

ACQUIRE Evaluation and Research Studies

Revitalizing Long-Acting and Permanent Methods of Family Planning in Uganda: ACQUIRE's District Approach

E & R Study #10 ♦ August 2008



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Acronyms and Abbreviations

ACQUIRE	Access, Quality, and Use in Reproductive Health
AIDS	acquired immune deficiency syndrome
COPE®	client-oriented, provider-efficient
CRHW	community reproductive health worker
DISH	Delivery of Improved Services for Health
DHMT	district health management team
FGD	focus-group discussion
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FHI	Family Health International
FP	family planning
IEC	information, education, and communication
IHRC	integrated health resource consultants
IUD	intrauterine device
LAPMs	long-acting and permanent methods of contraception
MAP®	Men As Partners
MEC	medical eligibility criteria
MOH	Ministry of Health
MSI	Marie Stopes International
NGO	nongovernmental organization
NMS	National Medical Stores
OPRH	Office of Population and Reproductive Health
PMTCT	prevention of mother-to-child transmission of HIV
PNA	performance needs assessment
RH	reproductive health
RHD	Reproductive Health Division
UPMA	Uganda Private Midwives Association
UNFPA	United Nations Population Fund
UPHOLD	Uganda Program for Human and Holistic Development
USAID	U.S. Agency for International Development
WHO	World Health Organization

Executive Summary

This case study synthesizes the ACQUIRE Project's experience and achievements in its efforts to revitalize family planning (FP), with a focus on long-acting and permanent methods of contraception (LAPMs),¹ in four districts in Uganda during the period January 2005 to November 2006. It describes the project objectives and strategies, challenges encountered, program adjustments made, results, lessons learned, and practices proven to be effective. It also offers recommendations for addressing the systemic challenges in the Ugandan health care system.

Uganda's Family Planning Program

The Government of Uganda is a signatory to all the major international agreements related to reproductive health (RH) and has developed several far-sighted national policies and strategies to promote it. FP is cited in several key documents as a national health priority, and the government has set ambitious goals for increasing contraceptive prevalence from 24% to 40% by 2010. Despite this supportive policy environment for FP/RH in Uganda, full implementation of existing policies and plans is made more complicated by multiple challenges.

Political commitment to FP in Uganda has not yet fully merged with its written declarations. The country's political leadership encourages large families to spur economic growth, which makes full implementation of FP policies challenging for national leaders and Ministry of Health (MOH) staff. At the district level, political leaders who allocate resources are not necessarily adequately informed about health-sector priorities and the importance of FP.

In Uganda, health programming responsibilities (such as policy formulation, resources, national strategy, action plans and targets, medical stores, training, and monitoring systems) are largely centralized, while budgetary decisions and service-delivery responsibilities are devolved to the district and village levels. However, numerous political and technical factors and funding limitations impede the latter's performance in these areas and restrict infrastructure development.

Health care in general, and FP in particular, is underfunded in Uganda, affected by shifts in focus and resources to HIV and AIDS programs due to donor priorities. Essential training, supervision, and contraceptive logistics systems face significant challenges. Staff recruitment, retention, and accountability are chronic problems, particularly in rural areas and especially in areas of prolonged conflict in the north. The result is a weak public-sector FP program hampered by a shortage of service providers and commodities.

LAPMs in Uganda

LAPMs afford numerous benefits to both individuals and health care systems. These methods are highly effective and safe; they are suitable for use by all categories of clients, for a variety of RH intentions; and, over time, they are very cost-effective. LAPMs reduce demands on health care systems, do not require continual resupply, and have much lower discontinuation rates than short-acting methods.

¹ LAPMs comprise the hormonal implant, the intrauterine device (IUD), female sterilization, and male sterilization.

Despite the distinct advantages of LAPMs, their availability and use are low in Uganda. Injectables have become the most widely used method,² while use of LAPMs has declined over the years. Female sterilization has dropped from 30% of the method mix in 1988 to about 13% in 2006. Currently, fewer than one in five FP users choose an LAPM (IUD, 1%; implant, 2%; sterilization (13%) (UBOS & Macro International, Inc., 2007).

ACQUIRE's Mandate and the District Approach to FP/LAPM Revitalization

The ACQUIRE Project is a global project with a mandate of making FP/RH services more widely available to expand contraceptive choice and use, with a focus on underutilized LAPMs. In 2004, ACQUIRE received field support from the U.S. Agency for International Development (USAID) and funding from the Office of Population and Reproductive Health (OPRH) to advance the Ugandan government's efforts to increase contraceptive prevalence. Specifically, ACQUIRE's task was to complement the FP component of the bilateral project Uganda Program for Human and Holistic Development (UPHOLD) with technical assistance for LAPM services.³ The goal for the two-year funding period was to revitalize LAPMs in four districts. Specific objectives were to:

- ◆ Increase the number of sites providing a range of LAPM services
- ◆ Increase the use of facility-based LAPM services

In addition, three special initiatives were set forth for increasing access to FP/LAPMs:

- ◆ Increase access to underutilized FP methods (with a focus on the IUD)
- ◆ Increase access to FP through integration with other services and through outreach
- ◆ Increase male involvement in FP and RH

The MOH and USAID/Uganda identified criteria for the districts in which to implement the revitalization project: FP need/underperformance; geographic spread; and opportunities for collaboration with other projects. As plans developed, ACQUIRE identified cooperating agencies and projects already engaged in FP activity in three districts—UPHOLD in Mayuge; the POLICY II Project in Hoima; and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) in Sembabule—as potential collaborators. There was no preexisting technical assistance (TA) partner in the fourth district (Apac). Family Health International (FHI) was also identified as a partner for implementing the revitalization project.

ACQUIRE used a district approach to revitalize FP and LAPMs in Uganda by strengthening district capacity for FP program decision making and service delivery. The goal of the district approach was to leave behind sustainable, functioning district FP service-delivery systems within a supportive environment for FP and LAPMs. Achievement of this goal was planned by working collaboratively with district stakeholders to strengthen FP systems for training (development of district training strategy and activities), supervision (ability of district supervisors to manage quality services), and logistics (capacity for commodity forecasting and requisition).

ACQUIRE applied four fundamental strategies in designing and providing technical assistance for its district approach:

1. Partnerships and stakeholder engagement
2. Strengthening of district service-delivery systems for training, supervision, and logistics

² This may also be due to increased availability of injectables in recent years and documentation of injectable use in Demographic and Health Surveys.

³ Under its mandate with OPRH, ACQUIRE's activities were to complement those of existing bilateral projects.

3. Holistic programming, sequencing of supply, demand, and policy/advocacy interventions, and coordination of demand for services with capacity improvements
4. Phased introduction and consolidation of program elements by district

Planned program inputs for FP/LAPM revitalization included the following:

- ◆ Stakeholder engagement: district performance needs assessments (PNA) and action plans
- ◆ Supply-side: capacity development through training and participatory quality improvement
- ◆ Demand-side: mass media campaign; information, education, and communication (IEC) materials; and engagement of community reproductive health workers (CRHWs)
- ◆ Policy/advocacy: national service-delivery guideline updates; participation in working groups
- ◆ Special initiatives: IUD revitalization; FP-integrated RH services; male involvement in FP/RH

Challenges Encountered and Program Adjustments

Time constraints up front and limited financial and human resources precluded a broad needs assessment of FP service-delivery systems to inform project design. Performance needs assessments (PNAs) conducted in the intervention districts, however, uncovered unexpected gaps in FP systems and services. These included weak/inadequate FP knowledge and skills among service providers; dormant or nonexistent pools of district trainers and limited national training capacity; limited infrastructure and staff for LAPM services; stock-outs of contraceptives and supplies; and inadequate supervision.

ACQUIRE expected to collaborate with existing bilateral projects to enhance districts' ability to address these challenges. However, collaboration proved problematic, due to differing timelines and priorities. These realities required scaling back expectations about what could be achieved with existing resources and the constrained ability to achieve sustained, systemic impact.

Several adjustments were made to implementation plans to address these gaps, working less with bilateral projects and district systems and more directly with sites. In addition, ACQUIRE strengthened service providers' capacity to deliver *basic* FP services before moving on to LAPMs; put relatively more emphasis on long-acting than on permanent methods; updated the knowledge and skills of private training consultants for rolling out FP/LAPM training; assisted with logistics training and actively helped to secure essential commodities and supplies; and addressed the need for district-level FP advocacy through rollout of the Reality √ Family Planning Forecasting Tool.⁴ Special initiatives were also scaled back.

Results

In Mayuge, Hoima, and Sembabule districts,⁵ ACQUIRE's interventions succeeded in generating increased awareness about, and a more positive perception of, LAPMs among service providers and communities. LAPM service capacity was created where it did not previously exist, expanding method choice and service access; and supervisors' skills for managing quality FP services were improved through the introduction of facilitative supervision and the COPE[®] (client-oriented, provider-efficient) problem-solving methodology. Finally, the program achieved substantial

⁴ Reality √ is a family planning forecasting tool that allows for assessment of past trends in contraceptive prevalence, testing of future scenarios and assessing feasibility of established goals.

