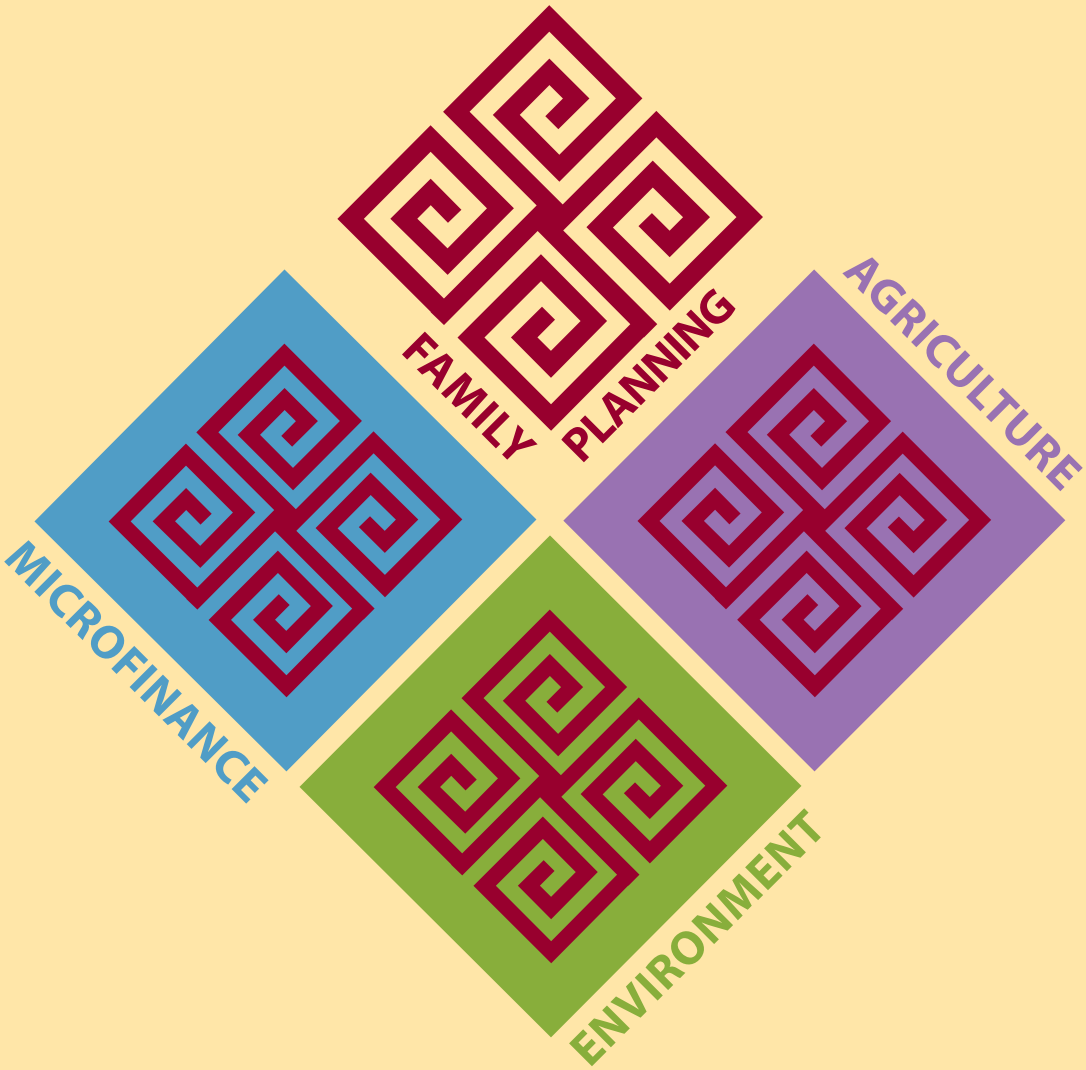
Integrating Family Planning into Other Development Sectors



Integrating family planning information and services into other development sectors offers multiple benefits. FHI 360 made this integrated programmatic approach a technical focus area under the PROGRESS project, to address the unmet contraceptive needs of underserved groups in a way that could mutually benefit the goals of partners in non-health development sectors.

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Integrating Family Planning into Other Development Sectors

Evidence confirms that family planning contributes to broad development goals of poverty reduction, enhanced education, environmental sustainability, and gender equality, but improving access to contraception has largely remained an effort contained within the health sector. While development programs outside the health sector increasingly recognize the connections between improving family planning and reaching their own goals, more evidence is needed on whether and how such efforts can work, and what types of models might be replicated and scaled up.

The FHI 360 PROGRESS project (2008-13) added to the evidence base on multi-sector integration, providing guidance on how development organizations can successfully expand their program model to include family planning services. Working closely with partners, PROGRESS developed, implemented, and evaluated three interventions, and then synthesized lessons learned and packaged materials for use in replicating and scaling up these interventions. Two additional partnerships also offered insights for the implementation of integrated models. The PROGRESS interventions integrated family planning into three other development sectors.

■ Microfinance: India and Kenya

PROGRESS worked in India with the Network of Entrepreneurship & Economic Development (NEED), a microfinance organization in Uttar Pradesh, and in Kenya with K-Rep, a bank with a microfinance arm.

■ Environment: Kenya and Uganda

PROGRESS worked in Kenya with the Green Belt Movement and in Uganda with Conservation Through Public Health (CTPH).

■ Agriculture: Kenya

PROGRESS worked with the Kenya Dairy Sector Competitiveness Program implemented by Land O'Lakes International Development.

