

Mapping of Community Based Distribution Programs in Uganda

Family Health International - Uganda
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USAID
FROM THE AMERICAN PEOPLE



ACRONYMS

ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immune Deficiency Syndrome
CBD	Community-based Distribution
CCF	Christian Children Fund
CRHW	Community Reproductive Health Worker
DHE	District Health Educator
DDHS	District Director of Health Services
DHO	District Health Officer
DHV	District Health Visitor
DMPA	Depot Medroxyprogesterone Acetate
EAD	East Ankole Diocese Family Planning Services Project
FHI	Family Health International
FLEP	Family Life Education Project
FPAU	Family Planning Association of Uganda
FPSDP	Family Planning Service Delivery Project
GTZ	German Technical Corporation
HIV	Human Immunodeficiency Virus
IEC	Information, Education, and Communication
MO	Medical Officer
MIHV	Minnesota International Health Volunteers
MSU	Marie Stopes Uganda
NGO	Nongovernmental Organization
NO	Nursing Officer
UNFPA	United Nations Population Fund
UPMA	Uganda Private Midwives Association
USAID	U. S. Agency for International Development

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EXECUTIVE SUMMARY

Introduction

Uganda has one of the highest total fertility rates in sub-Saharan Africa, at 6.9 children per woman. In addition, more than 80 percent of the population lives in rural areas where many women do not have adequate access to clinical family planning services. For these reasons, community health programs remain an important mechanism for distributing contraceptives. Though these programs typically provide only a limited selection of contraceptive methods, evidence shows that they are effective, generate demand, and increase and sustain family planning use.

The mapping exercise illustrated in this report was conducted to inform and support the efforts of the Ugandan Ministry of Health to increase the contraceptive prevalence through enhanced community-based distribution (CBD) of family planning. The specific objectives of the exercise were to 1) determine the historical and current coverage of CBD of family planning services in Uganda, by both governmental and nongovernmental programs, and 2) identify potential districts for scaling up these services.

Methods

The exercise was implemented during November and December 2006 via telephone interviews with district health officers, including district nursing officers, district health visitors, and district reproductive health coordinators. Interviews were also conducted with representatives of nongovernmental organizations involved in CBD of family planning services. A literature review was also conducted to assess the history and best practices of CBD programs in Uganda.

Key Results

Results of the mapping exercise indicate that CBD of family planning has been widely used in Uganda, as 66 (82.5 percent) of the 80 districts in the country have had a CBD program at one time. Currently, however, only 26 districts (32.5 percent) have active, financially supported programs.

Several key practices were identified for creating successful CBD of family planning programs. These included local communities selecting CBD workers using documented criteria; initial two-week training of CBD workers using a curriculum that covers family planning, reproductive health, and other health issues; and regular supervision of CBD workers using monitoring checklists.

Recommendations

- Develop a national strategy for CBD of family planning to guide implementation of CBD programs and projects in the country.

- Harmonize existing guidelines for selecting CBD workers, training manuals, tools, supervision checklists, and other materials developed by different programs.
- Conduct operations research on the feasibility of using existing community networks and partnerships to implement CBD of family planning. Existing networks and partnerships include clinics of the Uganda Private Midwives Association, traditional birth attendants, and faith-based organizations such as the Church of Uganda.
- Study the use of CBD workers for providing reproductive health, HIV/AIDS, and other services to determine whether providing integrated services marginalizes family planning.

SECTION 1: INTRODUCTION

A persistently high fertility rate is a key characteristic of Uganda's demographic profile. Currently, at 6.9 children per woman, Uganda's total fertility rate is the highest in the sub-Saharan Africa region covered by the 2006 Demographic and Health Surveys. Clearly, this is of concern for the health sector and its partners, as Uganda's high fertility rate has contributed to the third highest rate of population growth in the world. Indeed, family planning is an important priority for the Ugandan Ministry of Health and the country's second Health Sector Strategic Plan (HSSP II). The HSSP II provides the implementation framework for Uganda's National Health Policy.