⁵ Apac district was excluded from the case study, as program activities began in the first quarter of 2007, precluding substantive program analysis.

increases in the number of LAPM clients served in intervention sites through June 2007: Compared with negligible use at baseline, LAPMs were provided to a total of 1,597 clients (480 in 2005–2006 and 1,117 in 2006–2007), with a peak in uptake in the second year. Short-acting methods (injectables and pills) also increased in uptake, from 2,493 clients at baseline to 4,394 clients in 2005–2006 and 9,475 clients in 2006–2007.

Lessons

Despite persistent myths about and cultural resistance to specific methods, there is a sizable unmet demand for LAPMs in Uganda for achieving fertility intentions. Given weak service support systems (training, supervision, and logistics) for FP and for LAPMs in particular, much work remains before access to public-sector LAPM services can be assured. Lasting improvements require political will at central and district levels, coordinated planning, and sustained support—as well as exploration of private-sector partnerships. Effective bilateral partnerships for implementing FP revitalization require joint planning, shared priorities, and common time frames. Moreover, in Uganda’s decentralized health care system, where political leaders set priorities and allocate resources, evidence-based advocacy is critical for ensuring that FP and LAPMs receive adequate attention and resources. Though advocacy was not an explicit focus when ACQUIRE’s revitalization effort began, it emerged as an essential program element.

Effective Practices

ACQUIRE’s experience in three districts in Uganda generated evidence for the following effective practices in revitalizing FP and LAPMs at the district level:

- ◆ The PNA approach is effective for engaging stakeholders in identifying and prioritizing challenges and “owning” solutions and sustaining improved performance.
- ◆ A holistic approach to programming that coordinates and sequences mutually supportive interventions in supply, demand, and advocacy is important to service credibility.
- ◆ Facilitative supervision and COPE[®] can strengthen the capacity for ongoing quality improvement at the local level, despite problems higher up in the system.
- ◆ District planning and problem solving for closing the “last mile” gaps in logistics systems is essential for ensuring FP commodity and equipment distribution to sites.
- ◆ Engaging and supporting CRHWs can generate demand for FP and link clients with services.
- ◆ Evidence-based advocacy and planning (e.g., use of the Reality √ Family Planning Forecasting Tool) enables districts to assess the resources needed for FP and LAPM programs.

Recommendations

ACQUIRE identified the following recommendations to increase the service capacity for, and use of, FP in general and LAPMs specifically in Uganda:

- ◆ Participatory stakeholder engagement
 - ◇ Conduct needs assessments as a vehicle for engaging district leaders and communities
 - ◇ Partner with the private sector to increase access to LAPM services
- ◆ Supply systems
 - ◇ Develop district strategies to train, follow up, and retain service providers
 - ◇ Deploy and support supervisors to manage quality FP and LAPM services
 - ◇ Strengthen logistics management throughout the country
 - ◇ Systematically address the role of mobile services to supplement service gaps

- ◆ Demand creation
 - ◇ Address cultural resistance and myths, and increase awareness of FP service availability
 - ◇ Engage communities to disseminate FP information and address service barriers
- ◆ Advocacy
 - ◇ Foster evidence-based advocacy regarding FP and LAPM roles and resources
 - ◇ Integrate FP with other RH services to increase access and acceptability

Introduction

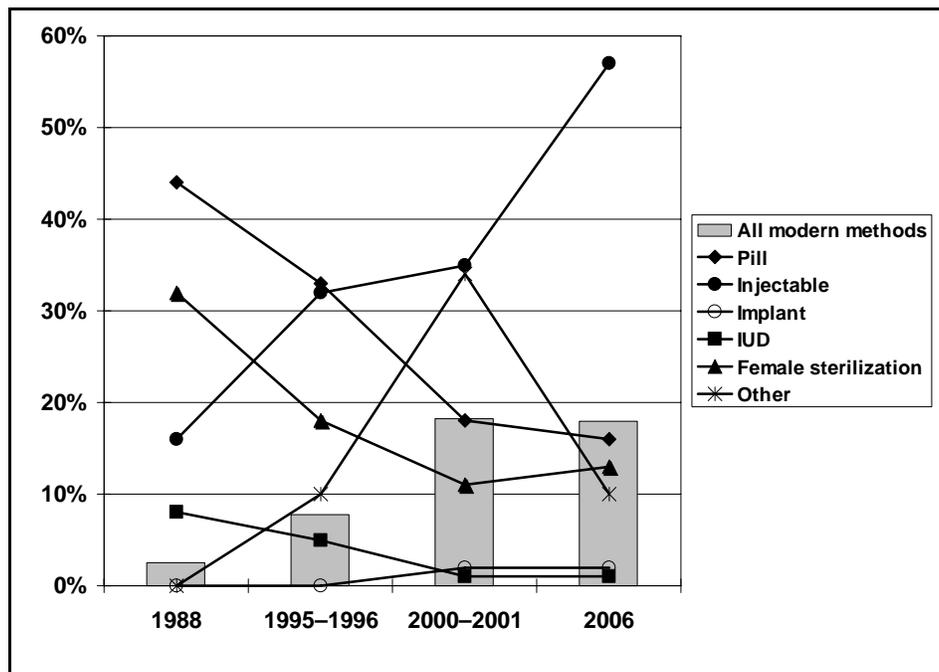
This case study on ACQUIRE’s two-year program to revitalize long-acting and permanent methods of contraception (LAPMs) in Uganda identifies lessons learned and effective practices for strengthening district systems to provide quality family planning (FP) and LAPM services.

The Status of Family Planning in Uganda

High fertility rates and a cultural preference for large families are the norm in Uganda. The total fertility rate of 6.7 lifetime births per woman represents 1.6 more births, on average, than Ugandan women want (UBOS & Macro International, Inc., 2007). There is a need to improve access to FP services in general, and to LAPMs in particular, to enable women to achieve their fertility desires.

Uganda’s FP program is losing ground to the growing unmet need for FP services. Contraceptive prevalence has not kept pace with the increasing number of people who wish to space or limit births. Uganda is also experiencing a shift from LAPMs toward short-acting methods. Implants and intrauterine devices (IUDs) have consistently represented a small proportion of the modern method mix; female sterilization has dropped from 30% of the mix in 1988 to 13% in 2006, while injectables, currently the most widely used method in Uganda, increased from less than 20% of the method mix 20 years ago to 60% in 2006. Short-acting methods require continual procurement and resupply and have higher discontinuation rates than do LAPMs.

Figure 1: Trends in contraceptive prevalence rate and modern method mix among currently married women in Uganda, 1988–2006



A continuing shift away from LAPMs toward short-acting methods will require increased programmatic and financial inputs to Uganda's population and health care system. Revitalizing LAPMs in the context of choice and increased access is a cost-effective, efficient strategy for addressing the unmet need for FP.

FP Service Capacity

The capacity to routinely provide quality FP services in Uganda's public sector is undercut by weak service-delivery support systems at both the national and district levels. FP goals are more politically driven than evidence-based, making these goals unrealistic to achieve. As of 2004, the Ministry of Health's (MOH's) FP training curriculum had not been updated since 1993, and its training system, now defunct, relied on private trainers hired with outside donor support for specific trainings. Responsibility for in-service training of service providers currently resides at the central level with the Ministry of Education, which does not have the capacity for clinical skills development. Routine in-service training takes place at the district level, but there is no budgetary support to systematically deploy district trainers even when they are available. Developing training capacity at the district level remains a significant challenge.

Among service providers who are trained, recruitment and retention are serious problems. High turnover among health personnel results in gaps in service capacity. Doctors who hold public-sector posts commonly spend more time in their private practices than at government service sites. Accountability is sorely lacking.

Understaffing and resource constraints have contributed to a weak supervision system. Medical officers with clinical and administrative responsibilities have little time for adequate supervision and lack resources for making regular site visits. The MOH has some supervisory capacity via regional reproductive health (RH) coordinators, developed by the United Nations Population Fund (UNFPA), whose job is to monitor and support district RH activities within their respective regions. However, not all districts are covered by these regional coordinators.

Uganda's logistics system faces numerous challenges. The National Medical Stores (NMS) is currently transitioning from a "push" system for contraceptive commodities (sending regular shipments to districts based on estimated facilities' needs) to a new "pull" system. As staff have not had adequate training in requisitioning FP commodities, stock-outs are common. Lack of resources for transporting commodities within districts also disrupts the supply chain to sites. Basic supplies, equipment, and commodities for providing FP services are frequently lacking.

Revitalizing FP in Uganda

Prior Projects' Activities: In recent years, various projects have worked to improve FP services in Uganda. The Uganda Program for Human and Holistic Development (UPHOLD) has incorporated a small FP component into its broader health and education services program in several districts, and the POLICY II Project has worked to create an enabling environment for FP. The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) has worked to integrate FP into services for the prevention of mother-to-child transmission of HIV (PMTCT) in several districts. UNFPA has worked in logistics management, mobile services, and FP service provider training, as well as on the development of integrated health resource consultants (IHRCs); John Snow International (JSI)/DELIVER has worked on improving supply-chain management for contraceptive commodities; and Family Health International (FHI) has done FP research and work with national working groups.