Research Findings

Evaluations of the FHI 360/PROGRESS interventions discussed in this report found that integrating family planning with a program in a non-health development sector is feasible, acceptable, and effective.

Lessons Learned from the Integrated Interventions

1

Highlighting Mutually Beneficial Goals Formed a Solid Link between Organizations
Programs in non-health development sectors found that adding family planning services to their program model benefited their broader goals. In initial conversations with a program in another development sector, family planning organizations may need to make concerted efforts to raise awareness about the potential benefits of the joint effort.

2

Building on Existing Structures Facilitated Expanded Services
The development partners' existing infrastructure, community relationships, and systems of delivering services provided a solid base on which to add family planning services.

3

Engaging Government Stakeholders Can Generate Support for Integrated Models
By linking with the public health system rather than competing with it, the intervention projects gained the support of government stakeholders. This support helped expand access for underserved populations. The projects referred clients to government clinics or invited community health workers to work with their programs.

4

Tracking Intervention Implementation Provided Information to Inform Scale-Up
In addition to assessing the final outcome or impact of the integrated interventions, each study team documented the implementation process, tracked costs, and packaged intervention materials to share externally. These steps are facilitating scale-up planning and supporting local and global advocacy efforts for replication.

5

Programs in Non-Health Sectors Need Resources to Sustain and Expand the Model
Two organizations implementing the interventions had funding streams independent of the donor award that supported integration of family planning services. This financial diversification enabled these groups to consider ways to sustain the demonstration model and scale it up within their organizations. Two other projects, however, will require additional donor awards to sustain the pilot activities.

6

Programs Need to Expand Organizational Capacity for New Service Delivery Model
Even when programs integrate family planning information and referrals into their existing infrastructure, their organizational capacity for conducting training and supervision, monitoring and evaluation, and advocacy around the expanded model may need to be enhanced for the program to succeed in the long term.

Network of Entrepreneurship & Economic Development (NEED), India

Microfinance programs reach poor, underserved individuals who may not have access to family planning information and services. Such programs have regular contact with small groups, whose members are generally motivated to improve their lives. Often the microfinance organizations put a priority on reaching women, many of whom are of reproductive age. Because microfinance agencies have repeated contact with their members, key concepts can be reinforced and trust develops in the presenter as a reliable information source.

The Network of Entrepreneurship & Economic Development (NEED), a microfinance group based in Uttar Pradesh, India, when approached by FHI 360 expressed an interest in strengthening family planning information as part of the health information provided through Village Health Guides (VHGs). Working with NEED and the Institute for Reproductive Health (IRH)/India, PROGRESS developed an intervention targeting members of the NEED self-help and joint-liability groups in 70 villages of Sitapur District, Uttar Pradesh.

The key findings (box at left) suggest that adding family planning information and referrals to a microfinance program can reach people poised to make positive changes in their lives and can be delivered by lay health workers from this development organization. The most obvious challenge was determining how to mobilize the NEED VHGs to deliver messages and be able to handle questions about family planning options. About half of them were illiterate.

Key Findings

- Within the intervention group of 800 women, family planning use for all methods increased significantly from 40% at baseline to 69% at endline, with a majority of new users reporting using rhythm/periodic abstinence.
- During the intervention, the unmet need for family planning declined from 42% to 12%.
- The 35 Village Health Guides held 965 group sessions in 70 villages and made 15,939 home visits to discuss family planning over 7 months.

Intervention and Study Approach

The primary objective of the study was to assess whether the provision of family planning messages by the VHGs was associated with a meaningful increase in family planning use and reduced unmet need. Women have unmet need for contraception if they are sexually active and fecund, do not wish to become pregnant, and are not using a family planning method to avoid becoming pregnant. The intervention was designed to be integrated into the existing NEED operations with the goal of enhancing the sustainability of the intervention and facilitate scaling up within NEED.

The intervention started with a five-day training session for 35 VHGs on the basics of fertility, family planning methods, and the delivery of specific thematic messages on how

family planning can benefit different families, depending on their goals for when to have a child. The VHGs received job aids and created a referral resource directory listing the available family planning providers in a village and the methods available from each provider. After the training, the VHGs conducted group meetings on specific topics each month over a nine-month period as part of regular NEED self-help/joint-liability group (SHG/JLG) meetings. The meetings covered the benefits of family planning and the various methods available in India, with a repetition of three key messages each month: family planning can benefit families, couples have different family planning goals, and options exist for each goal. There were monthly refresher sessions with the VHGs to address challenges of low literacy. The VHGs also made home visits to follow up on topics or to reach those who were unable to attend the group meetings. These visits provided more confidentiality and also an opportunity to discuss topics within a larger family context (spouse, mother-in-law). For women or men seeking services, the VHG was prepared to provide referrals to nearby services and accompany the person if need be.

The evaluation of the intervention used three data sources:

- A cohort of 800 women members of the SHG/JLGs was interviewed before the intervention and about 15 months later to document changes in knowledge, awareness, attitudes about family planning and the intervention, and family planning use.
- The VHGs were requested to complete monthly activity reports documenting the topics discussed and challenges faced in delivering the information.
- The district coordinators were asked to report on the refresher reviews and supervisory visits they led with the VHGs.