In Uganda, more than 80 percent of the population lives in rural areas. Many women do not have adequate access to clinical family planning services. For this reason, community health programs remain an important mechanism for distributing contraceptives. These programs typically provide only a limited selection of contraceptive methods, including condoms and pills. However, evidence shows that these programs are effective and that they can increase and sustain family planning use, particularly when unmet need is high. Furthermore, in areas where contraceptive prevalence is low, community health programs can generate demand for family planning by imparting knowledge of and preferences for certain methods.

Uganda's government, health sector, and development partners are committed to identifying and supporting best practices and programs that improve access to and quality of family planning services, particularly in hard-to-reach areas. Increased attention is being paid to community-based distribution (CBD) programs, with a focus on harmonizing services and standards.

The mapping exercise documented in this report was conducted to support the Ministry of Health's efforts to increase contraceptive prevalence through enhanced CBD of family planning. The specific objectives of the exercise were to 1) determine the historical and current coverage of CBD of family planning services in Uganda, by both governmental and nongovernmental programs, and 2) identify potential districts for scaling up these services.

SECTION 2: METHODS

We began the mapping exercise by developing a tool for assessing the extent of CBD programs in different districts of Uganda. The Ministry of Health, Family Health International (FHI), and the U.S. Agency for International Development (USAID) were all instrumental in developing this tool. Two versions of the tool were created (Appendix A). One was designed to be used in interviews with district directors of health services (DDHSs) or their representatives. The other was designed for conducting interviews with representatives of nongovernmental organizations (NGOs).

A list of Ugandan DDHSs was obtained, and DDHSs were contacted to see if they or their representatives would participate in the mapping exercise. In November and December 2006, telephone interviews were conducted with district health officers, including district nursing officers, district health visitors, and district reproductive health coordinators. Representatives of NGOs involved in CBD of family planning services were also interviewed via the telephone. To help prepare this report, the available literature on CBD was also reviewed to identify best practices in CBD of family planning in Uganda and other African countries.

SECTION 3: KEY RESULTS

Fifty-six interviews were conducted with district health staff and representatives of NGOs involved with CBD of family planning (Appendix B). The following key results are based on those interviews.

3.1 Coverage of community-based distribution programs

Sixty-six (82.5 percent) of the 80 districts in Uganda have had a CBD program at one time since 1986. Forty-two (63.6 percent) of these districts have had programs supported by the United Nations Population Fund (UNFPA). Programs in the remaining districts have been supported by either USAID or the German Technical Corporation (GTZ).

Data on the current status of CBD programs is included in Appendix C. Twenty-six (32.5 percent) of the 80 districts in Uganda currently have active CBD programs receiving outside financial support. Another 30 districts (37.5 percent) have weak CBD programs, according to reports from interviewees. These programs no longer have outside financial support and appear to be inactive, as little district-level information is available for evaluating their performance. Fourteen districts (17.5 percent) have never had a CBD program.

Fifteen districts (18.8 percent) have integrated CBD activities into the activities of village health teams. In addition to providing family planning services, these integrated programs offer treatment for malaria, immunizations, information on health and nutrition issues, and more. As shown in Appendix C, some districts have both traditional CBD programs and integrated programs.

3.2 Quality of community-based distribution programs

Overall, the quality of the CBD programs varied depending on the policies and experience of implementing agencies. Based on the services they provided, some programs were stronger than others. Work is needed to make the programs more consistent, including encouraging them to share resources such as strategies for training CBD workers, training curriculums, and program designs. The following are the specific quality-related issues highlighted during interviews.

Selection and training of community-based distribution workers

Each program provided guidelines for selecting CBD workers and allowed communities to select their own candidates for training. In most of the programs, workers were initially trained for two weeks using a curriculum that covers family planning, reproductive health, and other health issues. Some programs provided refresher trainings. The various programs developed different training manuals, materials, and tools.