Strengthening LAPM provision has been a focus of several projects. In the mid-1990s, the Delivery of Improved Services for Health (DISH) Project attempted to integrate sterilization into MOH services as part of its effort to strengthen district health services. In the early 2000s, the DISH II project implemented outreach camps for LAPMs, with support for transportation, commodities, supplies and equipment, and staff. However, the MOH could not financially support the outreach model after the DISH II Project ended in 2002. Access to LAPM services dropped dramatically, resulting in high unmet demand for Norplant implants in particular (Putnam et al., 2003).

To a large extent, LAPM service delivery has been outsourced to Marie Stopes International (MSI), a British nongovernmental organization (NGO) providing RH services. MSI has used an outreach model to provide voluntary sterilization in Uganda. However, this model involves remuneration for public-sector service providers to refer clients to MSI mobile services, leaving them little incentive to provide these services at their own facilities. Consequently, lack of trained service providers and facilities capable of providing LAPMs on a routine basis remains a major barrier to meeting demand for these methods.

Rationale for Revitalization: In 2004, USAID stakeholders attending the Implementing Best Practices Initiative (Repositioning RH in Africa: Linking Challenges with Best Practices) in Entebbe, Uganda, recognized the need to revitalize FP. As noted by USAID/Uganda staff, “the decision came about as the participants in the [Implementing Best Practices] meeting decided that something had to be done about family planning, that it was slipping off the public and political radar, yet there was an unmet need and persistent high fertility.”

Efforts were already under way to increase the use of short-acting methods (injectables, pills, and condoms) through social marketing campaigns. On the other hand, LAPM provision had limited capacity. The MOH’s RH strategy aimed to scale up provision of LAPM in hospitals and in level-IV health centers to address the demand for these methods. Stakeholders therefore agreed on a revitalization project focused on LAPMs. Subsequently, the MOH requested and USAID/Washington provided OPRH country partnership funds⁶ to ACQUIRE to support this effort over a two-year period. USAID/Uganda also provided field support funds. In total, ACQUIRE received approximately \$950,000 to implement the FP revitalization program in four districts for the period 2004–2006.

ACQUIRE’s Goal and Objectives: The goal for the two-year funding period was to revitalize FP in four districts: Mayuge, Hoima, Sembabule, and Apac. Specific objectives were to increase the number of sites providing a range of LAPM services and to increase the use of facility-based FP services. In addition, three special initiatives were to be introduced: to increase access to underutilized methods (the IUD); to increase access to FP through integration with other RH services and through outreach; and to increase male involvement in FP and RH.

Program Strategy and Design: Strengthening District Capacity for FP Provision: In recognition of the need for decentralized capacity to support facility-based provision of FP and LAPMs at the district level, ACQUIRE applied four fundamental strategies in designing and providing technical assistance:

1. Foster partnerships and stakeholder engagement among other USAID-funded projects and cooperating agencies, the MOH, and district health management teams (DHMTs), to maximize resources and ensure necessary linkages. A performance needs assessment (PNA) was conducted in each district, in collaboration with local DHMTs, site personnel, and other RH stakeholders working in the district, to identify and prioritize areas of intervention, gain buy-in

⁶ Funds intended to support global-Mission partnerships.

and ensure participation of district officials, and obtain baseline service statistics. Participants viewed the PNA process as critical in identifying service gaps and developing strategic solutions to address these gaps.

2. Focus on a district approach to strengthening systems required to sustain quality facility-based FP services:
 - a. *Training*—help districts identify areas for service provider improvement, develop a strategy and budget for training activities and follow-up, and strengthen provider skills in FP and LAPMs
 - b. *Supervision*—train district supervisors in the fundamentals of care, use of data for decision making, and facilitation of improved provider performance
 - c. *Logistics*—train district staff to improve their capacity for commodity needs forecasting, for contraceptive requisition, and for coordination of supply systems
3. Program holistically, sequencing supply, demand, and advocacy interventions to pace service capacity and demand for services in a coordinated manner.
4. Work in a phased manner to introduce and consolidate program elements district-by-district in six-month implementation periods from January 2005 to November 2006.⁷ This approach was chosen to maximize resources for the planning, designing, implementation, and monitoring of program activities, given lean country staffing.

⁷ Mayuge (February 2005), Hoima (September 2005), Sembabule (January 2006), and Apac (November 2006).

Methodology

Study Objectives

The primary aim of this study was to assess the ACQUIRE Project’s approach to strengthening district systems (training, supervision, and logistics) to increase the availability and use of facility-based LAPM services in Uganda. A secondary objective was to use ACQUIRE’s experience in Uganda to inform and describe a district approach to strengthening systems for FP. To address these objectives, the following study questions were developed:

- ◆ What were the key inputs for revitalizing district provision of LAPMs?
- ◆ What aspects of the district approach to program implementation worked well? What were the challenges in implementing this approach?
- ◆ Did strengthening the district systems for LAPM services lead to increased availability and use of facility-based services?
- ◆ What lessons were learned regarding the strengthening of district systems for LAPM revitalization, and which best practices should be replicated?

Study Design and Sampling

A case study methodology was used to document program implementation and formulate lessons learned from the FP revitalization program in Uganda. The case study design reflected the phased implementation of program activities in Mayuge, Hoima, and Sembabule districts from January 2005 to July 2007. (Apac district was excluded from the case study because program activities did not begin until 2007, precluding substantive program analysis.) The sampling frame consisted of MOH personnel; staff from the 17 facilities (one hospital, five level-IV health centers, and 11 level-III health centers) and DHMTs receiving technical assistance from ACQUIRE in Mayuge, Hoima, and Sembabule; and USAID Mission staff.

Data Collection Methods

Existing methodologies and data collection tools were adapted from those previously used in ACQUIRE’s case studies of IUD revitalization. Methods included review of service-delivery statistics and program reports, facility assessments, interviews with key respondents, and group discussions with community members (see Table 1). This combined methodology allowed for a comprehensive assessment of program implementation.

Table 1: Data collection methods

Method	Total sample	Mayuge	Hoima	Sembabule
Service-delivery data (facilities)	17	6	6	5
Facility assessments (facilities)	4	1	2	1
In-depth interviews (individuals)				
District/facility staff	15	6	5	4
Regional/central MOH staff	4	na	na	na
USAID/Uganda staff	1	na	na	na
ACQUIRE/Uganda staff	3	na	na	na
Group discussions (groups)	8	4	4	0

Note: na=not applicable

The evaluation team collected information on ACQUIRE's inputs to improve LAPM services at the systems level and at the site level (staff trained, follow-up and technical visits conducted, and equipment/materials provided). The team also conducted facility assessments at four sites to determine if key service gaps identified in the PNA had been addressed. A retrospective document review was conducted to help further explain the study questions and project context. (See Appendix 2 for a complete list of documents reviewed.)

In-depth interviews were conducted in July–August 2007 by Sarah Gutin (Rotary Ambassadorial Scholar, Kampala) and Dr. Henry Kakande (technical manager, ACQUIRE/Uganda). Interview respondents were purposefully sampled from each district according to site affiliation, level of involvement in program activities, and participation in the PNA. In total, 19 staff were interviewed, of which 13 were PNA participants. Respondents included district directors for health services, district nursing officers, district health visitors, and regional and central MOH staff. The six respondents not involved in the PNA included MOH supervisory staff, district management staff and facility-based service providers. ACQUIRE/Uganda and USAID/Uganda staff were interviewed by ACQUIRE/Global staff.

Focus-group discussions (FGDs) were conducted in Mayuge and Hoima districts to estimate the impact of demand-creation activities by eliciting information on participants' awareness and use of FP services. FGDs were not conducted in Sembabule, where no demand-creation activities were carried out. Group discussions were conducted in each district with married women aged 15–49 (FP users and nonusers), married men (aged 20–50), and unmarried youth (aged 15–20) residing around the ACQUIRE-supported health facilities.

Data Analysis

All data were analyzed by ACQUIRE staff. When necessary, notes were cross-checked against tape-recorded interviews. Data analysis included context and content analysis of reports and interviews and trend analysis of service statistics from the PNA and monitoring reports. Analysis was undertaken across the three districts (Hoima, Mayuge, and Sembabule).

Protection of Human Subjects

Ethical approval for this study was obtained in accordance with EngenderHealth's Evaluation and Research Standard Operating Procedures. Interviewers obtained documentation of informed consent from all interview respondents prior to participation. No information from individual interviews was shared with anyone outside the study team.

Study Limitations

The qualitative nature of the case study methodology allows for a rich, detailed documentation of ACQUIRE's experiences with LAPM revitalization in Uganda. However, the use of qualitative methods prevents us from being able to make definite claims to causality or generalizations beyond the districts being studied. In addition, service statistics provide approximations of the number of FP users, due to limitations in data-collection systems in the districts.