Rick Homan/FHI 360

Findings and Challenges

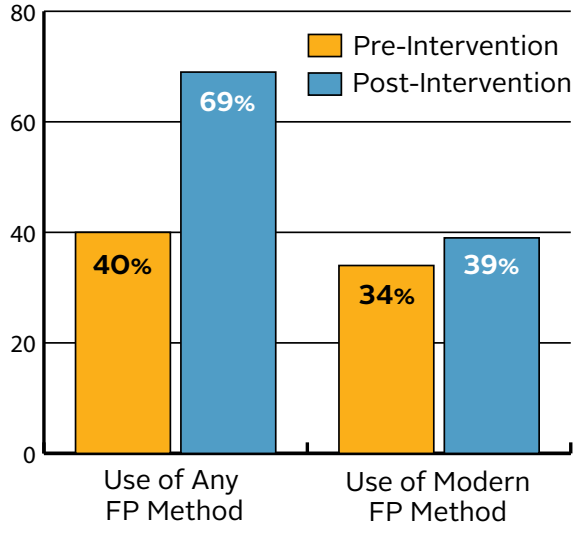
The VHGs were able to provide activity reports for 7 of the 9 months of the intervention. During that period they conducted 965 group sessions (with about 16 persons per session) in the 70 villages, about 2 sessions per village per month. The group sessions attracted group as well as non-group members, which is NEED's practice of supporting group members and the communities in which they live. The large number of home visits, while not all related to family planning issues, did provide other opportunities to discuss family planning one-on-one.

More than 90% of cohort members reported the information was helpful and easy to understand, which indicates that the messages provided the correct level of detail. The respondents reported

attending most of the monthly sessions, and most of them received a home visit from the VHG over the 9-month period. The women were interested in discussing family planning with the VHG in the home setting, and over half asked questions about how to access services. The monthly reports by the VHGs noted the challenges in discussing sensitive topics in the group meetings but this improved over time as they and the attendees became more comfortable with the topic of family planning. In addition, 501 women requested a referral to a family planning provider, and the VHGs assisted about one-third of these to access services, either by identifying possible providers or in some cases accompanying the woman to a provider.

The figure below shows the change in family planning use among the cohort of women pre- and post-intervention, going from 40% to 69% (all contraceptive methods) and 34% to 39% (only modern methods). Almost one-half of the new use is comprised of women reporting use of rhythm or periodic abstinence, a method less effective than modern contraceptive methods. The majority of the new modern method use is female sterilization and male condoms. (In both comparisons shown in the figure, the change was statistically significant at the 0.001 level). Looking ahead, there is a need to develop strategies to assist the women who are new to fertility control via rhythm/periodic abstinence to transition to more effective modern method use.

Increase in Family Planning Use Among Cohort of SHG/JLG Members (n=628)



The second key outcome of interest was whether there was a reduction in unmet need for family planning, which fell markedly, from 42% of cohort members at baseline to 12% at endline. (The reduction in unmet need was statistically significant at the 0.001 level.)

These positive findings occurred despite some challenges. Reports from the district coordinators and the IRH training support personnel found that training the VHGs initially was difficult due to unfamiliarity of the technical aspects of the topics and low literacy. However, the refresher reviews, while time-intensive, helped reinforce the technical skills and created an environment for collective learning and support among the VHGs.

Particular accomplishments that addressed various special issues included:

- The creation of the referral resource directory made the VHGs familiar with family planning resources in the community and sensitized the local providers of family planning services to the intervention.
- Newlywed women rarely came to group meetings but the VHGs were able to bring the messages to them through home visits. Depending upon age at marriage, this can be an important group to reach as the risk of maternal and/or fetal mortality is much higher before age 20.
- The process that NEED used to document the intervention activities helped the VHGs

understand what their peers were doing and reinforced effective communication of the new family planning information.

- Initial tension with the local community-based health workers, who worried that the VHGs were going to replace them, dissipated once the intent to complement them became clear.

Next Steps and Success Factors

NEED and IRH/India were committed to improving women's lives and saw the potential benefits of family planning towards reaching that objective. The VHGs were eager to learn and took pride in their ability to deliver messages on family planning to the women and men in the villages they support. Because they were so motivated, they were effective at repeating the simple messages and taking the time to visit women in their homes and provide one-on-one information exchanges. Initial hesitancy by community members to discuss these topics waned over time, which points out the advantage of repeated exposure.

From the beginning, this intervention was designed to complement the activities of the microfinance organization as well as the current family planning programs run by the Government of India and the local providers in the villages of Sitapur District. These factors reduced the cost of the intervention and increased its sustainability after the research activity was completed.

Because the VHGs were typically addressing groups of about 16 persons in a meeting, there is more of a personal connection and trust develops over time. Because the VHGs address other health topics, they are not perceived as solely family planning promoters. Rather family planning information is one more piece of guidance and advice they can offer to group members and the community. This increases their standing in the community and allows them to respond to individual needs beyond just a single issue.

NEED is seeking additional funds to expand the service within the organization and to ensure that the services in the intervention area continue.

Integration of Family Planning into Kenya Microfinance Project Showed Promise

PROGRESS worked with K-Rep Bank, the largest microfinance organization in Kenya, with a project design similar to the one used in India. This nine-month intervention, which began in July 2011, employed a cluster-randomized trial design with 29 microfinance officers randomized into an intervention or control group. Those in the intervention group were trained to deliver information on family planning methods, which they did at the end of their biweekly microfinance meetings, and make referrals to local MOH clinics. The study planned to assess whether modern contraceptive use increased. The intervention was prematurely stopped, however, because K-Rep Bank was unable to continue dispersing loans through the microfinance groups, which gradually dissolved. The funding for the microfinance program was through a separate USAID mechanism; its discontinuation had nothing to do with the PROGRESS study, intervention, or partnership with K-Rep. Although the program was terminated before completion, anecdotal reports indicated the intervention was highly acceptable to the target population and microfinance officers, was feasible in terms of the bank adding family planning messaging to the microfinance officer duties, and added value with limited costs.

