expansion of the work of the village health workers in FP requires training, supervision, and ongoing incentives. USAID is supporting this work for some areas through the STRIDES project, and private sector efforts are expanding such efforts. However, financing from the Ugandan MOH for such services will take greater focus. This could involve a dedicated line-item budget approach for community FP services or other approaches, such as developing a costed implementation plan with stakeholder involvement at all levels.

Appendix 1.

Key Informant Interviews

Group Type	Data Collection Method	Number conducted
Ministry of Health	Interview	5
Professional Associations	Interview	1
Implementing agencies	Interview	3
Donors	Interview	2
Regulatory boards	Interview	2
Total		**13**

Focus Group Discussions

Group Type	Data Collection Method	Number conducted	Number of Participants
Members of Parliament	Group discussion	1	
Community Health Workers	Group discussion	1	
Nakasongola District Health Management Team	Group discussion	1	
Total		**3**	

Appendix 2. Family Planning Service Provision by Cadre of Staff[29]

Type of Service	Health promoters and social marketing agents	Village Health Teams	Nursing Assis-tants	Nurse	Mid-wife	Clinical Officer	Doctor
Counseling		✓	✓	✓	✓	✓	✓
Home visits		✓	✓	✓	✓	✓	✓
Health education talks	✓	✓	✓	✓	✓	✓	✓
Print media messages				✓	✓	✓	✓

Electronic media messages	✓			✓	✓	✓	✓
Combined oral contraceptives		✓	✓	✓	✓	✓	✓
Progesterone only pill		✓	✓	✓	✓	✓	✓
Condoms	✓	✓	✓	✓	✓	✓	✓
Depo Provera Inj.		✓+	✓+	✓	✓	✓	✓
Intra uterine device				✓	✓	✓	✓
Foam tablets**		✓	✓	✓	✓	✓	✓
Creams/jellies **		✓	✓	✓	✓	✓	✓
Bilateral tubal ligation				✓+	✓+	✓	✓
Vasectomy				✓+	✓+	✓	✓
Implant insertion and removal				✓	✓	✓	✓
Emergency contraception		✓	✓	✓	✓	✓	✓
Periodic abstinence methods		✓	✓	✓	✓	✓	✓
LAM		✓	✓	✓	✓	✓	✓
Supervision of lower cadres				✓	✓	✓	✓

*will require special training and close supervision
**pending evidence on non oxynol 9

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