Program Implementation

Given time and resource limitations, an in-country needs assessment of FP service-delivery systems was not undertaken prior to developing a program strategy. Instead, ACQUIRE reviewed available data and solicited input from the Revitalizing Family Planning Working Group (MOH and representatives from USAID implementing partners), and other donor agencies and NGOs. The resulting program strategy, to strengthen decentralized capacity for FP program decision making and resources and leave behind sustainable, functioning FP district service-delivery systems, was assumed to be feasible with bilateral support in a two-year period.

Challenges to Program Implementation

- ◆ **Planning for needs:** The intervention districts identified by the MOH/USAID were selected due to underperformance in FP service provision. These districts also faced major challenges in infrastructure (roads, sanitation, and power), compounding the poor FP indicators. PNAs conducted in each district at a total of 16 sites⁸ (see Appendix 1) collected baseline data on available services, trained staff, and service statistics and assessed demand for FP. Across the three districts, PNA findings centered on several common performance challenges:
 - ◆ Service providers' lack of knowledge in FP (basic counseling and method provision, IUD/implant insertion/removal techniques, and infection prevention)
 - ◆ Medical officers' limited availability to provide permanent methods
 - ◆ Lack of a functional training system, readily available pool of trainers, or resources to develop LAPM skills and ensure availability of competent service providers
 - ◆ Inadequate supervisory systems to ensure service provider performance
 - ◆ Supply-chain gaps and poor logistics management resulting in commodity stock-outs
 - ◆ Infrastructure limitations for FP and LAPM services
 - ◆ Widespread cultural resistance and myths/misconceptions about FP in the community, and limited male involvement in FP
- ◆ **Partnership model for global-bilateral project support:** According to the OPRH mandate, the FP revitalization program was to complement existing bilaterals' FP activities. The Uganda Mission had also asked ACQUIRE to partner with UPHOLD and/or other cooperating agencies to provide technical assistance aimed at increasing access to LAPMs within its FP activities. On the ground, however, bilateral projects were either midway in their activities or ending, had different priorities, and were facing implementation and staffing challenges. These practical realities precluded joint planning and collaboration. Limited bilateral support in selected districts, coupled with technical and systemic issues (PNA findings), required focusing more resources on basic system support and thus scaling back expectations on what could be achieved with limited resources during the two-year implementation period.
- ◆ **Target sites and personnel:** In accordance with the MOH RH strategy, ACQUIRE originally planned to focus its technical assistance on hospitals and level-IV health centers. In the absence of district hospitals⁹ providing FP, the focus was adjusted to level-III and level-IV health centers with the capacity to provide IUDs and implants. Six of the 17 sites in Mayuge, Hoima, and

⁸ With the exception of Lwebitakuli Health Center in Sembabule, all sites participated in the PNA.

⁹ Only Hoima Hospital received technical assistance from ACQUIRE. (Mayuge's Catholic hospital does not provide FP, and Sembabule has no hospital.)

Sembabule receiving technical assistance were hospitals or level-IV health centers; the remaining 11 sites were level-III health centers (see Appendix 1 for a full list of sites). As medical officers were not available at most sites, ACQUIRE worked primarily with clinical officers, nurses, and midwives.

- ◆ **Systems:** Gaps in Uganda’s training, logistics, and supervision systems left service providers and sites without adequate support. Among unanticipated issues encountered, some were central to the project’s systems-strengthening plans:
 - ◇ *Training:* One district (Mayuge) did not have a pool of trainers; where district trainers existed, there was no training plan or system for overseeing trainers’ activities, nor were there funds in district budgets to support the roll-out of training activities.
 - ◇ *Supervision:* Most supervisors at the facility and district levels lacked training in how to manage quality FP services, and resources to support supervision visits were limited.
 - ◇ *Logistics:* There was much confusion in districts about how to use the new contraceptive commodities “pull” system (which was being phased in from the central level) and how to assess and ensure stock inventories. National stock-outs and supply-chain gaps affected district- and facility-level logistics management.

Program Adjustments

Given these implementation challenges, several program adjustments were made. ACQUIRE staff:

- ◆ Conducted updates for IHRC trainers (not for district trainers, as initially intended) on LAPM skills and collaborated with IHRC trainers in rolling out FP/LAPM training to district staff
- ◆ Organized a leadership workshop (in Year 2) to promote MOH partnerships with DHMTs and support district supervisors
- ◆ Introduced the Reality √ Family Planning Forecasting Tool¹⁰ to enable districts to generate data for evidence-based planning and advocacy for FP and LAPMs
- ◆ Strengthened district service providers’ capacity for basic FP skills, not just LAPMs
- ◆ Weighted interventions toward long-acting methods that could be delivered by lower-level cadres and provided less technical assistance and on-the-job training for periodic vasectomy and tubal ligation outreach
- ◆ Worked to secure FP commodities and equipment directly from NMS to support FP/LAPM training and services; collaborated with DELIVER to address the supply-chain gap between districts and sites; provided technical assistance to district and site staff to properly employ the “pull” system
- ◆ Scaled back special initiatives for male involvement and integration

Collaborating Partners

The FP revitalization program was implemented in collaboration with the DHMTs, with support from USAID/Uganda, the MOH, and FHI. FHI collaborated on updating FP guidelines with the new World Health Organization (WHO) Medical Eligibility Criteria, and introduced an LAPM cost-analysis tool (see “Advocacy/Policy” p. 11). A subagreement was also negotiated with the Uganda Private Midwives Association (UPMA) to broaden the scope and quality of FP services offered by UPMA through the provision of implants and IUDs.

¹⁰ Reality √ is a family planning forecasting tool that allows for assessment of trends in contraceptive prevalence, testing of future scenarios for the geographic area in which a program is operating, and testing of whether established goals are reasonable for the local context.

Project Activities, by Program Objective

This section summarizes activities undertaken in this project, categorized by objective: 1) supply-side improvements (the primary vehicle for technical assistance to districts); and 2) complementary demand creation and advocacy activities and special initiatives.

Objective I: Increase the Number of Sites Providing a Range of LAPM Services

Technical assistance for the FP revitalization project focused on strengthening service capacity and related supply systems for training, supervision, logistics, and referral. Supply-side activities supported the fundamentals of care (informed choice, safety for clinical techniques and procedures, and quality assurance and management) and expanded the FP method mix to include LAPMs. ACQUIRE (with FHI) also supported dissemination of the WHO's FP-related Medical Eligibility Criteria and of the national policy guidelines and service standards for sexual and RH and rights. These were essential prerequisites to staff updates on the provision of FP and LAPMs.

In total, 22 technical assistance events¹¹ were conducted for 317 staff members in Mayuge, Sembabule, and Hoima districts, and four multidistrict workshops were held for 61 regional MOH and district staff from July 2005 to June 2007. ACQUIRE also supported the UPMA with two training events for 60 UPMA trainers and service providers (see Appendix 3).

Training: The original intent of the FP revitalization program was to focus on developing LAPM service capacity. As previously noted, however, it was necessary to update providers in basic FP counseling and provision before building their LAPM skills. Furthermore, given the dearth of medical officers available for training, interventions focused largely on skills training for nurses, midwives, and clinical officers in the IUD and implant. Leadership training for the MOH Reproductive Health Division (RHD) and for regional and district supervisors and coordinators was also undertaken to cultivate MOH/RHD support for district PNA action plans and encourage collaboration with DHMTs for FP service delivery.

In collaboration with the Family Planning Association of Uganda (Reproductive Health Uganda) a central two-day update for IHRC trainers was conducted, including an update on insertion and removal skills for the Norplant implant and the IUD and preparation of training materials and approaches for the rollout. Subsequently, the IHRC trainers collaborated in conducting contraceptive technology updates on the latest clinical/programmatic recommendations and on the WHO medical eligibility criteria for all FP methods, and trained district service providers in IUD and implant insertion and removal. ACQUIRE also provided technical assistance for three outreach activities (mobile services) for vasectomy and bilateral tubal ligation in Mayuge as a temporary strategy to meet demand for permanent methods and as an opportunity for on-the-job training for medical officers.

In the private sector, ACQUIRE led an FP and IUD/implant update for the UPMA to increase its members' awareness of the IUD and supported skills training for 10 UPMA trainers and the subsequent training of 50 service providers in IUD/ implant insertion and removal, including a session on record keeping and contraceptive logistics management.

¹¹ Excluding the PNAs conducted in each district.

Supervision: Facilitative supervision and COPE[®] trainings¹² are best practices introduced by the ACQUIRE Project in programs worldwide to improve the quality of FP services. In Uganda, both facilitative supervision and COPE[®] trainings were conducted to complement UPHOLD's previous supervisor trainings in the Yellow Star Program (the MOH approach for quality improvement).

A training was conducted for 14 national COPE[®] facilitators, including IHRC and district staff from Mayuge, Hoima, and Sembabule. One-day updates were also conducted in infection prevention for service providers from the three districts. In Mayuge, supervisory personnel from the DHMT and from level-III and level-IV health centers (16 total) participated in a workshop on facilitative supervision for medical quality improvement. The workshop included exercises in giving feedback, practice visits to two level-IV health centers, and planning for ongoing support for problem resolution.