Green Belt Movement, Kenya

Founded by the Nobel Laureate, Professor Wangari Maathai in 1977, the Green Belt Movement (GBM) is best known for its environmental conservation achievements. Volunteer Tree Nursery Groups have planted some 51 million trees throughout Kenya to date. While known as an environmental group, GBM's goals and mission have always sought to improve lives and communities, with special focus on advancing women's status through increased income generation potential, increased self-sufficiency and leadership capacity, and healthier life choices. The goal of improving the health of women and families through healthy timing and spacing of pregnancies is consistent with GBM's ideals of promoting household well-being and conserving natural resources.

FHI 360 teamed with GBM to evaluate the feasibility and value of incorporating family planning (FP) promotion into the activities led by GBM's community-based environmental workers, known as Green Volunteers (GVs). The GVs received training to share messages about the links between environment, health, and population. They then educated the community about healthy timing and spacing of pregnancies achieved by using family planning. GVs were further charged with strengthening ties between the community and health facilities offering FP services.

Key Findings

- *Green Volunteers:* The GVs acquired adequate knowledge to teach the community about the relationship between family size and the health of families, communities, and the environment. They viewed the promotion of FP to be an acceptable added responsibility and carried out their newly assigned tasks according to plan.
- *Community:* GBM members and the larger community appreciated GVs' efforts to communicate messages about the links between environment, health, and population and to promote FP services. There was some evidence of improved knowledge, attitudes, and behaviors related to FP use. The program reached men and couples.
- *Health sector:* Health care providers and managers appreciated GBM's work to strengthen ties between the community and FP services. They expressed interest in continuing the collaboration, including having Community Health Extension Workers play a greater role in environmental, health, and population activities.

Intervention and Study Approach

The project team first introduced the "Environment, Health, and Population" (EHP) intervention in four areas where GBM worked. Forty-two GVs completed a 5-day course designed to increase their understanding of the inter-relations between population and family size and the health of individuals, households, communities, and the environment. GVs learned how timing and spacing of pregnancies affect the health of women and children, how FP use allows couples to have well-planned pregnancies, and the benefits and drawbacks of FP methods available in Kenya. They practiced using a flip book developed

by the project to guide group education. They were further equipped with a booklet to inform the community about FP methods available in Kenya and posters illustrating EHP themes to display in community spaces.

Trained GVs were charged to deliver EHP messages in their regular meetings with Tree Nursery Groups and to organize public events to educate the community about EHP topics. They were expected to invite government-supported Community Health Extension Workers to attend these community meetings to present more detailed information on FP methods. Finally, GVs were expected to refer community members to health facilities to seek FP services. The GBM extension workers already in place to support GVs' pre-existing activities were responsible for providing supportive supervision of the new EHP activities.

The study team collected data to assess the success of the intervention 8 months after its full implementation, using several sources:

- A survey of the 42 trained GVs assessed job knowledge and experiences conducting EHP activities.
- Review of data from GVs' monthly activity reports, referral log books, and supervisors' monitoring forms provided information on intervention implementation.
- Interviews with 20 key informants representing the health sector, community leaders, and GBM explored the contributions made by GVs in conducting EHP work.
- Focus group discussions with 7 Tree Nursery Groups and 9 groups of community members examined perceptions about GVs' capacity to conduct EHP activities and the effect of the messages on community perspectives regarding FP.

Findings

One of the main research objectives was to assess GV capacity to acquire and retain essential FP knowledge over time. Among the 42 trained GVs, 81% answered correctly at least 7 of 10 questions reflecting essential FP knowledge 8 months after the intervention began (see table below). GVs demonstrated clear capacity to conduct EHP activities in other ways. GVs indicated they had a good understanding of the EHP activities they were expected to conduct; nearly all were able to describe expectations related to this activity. Almost all GVs also expressed favorable attitudes about conducting EHP activities, and all said they were interested in continuing these activities. Two-thirds of GVs interviewed reported it was completely acceptable to discuss FP in a public meeting, and another third

Family Planning Knowledge, Eight Months after Training (N=42)

Knows...	% GVs
FP methods help achieve healthy timing and spacing of pregnancies	100
At least two natural resources affected by population growth	100
At least four FP methods (spontaneously mentioned)	98
At least two non-health benefits of healthy timing/spacing of pregnancies	98
Women should have birth to pregnancy intervals of at least two years	81
At least two health risks to mothers from poorly spaced births	81
Women should wait until 18 years of age before becoming pregnant	69
At least two health risks women face if becoming pregnant before 18 years of age	55
At least two health risks to children from poorly spaced births	48
Women should wait six months after a miscarriage before becoming pregnant	40
Proportion who got seven or more knowledge questions (above) correct	**81**

* *Mean number of correct responses to knowledge questions (above)=7.7*

Caroline Mackenzie/FHI 360

said it was acceptable, depending on the message. The activity most frequently mentioned by GVs (76%) as easy to conduct was educating their Tree Nursery Groups. The activity most frequently mentioned as difficult (38%) was organizing community meetings to deliver EHP messages. A few GVs reported difficulties coordinating activities with Community Health Extension Workers, most commonly because the health workers faced constraints making it hard to travel to communities.

All 42 GVs conducted EHP activities in their communities, but only 30 of them submitted a report documenting EHP activities. On performance monitoring forms of the GVs (47 forms), supervisors noted good preparation for meetings, widespread use of flipbooks, effective presentation skills, and clear and simple answers to questions. The study team observed, however, that the system designed to track GVs' referrals of community members to health services did not function well. Accounts from GVs and key informants revealed that GVs could effectively encourage community members to seek services from health facilities without issuing formal referrals.

Nearly all key informants reported that GV's were well-trained and could confidently conduct community education on EHP topics, based on observing GVs conducting community education with groups ranging in size from 20 to 150 participants. Several key informants noted that the EHP activities served as a way to deliver FP messages to men who otherwise would have no exposure to this information. Several key informants also appreciated the way that GBM's EHP activities facilitated the Community Health Extension Workers to conduct the outreach activities they are intended to do, but often struggle to complete due to inadequate ties to communities. Commenting on program limitations, a few key informants reported GVs' knowledge about FP methods is limited and that they should continue to be supported by a nurse to ensure the community receives complete information. Some informants also mentioned that GVs could be aided by transport resources that would allow them to move more effectively across communities. Nonetheless, every key informant interviewed advocated for GBM to continue conducting EHP activities and to spread them to new areas.

Results from the 16 focus group discussions further supported the feasibility and acceptability of GVs engaging in EHP activities. Participants in all groups affirmed that GVs promote healthy timing and spacing of pregnancies, and in all but one group, participants thought GVs were credible in discussing FP. The focus groups confirmed the idea that an important benefit of EHP community education is to expose men to FP messages. This exposure reportedly allowed couples to talk more freely about their FP choices, and it motivated some women and men to seek FP services as a couple. The focus groups indicated that the EHP activities had a positive impact on FP-related knowledge and behaviors. In all 16 groups, participants reported that they shared with others the FP information they received from GVs. In all but one group, participants spoke of knowing someone who sought FP services as result of GVs' discussion of EHP matters.

Next Steps

GBM leadership is currently reviewing findings and considering implications for future programming. These managers are encouraged by the results and see the value in developing a strategy for incorporating the EHP intervention more broadly in GBM's activities throughout Kenya.

Broader Organizational Capacity Needed for PHE Program Model

Conservation Through Public Health (CTPH), a nonprofit organization in Uganda, promotes conservation among the world-famous gorilla population in Bwindi Impenetrable National Park by enabling humans, wildlife, and livestock to coexist through improving primary health care in and around the park. Noting an unmet demand for contraception among the remote population living near the park, around 2007 CTPH began integrating family planning into its program activities. The expanded program activities posed challenges for CTPH with regard to monitoring and evaluating (M&E) family planning services and advocating for the integrated Population, Health, and Environment (PHE) model in Uganda and beyond. PROGRESS and CTPH addressed those challenges in a partnership to enhance CTPH's capacity to do both.

Monitoring and evaluation: The PROGRESS team worked with CTPH to develop, refine, and finalize an M&E system that included an updated planning approach (i.e., "logic model"), expanded indicators, data collection forms, and a comprehensive database specifically designed to capture the impact on population and environment issues, as well as health measurements on other health issues such as tuberculosis and hygiene. The partners also developed data collection forms for CTPH volunteers and guidance to help ensure consistent interpretation and use of each indicator. Workshops served to review the indicators, introduce the data collection forms, and train staff on using the new database. CTPH management then led the rollout of the indicators and data collection forms to its staff and volunteers with ongoing technical guidance and troubleshooting from PROGRESS. Through this capacity building approach, CTPH strengthened its M&E platform, including improved skills in interpreting and applying M&E results.

Advocacy: PROGRESS worked together with CTPH to develop an advocacy plan for the organization, including goals, objectives, and key annual activities. As the first secretariat of the Uganda National PHE Working Group (comprised of 35 conservation and health organizations dedicated to advancing PHE in Uganda), CTPH was able to use its own newly formed organizational advocacy strategy to catalyze and inform the development of an advocacy plan for the broader working group (partially funded by Population Reference Bureau), and to build the capacity of these groups by hosting a three-day study tour to the CTPH integrated PHE sites.

Land O'Lakes, Kenya

This project sought to integrate delivery of family planning and health services during recurring community educational events in the dairy sector. These one-day events known as "farmer field days" (FFD) attract a large number of attendees from across rural society, including dairy cooperative households and employees, providers for materials used in the dairy industry, and members of the community where FFDs are held. Exhibitors set up tents where they market products and services directly to attendees, and development partners conduct open-air training sessions where attendees can learn about improved agricultural practices.

Key Findings

- Utilization of the health camps was high; more than 80% of the 2,344 attendees at 7 field days received health consultations.
- Among the attendees, 319 agreed to participate in a survey; 60% of these reported receiving family planning information.
- Of the 319 in the survey, 206 were married and non-pregnant. Among these 206, 42 (25%) received additional supplies of a modern method (pills, condoms, or injectables), and 32 had an unmet need for contraception. Of the 32, none initiated a modern method at the visit.
- Of all surveyed, 83% preferred receiving health services at a field day rather than a health facility.
- The health camp served members and non-members of the dairy cooperatives.

The Kenya Dairy Sector Competitiveness Program (KDSC), implemented by Land O'Lakes International Development, worked with local dairy cooperatives to integrate a health camp into the regular field days for their cooperative members, where health providers offered counseling, some family planning methods, and referrals to clinics for long term methods.