Logistics management: Due to the urgent need to get services up and running, ACQUIRE worked with the MOH to transport FP commodities (pills, injectables, implants, and IUDs) from the NMS for Hoima (August and October 2006) and Sembabule (September 2006), and provided project sites with instruments (e.g., tenaculums, uterine sounds, and speculums) and essential supplies (e.g., towels, bleach) for rollout of LAPM services. Subsequently, sessions on the new "pull" system's commodity calculations and supply-chain links were incorporated in the FP skills and COPE[®] trainings.¹³

Referral: The majority of sites receiving technical assistance were not prepared to offer a full range of LAPMs. Consequently, ACQUIRE worked with districts to strengthen referral systems for both permanent and long-acting methods. This included strengthening linkages between smaller level-III and level-IV health centers to Hoima Hospital or MSI, and conducting FP updates for community-based reproductive health workers (CRHWs). CRHWs were to disseminate information about LAPMs and services, mobilize potential FP clients, and refer them to trained service providers and/or for LAPM outreaches in Mayuge.

Objective 2: Increase Use of Facility-Based LAPM Services

Demand activities helped increase awareness of FP/LAPM services in the community. Advocacy/policy activities contributed to an enabling environment for FP revitalization. These interventions, coordinated with those of the supply side and special initiatives, provided the platform for increased use of FP services.

Demand creation: The demand-creation strategy for FP revitalization was developed and implemented in Mayuge and Hoima¹⁴ in collaboration with the MOH. Activities were designed to address informational barriers to the use of services, including lack of knowledge of LAPMs, method myths and biases, and service-related issues. Content was largely but not exclusively directed at IUDs and toward women wanting to space or limit their next birth. Secondary target audiences included service providers, men, and key community stakeholders.

ACQUIRE worked closely with the MOH/Health Promotions Division and other organizations to develop campaign messages and IEC materials (brochures, posters) for voluntary LAPM use, as

¹² Facilitative supervision is an approach to supervision emphasizing mentoring, joint problem solving, and two-way communication (The ACQUIRE Project, 2008). COPE[®] (client-oriented, provider-efficient) is a process that helps staff improve the quality and efficiency of services (EngenderHealth, 2003).

¹³ At the time, DELIVER had embarked on a major initiative to train central- and district-level officials in the commodities system.

¹⁴ Due to time and resource constraints, demand creation activities were not conducted in Sembabule.

well as to review other FP materials. Media messages (radio spots/talk shows and newspaper articles/editorials) publicized service availability and provided information on LAPMs. CRHWs were also called upon to disseminate messages about LAPMs.

As part of the campaign launch in the second year of the project, training and a media kit on LAPMs were provided for spokespersons (service providers, satisfied FP clients, media, CRHWs, and local leaders). The launch included a display of and information on various FP methods, drama shows, speeches from district personnel and satisfied users, and briefings to various media houses.

Advocacy/Policy: With fiscal allocation and management outside of its control, it is not easy for a DHMT to support expansion and scale-up of LAPMs. For this reason, FP policy and advocacy efforts focused on garnering buy-in and resources for supporting districts in their efforts to expand delivery of FP and LAPM services. ACQUIRE supported FP policies at the national level by serving on various working groups and updating service-delivery guidelines:

- ◆ Participating in the FP IEC Working Group coordinated by the Health Communications Partnership, and in the working group on contraceptive security
- ◆ Making technical review contributions to the development of national FP flipcharts for service providers and community health workers
- ◆ Reviewing the MOH FP policy and services guidelines addendum
- ◆ Participating in the review and revision of the MOH communication strategy for FP and of new practice guidelines for all methods, including the liberalization of IUD use
- ◆ Developing preliminary plans to update the MOH's national FP training curriculum for service providers (which was unfortunately not implemented due to lack of time and funds)

ACQUIRE and FHI collaborated on several activities in support of policy and advocacy for FP and LAPMs. FHI helped to review and update the MOH's FP service-delivery guidelines for their consistency with the 2004 WHO medical eligibility criteria, supported printing of the guidelines for distribution, and held an orientation on the new medical eligibility criteria for key district staff and UPMA representatives. FHI also introduced an LAPM cost-analysis tool¹⁵ in Mayuge and Hoima to help inform DHMT advocacy and planning for LAPM expansion.

Although not part of the original project design, ACQUIRE introduced the Reality √ Family Planning Forecasting Tool to districts as a means to assess past trends in the contraceptive prevalence rate and test future scenarios and goals. Reality √ applies the concept of evidence-based advocacy and decision making to support the allocation of resources for FP. As a separately funded global activity in early 2007,¹⁶ ACQUIRE conducted a workshop for 14 participants from the MOH, districts, DELIVER Project, and ACQUIRE/Uganda staff on using Reality √ to set realistic goals and use data for decision making to advocate for FP commodity and staff needs.

Finally, in 2006, ACQUIRE conducted a one-day IUD learning seminar for 50 delegates attending an East, Central, and Southern Africa College of Nursing meeting. This seminar addressed the new IUD guidelines and the crucial role that nurses and midwives play in assisting families to make informed decisions about their fertility desires. Ultimately, the seminar aimed to encourage nurses and midwives to include LAPMs in training and services to increase access to these methods.

¹⁵ FHI's Excel-based costing tool allows providers and managers to calculate unit costs for LAPM services, as well as to assess costs for LAPM scale-up. This, in turn, provides an empirical basis for informed arguments and decisions related to the expansion of FP services.

¹⁶ Although the Reality √ training was conducted after the initial two-year project period, it was significant in the minds of those interviewed for the case study and so we have included it here.

Special initiatives: The need to address basic FP capacity before undertaking LAPM interventions (previously discussed) put the program several months behind its original design. As a consequence, the original intentions for special initiatives were not feasible. Despite these constraints, the following activities were carried out in IUD revitalization, FP-HIV integration, and male involvement in FP:

- ◆ Conducted demand-creation activities in Mayuge and Hoima districts and learning seminars on the IUD (part of Objective 2, demand-side activities)
- ◆ Reviewed EGPAF training materials, including job aids to support integration of FP counseling within PMTCT activities
- ◆ Held a multidistrict Men As Partners[®] (MAP) orientation and planning meeting for participants from Mayuge and Hoima districts
- ◆ Assisted two districts to develop action plans to engage men as a strategy for increasing access to LAPMs, as called for in key PNA findings

Supply-Side Achievements

The training of health care workers at level-III and level-IV health centers to provide IUD and implant services was viewed as one of the most successful components of ACQUIRE's technical assistance. Most respondents interviewed in all three districts noted that trained service providers now have the skills to provide IUDs and implants and to manage complications and side effects. Many respondents also noted improved service provider performance in basic FP counseling and provision and updated knowledge of WHO medical eligibility criteria. Facility assessments indicated that sites now have copies of the National RH Policy Guidelines.

Respondents noted that despite the larger systemic weaknesses in supervision and quality management, facilitative supervision and COPE[®] helped districts and sites improve their quality management systems through strengthened supervision, and increased staff motivation through improved supervisor-staff communication. This, in turn, improved the quality of care.

The relationship between the clients and health workers has improved following the COPE[®] training. Initially, there was a gap between the clients and [service] providers. After the training, we realized there are some things we need to do to retain our clients. There was a change in attitude.

—Mayuge clinical officer

COPE[®] training helped us to know our rights as service providers and also the rights of clients.

—Sembabule nursing officer

Facilitative supervision has changed us greatly. We have better relationships with the supervisors now and the supervisors are more involved. They guide, they coach, and help.

—Mayuge clinical officer

Support supervision helps so that we can learn more from supervisors and see where we have gone wrong and where to improve. They can give us courage.

—Hoima midwife

Respondents also noted improvements in infection prevention practices:

When you prevent infections, the client is satisfied—if they get infections, people won't come for the methods. But if it can be aseptic—many come.

—Mayuge medical officer

The [infection prevention] training helped to reduce the rate of infection when inserting IUDs and Norplant [implants]. We are sensitized in new methods and techniques which can be used in sterilizing our equipment.

—Sembabule nursing officer

Facility assessments of four sites revealed that internal supervision to assess staff performance and training needs was being conducted on a regular basis. Staff reported sitting together to review data

for decision making and to discuss strengths and weakness and follow-up actions. Sites in Mayuge and Sembabule hold frequent formal quality improvement meetings.

In the PNAs, many facilities had difficulty calculating commodity needs and requesting FP commodities. After the ACQUIRE technical assistance for commodity requisition and the Reality √ workshop, facility assessments showed that the sites had improved their ability to calculate commodity needs and navigate the logistics system using the appropriate forms. A Mayuge district officer noted that ACQUIRE’s activities “helped [service] providers learn how to order, correctly and in time, to avoid stock-outs.” In Mayuge and Hoima, updated stock cards were available and accurately reflected the physical stock in the facility; in Sembabule, staff reported being able to calculate commodity needs and request commodities “...before stock is finished.” Facility assessments also indicated that some health centers now have LAPM equipment that was previously absent (e.g., trocars, cannula, tenaculums, autoclaves, and uterine sounds).

Many respondents mentioned the CRHWs as key members of the FP revitalization effort. CRHWs successfully provided information to community members on FP and LAPMs, referred clients for services, and mobilized clients for successful outreaches (mobile services).