Intervention and Study Approach

PROGRESS and KDSC programs planned and implemented health camps at three FFD sites in Central Province and four FFD sites in Rift Valley Province, working with the Ministry of Health, local health authorities, and stakeholders. The KDSC field coordinators worked with the cooperatives in planning the study. Participating cooperatives posted announcements about the health camps one week before the FFDs, inviting not just cooperative members but the entire community to attend. The all-day health camps took place during scheduled field days between August and December 2010.

Stakeholders suggested the package include various health services, not just family planning. PROGRESS staff visited each site at least two weeks before the field day to identify health providers to deliver services during the health camps. Both private and public health providers were selected based on their availability to work at the field days and on their interest in following up with clients who required additional services. To address low drug stocks among private providers, pharmacists were made available at the

camps to dispense drugs based on a clinician's prescription. Three health service providers were available at each health camp (all trained clinicians from the public and private health sector). The service package offered focused on women's health. Family planning services offered consisted of information and counseling; provision of oral contraceptives, injectables, and condoms; and referrals for long-acting methods. Standard Kenya MOH job aids and checklists were used to help interested clients choose an appropriate family planning method. The package also included child immunizations, antenatal care, screening and treatment for sexually transmitted infections, HIV counseling and testing, treatment of minor illnesses, and referrals. All services were provided free of charge, but attendees were responsible for the costs of follow-up care and referrals. In Kenya, women pay a nominal fee at a public clinic and various levels at private providers.

A descriptive study measured participant levels of contraceptive use, unmet need for family planning, and demand for various health services at the cooperative-sponsored field days. All women 18 to 49 years old who received any health services from an on-site clinician were invited to participate in a survey that included questions about their contraceptive history, the field day health camp model, and the package of services offered at the camps. Each on-site provider also completed a checklist at the end of each client session to indicate which services he or she provided from the package.

At the end of each field day, study staff collected attendance statistics from standard cooperative registers. In addition, cost information of the major components of the event was collected in order to estimate the cost of scaling up the model in other cooperatives within Kenya. This included the costs of organizing stakeholder meetings, identifying providers, advertising and implementing the health camps, and other logistics.

Findings

Utilization: Health camps were highly utilized by FFD attendees; more than 80% of the 2,344 attendees received health consultations, and 73% of them were women. Among all attendees, the most frequently received services were general physical examinations (66%), family planning services (18%), and HIV counseling and testing (14%). Services received by men and women differed slightly. A greater proportion of men (20%) than women (11%) received HIV services, but no men received family planning services. The mean cost of implementing a health camp was US$1,445 (US$5.87 per consultation or US$4.04 per cooperative member).

Characteristics of Female Health Camp Attenders: Interviews were conducted with 319 women. The mean age of the women was 33 years. The majority was married (76%) and poor (80% in the lowest two wealth quintiles), and about half had no more than a primary education. Only 40% were affiliated with a dairy

Rose Otieno-Masaba/FHI 360

cooperative, either by family ties or employment. The services they most frequently reported receiving at the field days were general physical examinations (96%), family planning information (60%), family planning methods (16%), and HIV counseling and testing (14%).

Contraceptive Use: A subset of 206 out of the 319 women had a current need for contraception, defined as being married, not pregnant, and able to have children. Among this group, about four of five (81%) were currently using a modern contraceptive method. The most popular methods being used were injectables (38%) and pills (17%), followed by the intrauterine device (9%). Of the current contraceptive users, 25% reported having received additional supplies of condoms, pills, or injectables at the health camp.

Unmet Need: Fifteen percent of the 206 women (N=32) had an unmet need for contraception. A woman was classified as having an unmet need if she was married, not pregnant, did not want a child in the next year, and was not currently using a modern method of contraception. Even so, among these 32 women, 22 of them did not want a contraceptive method. Four others wanted a method that was not available at the field days and so were referred to other health facilities (data not shown in table). The other six women did not discuss family planning with a provider. Thus, none of the women with an unmet need initiated a modern method of contraception during a field day health camp.

Attitudes toward Health Camps: Eighty-three percent of those surveyed reported that they preferred receiving services at the field day rather than at their customary health facility. Sixty-eight percent said they would have attended the field day even if health services were not offered. Two-thirds of the women in the overall survey reported knowing about the field day health camp prior to arriving at the event. Of these women, nearly all (96%) desired to get a general physical health examination. The second most desired services were family planning and HIV counseling and testing (12% each). Very little demand was reported for immunization or antenatal care services (3% and 1%, respectively). The women learned about the health camps from a broad set of sources, including a representative of a dairy cooperative

Family Planning Services Received by a Subset of Married, Non-Pregnant Women, Sorted by Contraceptive Need

	Unmet Need (n=32, 15%)		Currently Using a Modern Method (n=166, 81%)		No Need (n=8, 4%)		Total* (n=206)	
	#	%	#	%	#	%	#	%
Discussed family planning	26	81	148	89	5	63	179	87
Received a modern method	0	0	42	25	0	0	42	20
Received a non-modern method	1	3	0	0	1**	13	2	1

* All women for whom contraceptive need could be established. Of the 319 women who were surveyed, 113 were excluded from this group for one of the following reasons: unmarried, pregnant, infertile, or contraceptive use could not be determined.

** One woman who wanted to have a child in the next year, and thus was considered to have no need for contraception, received a non-modern method.

(46%), a cooperative committee member (25%) and a neighbor (17%).

Conclusions and Next Steps

The results of this study suggest that the health camp model is a feasible way to offer health services, including family planning services, through cooperative-supported FFDs in rural Kenya. One obvious advantage of the health camps is that they leveraged an established convening mechanism (the FFD) that already was effective in bringing people together at an established time and place.