Demand-Side Achievements

Increased demand for and use of LAPMs is largely attributed to awareness generated by radio advertisements and the messaging work of CRHWs. Focus-group participants had a positive attitude in general toward FP and recognized its health, financial, and social benefits.

*Family planning helps men and women to produce children they want by choice and not by chance.*¹⁷

—Male FGD participant, Hoima

In contrast to the PNA focus groups, most FGD participants could identify and differentiate among FP methods, including LAPMs. In focus-group discussions, female FP users reported choosing methods for economic reasons, spacing of children, and completion of family size. In particular, they liked LAPMs because they did not have to concern themselves with remembering to take the method.

Advocacy Achievements

Using Reality √, participants from ACQUIRE-supported districts developed action plans for advocating for LAPMs. Respondents spoke of the tool as helping them determine their contraceptive prevalence rate and level of effort for FP programming.

It helped because you can look at trends and find opportunities to recruit more clients to utilize the services. [We] took all the health units using LAPM through the tool. Using service statistics, we showed them how it helps as a tool. The tool shows the effort we need to put in.

—Sembabule nurse

Staff have used data to demonstrate the importance of FP resource allocation to the districts. Financial projections for scaling up FP/LAPM services, developed with FHI’s cost-assessment tool, have informed staffs’ advocacy and planning efforts. However, subsequent departures of district staff trained in Reality √ have hampered further progress in using this tool.

¹⁷ “Children by choice” was an ACQUIRE campaign message.

Special Initiatives Achievements

Activities in IUD revitalization, FP integration and male involvement, while modest, nevertheless discerned opportunities in service delivery and detected barriers to FP/LAPM use still to be overcome. In particular, the exploration of FP integration paved the way for a pilot in FP/HIV integration (with Global Leadership Priority funding) and for subsequent scale-up of integration efforts in Uganda. As a Hoima midwife noted, there is recognition that, “now, when you are counseling on PMTCT, family planning has to come in.”

Focus-group discussions revealed continuing low involvement of men in FP and highlighted a need for future work engaging men as partners in FP and RH. A Mayuge district officer stated, “[Men] think that FP is a woman’s affair and many men desire big families...the men never come to be involved in FP.” Men also indicated that there was a need for more male health care workers to provide services, indicating that this would encourage them to use services.

Use of Family Planning Services

Prior to the revitalization project, most public-sector health facilities in Mayuge, Hoima, and Sembabule did not have the capacity to offer LAPM services. Accordingly, the district PNAs revealed negligible baseline use of LAPMs in the six months before the project was implemented in each district, as seen in Table 2.

Table 2: Baseline FP service statistics for Mayuge, Hoima, and Sembabule

FP methods	Mayuge (July–Dec. 2004)	Hoima (Feb.–July 2005)	Sembabule (July–Dec. 2005)	TOTAL Baseline
Short-acting methods				
Pill	276	428	19	723
Depo-Provera	649	944	177	1,770
No. of clients served	925	1,372	196	2,493
LAPMs				
Norplant implant insertion	0	10	0	10
(Implant removal)	0	0	0	0
IUD insertion	2	0	0	2
(IUD removal)	0	0	0	0
Tubal ligation	0	1	0	1
Vasectomy	0	0	0	0
No. of LAPM clients served	2	11	0	13
Total no. of FP clients served	927	1,383	196	2,506

FP service statistics from the 17 ACQUIRE-supported facilities, compiled from July 2005 to June 2007, show substantially increased use of FP/LAPM services. Compared with a baseline of nearly zero, a total of 1,597 clients accepted LAPMs at public-sector facilities during the project period. Use of short-acting methods (injections, pills) also increased from baseline.

There has been a great improvement in the uptake of all FP methods, even the short-acting methods. People are coming for the services now.

—Mayuge clinical officer

[Clients] come because there was an [ACQUIRE-led] update on FP and service providers know how to conduct health education and counseling. Clients come because many facilities offer services and the [community workers] that were trained have helped to get clients.

—Sembabule nurse

As detailed in Table 3, in the first year of the revitalization project, LAPM uptake increased at 11 sites (in Mayuge and Hoima districts) to 480 clients, and rose to 1,117 clients at 17 sites (in all three districts) in the second year (includes UPMA-provided services¹⁸). LAPM uptake peaked in July–December 2006 and declined in January–June 2007, although remaining much higher than at baseline. Commodity stock-outs, relocation of trained service providers, data-reporting issues, and phase-out of ACQUIRE support to the districts could have contributed to this decline.

Table 3: FP service statistics for Mayuge, Hoima, and Sembabule, July 2005–June 2007

FP methods	Year 1 (11 service sites)			Year 2 (17 service sites)			Total July 2005–June 2007
	July–Dec. 2005	Jan.–June 2006	Total 2005–2006	July–Dec. 2006	Jan.–June 2007	Total 2006–2007	
Short-acting methods							
Pill	396	523	919	1,268	791	2,059	2,978
Depo-Provera	1,483	1,992	3,475	4,740	2,676	7,416	10,891
No. of clients served	1,879	2,515	4,394	6,008	3,467	9,475	13,869
LAPMs							
Norplant implant insertion	113	223	336	628	337	965	1,301
(Implant removal)	6	37	43	34	59	93	136
IUD insertion	11	4	15	11	15	26	41
(IUD removal)	0	0	0	0	1	1	1
Tubal ligation	0	84	84	2	28	30	114
Vasectomy	0	2	2	1	1	2	4
No. of LAPM clients served	130	350	480	676	441	1,117	1,597
Total no. of FP clients served	2,009	2,865	4,874	6,684	3,908	10,592	15,466

The implant was the most popular of the LAPMs, in part due to widespread demand for this method in Uganda. Unavailable at most sites prior to project implementation, the implant was received by 336 clients in the first year of the project, with 43 removals. In 2006–2007, implant utilization increased to 1,019 insertions (965 through the MOH and 54 through UPMA), with 99 removals¹⁹ (93 in the MOH and six by UPMA), although the number of acceptors declined in the second half of the year.

IUD uptake at ACQUIRE-supported sites also increased throughout the project. At the start of the project, Mayuge and Hoima each had only one level-III health center offering IUD services, and no services were available in Sembabule. In the first year of the project, IUD uptake remained low despite clinical training of service providers—only 15 clients were served. The launch of the

¹⁸ UPMA provided 54 implant insertions and six removals, as well as 25 IUD insertions.

¹⁹ Note: Data are not available on how long implants were in place before removal. It is not possible to determine if these were 3–5 year users who could not previously access removal services, or recent implant acceptors discontinuing early. If the latter, further provider training in preinsertion counseling and management of side effects may be needed.

demand campaign coincided with increased uptake of the IUD, to 51 insertions in Year 2. (Only one IUD was removed throughout the project.) There is some indication that service providers' low level of confidence in their IUD insertion skills and their weak grasp of clinical guidelines prevented the IUD being offered to women as often as it could have been.

Female sterilization had relatively high uptake (84 clients) in the first year of the project, largely due to three outreaches conducted in Mayuge district. The next year, however, outreaches were canceled due to the lack of trained medical officers to provide services, and only 30 female sterilizations were performed. Throughout the project, only four vasectomies were performed at ACQUIRE-supported sites. Low uptake of vasectomy was thought to be due largely to cultural norms and attitudes toward the procedure, though lack of access to a trained service provider may also have affected uptake.

Challenges and Emerging Opportunities

Interviews and group discussions revealed a range of challenges and opportunities for further FP service strengthening.

Supply Systems

Training: Training of service providers has translated into increased availability of LAPM services. However, the ongoing dearth of trained staff, even in communities covered by this case study, means that not all clients are able to obtain their desired method.

Some of the staff are not trained, so when one staff member is away, another one can't insert the methods. The client then has to wait for the trained [service] provider or take another method.

—Sembabule nurse

Clients have been hearing about LAPM from other women and they are interested. However, there is a shortage of staff, so mothers do not always receive the services.

—Hoima provider

Districts' ability to conduct mobile services for permanent FP methods has been similarly affected. Medical officers are overextended and were not able to attend on-the-job training or add permanent method service delivery to their responsibilities.

The problem of understaffing is compounded by the staff turnover and relocation, often soon after their receipt of LAPM skills training. Approximately 25–30% of ACQUIRE-trained staff, including key district administrative personnel, relocated and/or left their districts. Developing a pool of district trainers and/or further rolling out on-the-job training, whole-site training using internal or external experts, and some off-site centralized training could ultimately help address this problem. For now, however, staff newly trained in IUD and implant insertion and removal need to remain at their posts for sufficient time to strengthen their practical LAPM skills.

Quality improvement: Respondents indicated they would have liked to scale up COPE[®] to more facilities, including level-III health centers. Some respondents commented that supervisors should be trained in implant and IUD insertion and removal, so that “when they return to their facility, they can supervise on a skill that they know how to implement.” Infection prevention training addressed how to advise district staff on procuring disinfectants and equipment for sterilization. Nevertheless,

shortages of bleach and other disinfectants meant that optimal infection prevention practices could not always be maintained. Interviews revealed that service providers are aware of how systems challenges impact quality of services and are willing to offer suggestions on how the quality and availability of services can be improved.

Commodities: Many respondents mentioned ongoing equipment stock-outs (IUD-insertion kits, basic surgical instruments to insert IUDs, sterilizing equipment, scalpel blades) and lack of supplies (cotton, gloves, gauze, and bleach) for providing FP services. Clients were frequently asked to contribute money or supplies for LAPM services, particularly implant insertion, which resulted in lower daily client volume. (Clients knew that they would not be asked to provide anything during outreaches.) Nevertheless, a shortage of implant and IUD insertion kits posed problems during outreaches, when equipment had to be repeatedly resterilized.

Despite technical assistance from ACQUIRE and improved capacity for accurate and timely ordering of FP commodities, districts and sites continued to experience stock-outs, most notably for implants. National stock-outs and product wastage affected districts' commodity supplies, and fragile supply-chain linkages within districts affected commodity distribution to sites (the "last mile" gap). At some sites, stock-outs meant that service providers were unable to apply their new skills in implant insertion and removal, a critical step in posttraining reinforcement of skills. Stock-outs also prevented some clients from obtaining their desired methods. The MOH is training districts to use the "pull" system, but capacity has not yet reached the sites, leading to stock-outs at the facilities.

Referrals: While CRHWs helped facilitate referrals for FP and LAPM services, some noted that it was difficult to conduct follow-up with community workers. At the FP Revitalization Committee Meeting in August 2007, it was mentioned that MOH regional coordinators need to establish linkages between CRHWs and health care sites and facilities so that clients referred for FP are not turned away or lost to follow-up.

Demand for Services

Behavior change communication gaps: Despite the program's demand campaign,²⁰ counseling, and the CRHWs' role in information dissemination, focus-group discussions with community members revealed that myths and misperceptions about FP and LAPMs persist in district communities. Key fears about the IUD and the implant have not been allayed, and respondents expressed concerns about side effects of long-acting methods in general. Service providers also indicated that myths about LAPMs, particularly the IUD, remain prevalent.

Many women still have a low opinion about the IUD, although we counsel. Though we explain to them the procedure of insertion, [clients] still have misconceptions about how you can try to look at their private parts. Others fear the IUD being put in the uterus and staying in there for a long time. They fear that it will cause other diseases in the uterus like cancer and that during sex, the man can easily feel it.

—Hoima midwife

The demand campaign did not focus on permanent methods of contraception, although CRHWs discussed these methods. Negative attitudes about sterilization and misunderstandings and myths uncovered in the original PNA persisted among men, women, and adolescents. More education is needed on the appropriateness of tubal ligation and vasectomy for couples who have completed

²⁰ The demand campaign did not launch until late in the second year of the project, and consequently it had limited impact in the project period. However, it has contributed to subsequent demand creation work in Uganda.

childbearing. When thinking about FP, “*you should not consider your age but the number of children you have overall*” (Mayuge FGD respondent). This message needs to be more widely disseminated, especially by satisfied customers.

“Those who are satisfied—they try to sensitize others. If there is one who says I have it myself, you see women running to get it. Those people who have had the Norplant [implant] and are satisfied are doing a great job of telling others to come for services.”

—Mayuge NGO staff

Youth and men tend to receive FP messages more from health centers, family, and friends than from media sources. This suggests the need for strategic communications for diverse audiences, possibly using CRHWs as a dissemination vehicle. Engaging key community leaders and local grassroots organizations in disseminating FP information and identifying service gaps may also help tap into demand for FP among a variety of audiences.

Advocacy for FP/LAPMs

Stakeholder engagement and evidence-based advocacy: The PNA process of identifying issues and embracing solutions enabled district administrators and service providers to recognize the need for FP and LAPMs in the communities they serve. Project participants viewed the PNA process and action plan development as critical in thinking strategically about service gaps and taking ownership of actions to address these gaps.

“The [PNA] results showed gaps, areas that needed to be strengthened in FP and RH. [We] were able to find areas where we needed improvement as a district.”

—Sembabule nurse

The process also engaged stakeholders at multiple levels to advocate for FP and LAPMs. As politicians and traditional leaders can play a key role in supporting FP services, it is important to engage these groups in disseminating accurate and consistent messages about FP and LAPMs.

“Unless people (MOH) know the needed services, there wouldn’t be any services provided—they might think people don’t want permanent methods and that is not the case.”

—Mayuge NGO staff

The departure of staff trained in the Reality $\sqrt{\quad}$ tool has affected districts’ ability to use the tool for evidence-based planning of FP programs. Continued rollout of Reality $\sqrt{\quad}$ to district administrators would facilitate program planning and resource allocation for LAPM services. In Hoima, project participants used information generated by the tool to influence prioritization of LAPMs in the district workplan. Further support to districts in establishing corresponding budget line items for LAPM provision would be useful.

Lessons Learned and Effective Practices for FP Revitalization

The assessment of ACQUIRE's district approach to FP revitalization identified several key lessons and best practices. Successful FP revitalization requires strong stakeholder support and coordination between MOH and district health management teams. As health care systems become increasingly decentralized, a district approach to strengthening systems will be crucial in enabling districts to manage provision of quality FP and LAPM services.

Lessons

There is an unmet demand for LAPMs in Uganda. Sixty-four percent of married Ugandan women want to space or limit future births, yet only 3% are using LAPMs (UBOS & Macro International, Inc., 2007). Some LAPMs (particularly implants) are culturally acceptable, and demand for them exceeds the capacity of public-sector FP programs. Other methods are less popular and will require periodic marketing to create awareness and dispel myths. The public sector cannot compete with the NGO or private sector in meeting the demand for LAPMs, due to lack of trained personnel and to remuneration mechanisms that encourage referral to private LAPM services. In the short term, and in the absence of medical officers for training and service provision, one option is to expand public-sector mobile services for LAPMs. However, stakeholder commitment is required to sustain this mode of service delivery or to transition to static or community-based distribution services.

Strengthening service support systems is a long-term proposition. Limited resources can have only limited impact; FP services in Uganda are undercut by systems that require strengthening. This requires political will at the central and district levels, significant resources, careful, coordinated planning, and sustained inputs among DHMTs and district administration. In addition, project implementation to support systems strengthening requires adequate staff to carry out technical assistance activities, including postintervention follow-up.

“No product, no services.” A functional commodity logistics system is crucial to the expansion of LAPM service delivery. The absence or unreliable supply of commodities negatively affects training, method continuation, and service provision. Problem-solving planning in collaboration with MOH/RHD and DHMT leadership may be a first step in addressing this persistent barrier to care.

Successful global-bilateral project partnerships require joint planning. Working in partnership with bilateral projects requires consideration of respective partners' budgets, workplans, and implementation schedules. Joint program planning with USAID, the Mission, and partners needs to happen up front, to maximize synergy and to ensure that activities can be incorporated into partners' work. Project design should also be based on objective, in-depth needs assessments and should be realistic about what can be accomplished within the funding time frame, budget, and human resources.

Evidence-based advocacy for FP and LAPMs is critical. In a decentralized health care system where priorities and resource allocations are decided by political leaders, evidence-based advocacy

regarding the role and importance of FP is critical to inform programming. There is a need for increased advocacy regarding FP for healthy timing, spacing, and limiting of pregnancy to achieve desired family size. Tools such as Reality $\sqrt{\quad}$ can help districts use data to inform FP resource allocation.

Integrating FP into maternal and child health and HIV programs opens opportunities. In the face of ambivalence, at best, toward FP at the central level, framing FP as an effective approach to reducing maternal and child mortality promises to make FP more acceptable and viable. Similarly, integrating FP into HIV programs can be framed as an approach to preventing transmission of HIV infection. FP integration with HIV services and FP strengthening in maternal and child health services acknowledge FP as the unrecognized integral component of comprehensive client-oriented RH services.

Effective Practices

- ◆ The PNA approach is effective for engaging stakeholders in identifying and prioritizing challenges and “owning” solutions and sustaining improved performance. Streamlining the PNA approach may help reduce the time-intensiveness of the process while continuing to foster stakeholder ownership and sustainability.
- ◆ A holistic approach to programming that coordinates and sequences mutually supportive interventions in supply, demand, and advocacy is important to service credibility.
- ◆ Facilitative supervision and COPE[®] can strengthen the capacity for ongoing quality improvement at the local level, despite problems higher up in the system.
- ◆ District planning and problem solving for closing the “last mile” gaps in logistics systems is essential for ensuring that FP commodities and equipment get distributed to sites.
- ◆ Engaging and supporting CRHWs can help generate demand for FP and link clients with services.
- ◆ Evidence-based advocacy and planning (e.g., use of the Reality $\sqrt{\quad}$ Tool) enables districts to assess the resources needed for FP and LAPM programs.

Recommendations for FP Revitalization in Uganda

ACQUIRE's experience in three districts has informed development of broad recommendations for district-level FP/LAPM revitalization. To increase the service capacity for, and use of, FP in general and LAPMs specifically in Uganda, major considerations include the following recommendations.