Initial concerns that the health camps would divert farmers' attention from dairy-related activities proved to be unfounded. The health camps were highly acceptable, offering convenient access to services that women wanted and effectively targeting the poor. In addition to providing general health services, the health camps provided integrated family planning and reproductive health services and offered many current contraceptive users a convenient opportunity to resupply their family planning methods. About one in five women in the study subset received additional supplies of a modern method. The fact that none of the women classified as having an unmet need for contraception chose to initiate modern family planning at the health camp reflects what might occur in a traditional health facility, where providers often see many returning family planning clients but few new contraceptive users.

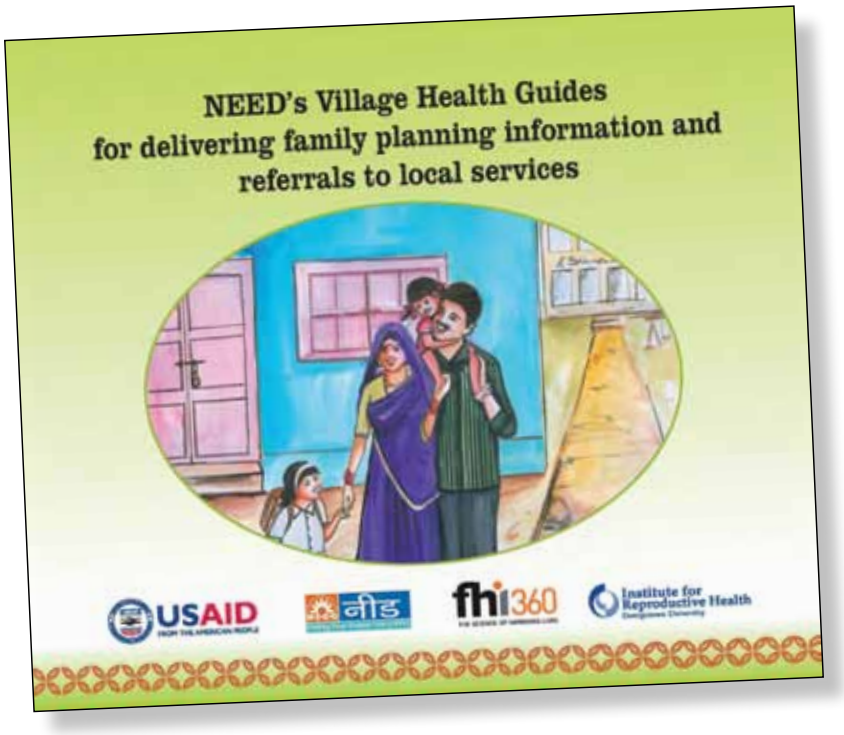
PROGRESS designed an institutionalization plan that distributed the piloted activities from the pilot to stakeholders deliberately in line with their interests and incentive structures. An HIV/AIDS treatment and prevention project implemented by FHI 360 and partners undertook promotion of the health camps, and the local District Health Management Teams (DHMT) identified and contracted clinicians to work at the Health Camps, and purchased medical supplies and drugs for the events. One pilot event with these new partners did take place, but the number of field days diminished sharply when the KDSC implemented by Land O'Lakes was reducing activities prior to the end of a grant from USAID. This raised the larger question of the sustainability of community educational events in rural areas when the development partner hands off responsibility to local entities.

Sustainability of the health camp model will depend on how cooperatives and other stakeholders such as the MOH work together to coordinate roles and local resources to organize the camps. Successful collaboration across sectors demonstrates how making such linkages can lead to locally generated solutions to improving rural access to family planning and other health services, especially in rural areas among poor women.

Microfinance, India

Anil Singh, Chief Executive, NEED:

Microfinance is not just about economics. So when we go to provide microfinance, we cannot ignore issues that are directly linked to people's health and life. Unless both run side-by-side, microfinance is incomplete. Social and economic enterprises go hand-in-hand in microfinance journey.



Village Health Guide, NEED:

Earlier I was not aware of any of these methods. Now that we are trained, I am able to spread correct information about all the options.

Agriculture, Kenya

Mary Munene, Development Specialist and Gender Advisor, Land O'Lakes:

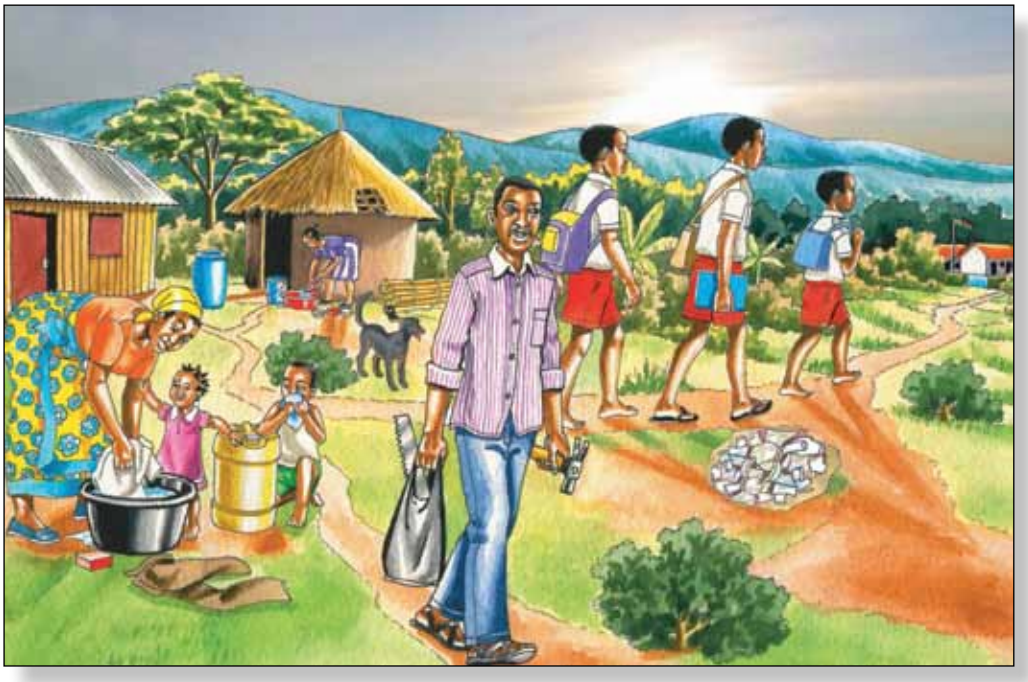
The dairy cooperatives were very skeptical at first, fearing that the health services would distract from the main focus of the field day – farmer training. The result of adding the health tent was an increase in attendance at the field days and in membership in the cooperatives. Other cooperatives began asking for the health services at their field days. This program was a 'wow'! What happened under this pilot was a seed that was sown. Now we would like to scale it up.

Environment, Kenya

Annual Report, Green Belt Movement:

Through our new Environment, Health and Population Programme, 26 of GBM's Green Volunteers reached more than 800 households with the message that a healthy environment supports healthy communities, and that healthy communities are likely to make choices for their families to ensure a high quality of life.

Job Aid Excerpt, Green Belt Movement



Report, Green Belt Movement:

At a Green Belt Movement project review meeting in July 2012, a project volunteer reported that a local chief had helped dispel a myth that fewer children due to family planning had led was led to local school closings. A second volunteer reported that a male villager had contacted the volunteer for a private demonstration on condom use. Still a third volunteer reported that another man had opened up to his community for the first time about having a vasectomy.

Moving Forward – Integrating Family Planning into Other Development Sectors

Given the sector-focused nature of development funding, even when multi-sector service delivery approaches are found to be acceptable, affordable, and effective (e.g., increase family planning use), ongoing resources will likely be needed for sustainability, expansion, and scale-up.

As the popularity of integrated multi-sector projects grows, implementers acknowledge that broader organizational capacities are required for delivering an expanded program approach. One strategy for building such capacity is to rely on nongovernmental partnerships between organizations from different sectors, such as the Population, Health, and Environment (PHE) networks that are evolving globally and in several African countries. The population and environment organizations collectively hold great potential to advance effective joint programming, through leveraging the comparative advantages of each individual sector. More knowledge on effective partnership models is needed to help build the capacity of development organizations in training and supervision, monitoring and evaluation, and advocacy around an expanded program model.

Future research projects linking family planning and other development sectors can expand the evidence behind this integrated approach. Specifically, more research is needed to document the implementation process, evaluate outcomes, track costs, and share strategies and materials both locally and globally to inform replication and scale-up. In addition, researchers should assess the impact of integrated programs on key family planning indicators (such as contraceptive uptake), and equally important, the impact on indicators related to the core development sector such as household loan repayment rates, soil and firewood use, water use, or agricultural productivity.

Caroline Mackenzie/FHI 360

Useful Tools to Support the Integration of Family Planning into Other Development Sectors

PROGRESS packaged materials that can facilitate replication or expansion of the models described in this report, along with research summaries and other information. They are organized by the respective development sectors below. For a summary of the PROGRESS work in this area, go to:

http://www.fhi360.org/projects/progress-technical-area-integration-family-planning-non-health-sectors

Caroline Mackenzie/FHI 360

Delivering Family Planning Information and Services through a Microfinance Program

http://www.fhi360.org/projects/progress-india-partnership-microfinance-organization

Project implementation tools used with the Network of Entrepreneurship & Economic Development (NEED) project in India are available, including a training manual and job aids for health outreach workers, plus a video on the project, useful for advocacy efforts. The implementation materials were designed for low-skilled health outreach workers or peer educators, who work with microfinance or development organizations. If you use or adapt the materials, please acknowledge FHI 360, Institute for Reproductive Health, and NEED.

Delivering Family Planning Information and Linkages to Services through Community-Based Environmental Programs

http://www.fhi360.org/projects/progress-kenya-partnership-green-belt-movement

Project implementation tools used with the Green Belt Movement (GBM) project in Kenya are available, including a training manual and job aids for environmental or conservation volunteers. A video about the PROGRESS and Green Belt Movement collaboration is also available. These materials will be useful to environmental organizations seeking to introduce family planning information and encourage links to family planning services. The implementation materials were designed for low-skilled conservation staff who work in environmental or development organizations. Please acknowledge FHI 360 and GBM if you use or adapt the materials.

Delivering Family Planning Services through Agricultural Field Days

http://www.fhi360.org/projects/progress-kenya-family-planning-services-through-agricultural-field-days

A more detailed summary of the Land O'Lakes project is available. The Kenya Ministry of Health and Land O'Lakes are now exploring how to continue offering the family planning outreach services begun under the PROGRESS collaboration at future farmer field days, with options being explored to sustain and expand the field day health camp model. Agricultural programs that are interested in establishing a similar program can get more information from FHI 360 about this project, including a client survey, provider perspectives, and cost analysis (contact Tricia Petruney at tpetruney@fhi360.org).

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