Participatory Stakeholder Engagement

Conduct needs assessments as a vehicle for engaging district leaders and communities. Prior to initiating revitalization activities, stakeholders need to plan for capacity building and sustained support for district FP and LAPM service provision. Needs assessments should involve multiple MOH stakeholders and the DHMT to elicit commitment and determine expectations for the roles of stakeholders in problem solving and in sustaining services. This can be formalized through memoranda of understanding between facilities, DHMT, and MOH, with clear delineation of roles, responsibilities, and shared goals. Such agreements require long-term commitment.

Partner with the private sector to increase access to LAPM services. Due to the constraints of the public-sector FP systems, further exploration of opportunities to expand LAPM service capacity through private-sector partnerships is warranted. This could involve private-sector service providers, NGOs, and/or employer-based services. In particular, a partnership between the public sector and MSI should be explored to increase access to permanent methods, particularly while the MOH's capacity to provide these services is being developed.

Supply Systems

Training system

Develop district strategies to train, follow up, and retain service providers. Ensuring sufficient numbers of trained service providers is a crucial component of LAPM revitalization. Leadership workshops can help get the needed commitment from the MOH and districts to develop a district training strategy to support service delivery. Districts can then budget resources to ensure a pool of competent trainers and cover training activities under an approved training plan, as well as sanction positions for service providers. On-the-job training can help expand and retain the necessary cadre of service providers to increase access to and meet demand for FP.

Train additional cadres of staff to expand access. Capacity-building to meet demand for LAPMs is of particular importance in districts with few or no medical officers and may require districts to budget resources for mobile services. A recent policy change now permits clinical officers and midwives to provide male and female sterilization, which could increase the availability of sustainable permanent method services if workloads permit. Because preservice training of clinical officers and midwives does not include surgery, a training and supervision strategy is needed to prepare these cadres to safely perform such procedures. Resistance from the medical community can also be expected.

Supervision system

Deploy and support supervisors to manage quality FP/LAPM services. Leadership workshops with MOH/RHD, regional RH coordinators, and DHMT can provide an opportunity to focus on problem solving for supervisory system challenges and to follow up on planned interventions. DHMTs must plan for ongoing supervisory visits in their workplans and budgets and must develop a plan to deploy and support supervisors. Facilitative supervision and COPE[®] trainings can strengthen the capacity of district- and site-level supervisors to manage service provision. Supervisors need to be oriented to FP/LAPM requirements and, if possible, receive training in the provision of LAPMs to effectively support trained staff. Linking supervision with training systems will strengthen supervisors to support new practices and improved performance.

Contraceptive security system

Strengthen logistics management throughout the country. An improved commodity distribution system would ensure that sites receive commodities in a timely manner and in adequate amounts. Aside from the issue of national-level stock-outs, district and site staff need further training in the process of calculating and requesting commodities. Short courses in logistics management would be strengthened by follow-up visits. Improved communication mechanisms with sites regarding stock-outs are also needed. ACQUIRE has developed a COPE[®] tool for contraceptive security (in collaboration with DELIVER) to help close the gap of the “last mile” between districts and sites, particularly in planning for commodity transport to lower-level health care centers. This approach, piloted in Tanzania, needs to be tested on a wider scale.

Demand for Services

Address persistent cultural resistance/myths and increase awareness of service availability. Demand-creation activities, including media campaigns and community-sensitization activities (dramas, IEC materials, satisfied users, and health talks) can address myths and misconceptions about FP and advertise service availability. Improved communications strategies are needed to address cultural resistance to specific methods (particularly the IUD). The successful crafting of effective media campaigns will require exploration of root causes for resistance to various FP methods, to inform messaging and marketing. Specific strategies for reaching men and youth will help meet respective FP needs. It is important to coordinate demand creation with the strengthening of supply systems, to ensure that trained service providers are available when clients seek services.

Engage communities to disseminate FP information and address service barriers. Engaging communities as active partners in disseminating FP information, in identifying FP/RH needs, and in advocating for improved services will improve the sustainability of revitalization efforts. Sensitizing local grassroots organizations and traditional leaders to FP/RH issues can help begin a dialogue about the demand for FP in their communities. CRHWs can play a key role in disseminating information about FP within their communities. They can also contribute to meeting demand for LAPMs by linking clients with periodic mobile services for vasectomy and tubal ligation. With service providers' agreement, CRHWs can accompany clients to facilities and mobile services, to strengthen referral linkages. A mechanism for remuneration and formal supervision would help encourage CRHWs to remain active and to strengthen their performance.

Advocacy

Foster evidence-based advocacy for FP and LAPMs. As districts expand FP revitalization, it will be crucial to address the underlying problems of competing priorities and limited resources. There is

a need to advocate for the role and importance of FP and LAPMs in promoting the achievement of desired family size through healthy timing, spacing, and limiting of pregnancies. Leadership should be cultivated among central MOH staff to support district FP programs. There is also a need for further rollout of the Reality \checkmark tool, to enable district champions to advocate for budget allocations for FP and LAPMs based on realistic projections of commodity and staffing needs. In addition, training in advocacy and in the use of data for discussion and decision making must be the norm.

Integrate FP with other RH service programs. Reframing FP as an approach to reducing maternal and child mortality (key goals in Uganda) and HIV transmission may help create a more supportive political environment for FP. Integrating FP into other maternal health and HIV services is a promising area of intervention in Uganda and can illuminate the critical role of FP in ensuring reproductive health.

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Appendix I: Hospital and Level-III and Level-IV Health Center Sites Receiving ACQUIRE Technical Assistance in Three Surveyed Districts, 2005–2007

District	Hospital	Level-IV health center	Level-III health center
Mayuge	—	Kigandalo Kityerera	Mayuge Baitambogwe Buwaiswa Malongo
Hoima	Hoima Hospital (district and regional referral)	Kikuube	Bugambe Kyangwali Butema Kigorobyia
Sembabule	—	Sembabule Ntusi	Lwemiyaga Matete Lwebitakuli

Appendix 2: Documents Reviewed for the Case Study

Uganda MOH Strategy to Improve Reproductive Health in Uganda, 2005–2010

Uganda DHS reports, 1988 to 2006

Final concept paper and workplan for revitalizing family planning in Uganda (March 2005)

Memorandum of understanding between the MOH and EngenderHealth (March 2005)

Trip reports: Farrell/Jaskiewicz January 2005; Farrell March 2005; Cisek July 2005; Farrell meeting notes July 2005; Farrell August 2005; Jaskiewicz/Kakande September 2005; Farrell November 2005; Kaniauskene/Farrell/Achwal March 2006; Kaniauskene/Achwal August 2006; Bernal/Farrell August 2006; Farrell December 2006; Johri February 2007; Kaniauskene/Farrell March 2007

PNA reports/action plans: Mayuge (February 2005), Hoima (September 2005), Sembabule (January 2006)

Uganda Private Midwives Association (UPMA) Mini-PNA report

FP revitalization communications strategy (January 2006)

Program reports: Training report on leadership skills and facilitative supervision/COPE[®] orientation for regional MOH personnel (March 2006); training report on community-based health worker FP training in Mayuge (July 2005); training report on FP service provider training in Hoima (December 2005); training report on Norplant implant/IUD provider training in Mayuge (August 2005); other training reports as appropriate

Training curricula and job aids for FP/LAPM

IEC materials adapted in conjunction with MOH/Health Promotions division

FP revitalization working group notes

ACQUIRE/Global and ACQUIRE/Uganda annual, semiannual, and quarterly reports (2005, 2006, and 2007)

FP service statistics for Mayuge, Hoima, and Sembabule districts, 2005–2007

Appendix 3: ACQUIRE Trainings and Workshops Conducted for LAPM Revitalization, July 2005–June 2007

Training event	Multidistrict		
	Year	No. of events	No. trained
Leadership workshop*	2006	1	19
MAP orientation workshop*	2006	1	14
COPE training of trainers (TOT)*	2006	1	14
Reality √ workshop§	2007	1	14
UPMA Norplant/IUD TOT*	2006	1	10
UPMA Norplant/IUD rollout§	2007	1	50
TOTAL		6	121

Training event	Mayuge			Hoima			Sembabule			TOTAL	
	Year	No. of events	No. trained	Year	No. of events	No. trained	Year	No. of events	No. trained	No. of events	No. trained
Norplant/IUD training*	2005	1	12	2006	1	12	2006	1	17	3	41
FP updates service providers*	---	---	---	2005	1	12	2006	1	15	2	27
Update training for CRHW trainers*	2005	1	6	2006	1	12	2006	1	6	3	24
Update training for CRHWs by trainers*	2005	3	45	2006	1	44	2006	1	30	5	119
Outreach LAPM*	2006	3	6	---	---	---	---	---	---	3	6
Facilitative supervision workshop*	2006	1	16	---	---	---	---	---	---	1	16
Media spokesperson training on IUD*	2006	1	15	2006	1	17	---	---	---	2	32
Infection prevention training§	2007	1	20	2007	1	12	2007	1	20	3	52
TOTAL		11	120		6	109		5	88	22	317

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