Community participation

Communities participated in the CBD programs, particularly in the selection of community health workers. They also participated in monitoring activities of the CHWs to ensure that they performed within their terms of reference. In some cases, they even contributed resources e.g. lunch and transportation allowances to sustain CBD activities.

Incentives

Incentives offered to CBD workers varied among the programs. Items provided as incentives included bicycles, gumboots, umbrellas, CBD kits, registers, and bags. Some programs also provided information, education, and communication (IEC) or behavior change communication materials.

Provision of contraceptives

Most programs offered only condoms and oral contraceptive pills. Programs in the districts of Luwero, Nakasongola, and Nakaseke also provided the injectable depot medroxyprogesterone acetate (DMPA). In all the existing programs, contraceptives were expected to come from district health officers. A small proportion of condoms were provided through social marketing agencies. However, supplying CBD programs with contraceptive is a big challenge. Many DDHSs and district health officers said they could not provide contraceptives to CBD programs because they did not have enough for their own health units. No deliberate efforts were made to provide contraceptives by establishing depots.

Supervision

Each program developed its own checklists and guidelines for supervision and notes that regular supervision using a monitoring checklist was an essential practice. CBD workers from programs implemented by NGOs were supervised well. However, after funding for certain programs ended, so did supervision and follow-up. Government-affiliated CBD programs had no effective systems for supervising their CBD workers. No evidence is available to show how long their workers continued to work. In some districts, CBD workers were decentralized to subcounties, and no information is available on their current activities.

Essential role of traditional birth attendants

Almost all CBD programs offered integrated services. In addition to providing family planning, CBD workers often provided safe-motherhood, HIV/AIDS, malaria, and nutrition services. Evidence from the Ssembabule Minnesota International Health Volunteers (MIHV) program has shown that, given proper training and support, traditional birth attendants are an essential family planning resource. They can make family planning information much more accessible by providing services and referrals and by reinforcing key family planning messages.

Absorption into other programs

In some districts, once funding of CBD programs ceased, the programs were absorbed into other programs. CBD workers from some districts joined village health teams, while those in other districts joined the common cadre of integrated community health workers who were mobilizing communities and providing health services, such as contraceptives and drugs to treat malaria. This approach could be harnessed to promote CBD within family planning programs.

Partnerships and networks

Partnerships and networks have not been adequately utilized in Uganda, as has been found in other countries such as Kenya. However, the Family Live Education Project (FLEP), the Family Planning Service Delivery Project (FPSDP), and the East Ankole Diocese Family Planning Service Delivery Project (EAD) utilized the networks of the Church of Uganda through its Busoga, East Ankole, South Rwenzori, and Bunyoro Kitara dioceses. For example, part of the success of FLEP has been attributed to the community-based infrastructure of the Busoga diocese, including its network of health units.

In addition, international agencies with extensive experience planning and implementing CBD programs in developing countries are working in Uganda. These agencies include FHI and Pathfinder International, among others. The experiences of these agencies could be further utilized and applied in the Ugandan context.

Community-based organizations

The Mayuge district's Adventist Development and Relief Agency (ADRA) program has shown that, after training and dialogue, communities can be encouraged to form associations (e.g., youth groups, income-generating associations) that can register with the district to turn into community-based organizations. These community-based organizations can help maintain a program's achievements after the program is completed, be used by local governments to channel funding for community health activities, and lobby with local authorities on behalf of their constituencies (MIHV and ADRA, 2004).

Mobilization of private outlets

Evidence from the Ssembabule MIHV program indicated that private outlets can quickly be mobilized to become major suppliers of contraceptives. Between 1996 and 2000, private vendors (e.g., drugstores, kiosks, bars) replaced family planning clinics as the primary supplier of condoms. Specifically, use of family planning clinics declined considerably, while use of these private sector outlets more than tripled (MIHV and ADRA, 2004).

Sustainability

Most programs reported that their biggest challenge was sustaining CBD activities. Some tried to sustain activities by selling contraceptives, providing commissions to CBD workers, and supporting income-generating activities. No evidence is available to determine whether these efforts have been successful, but they should be explored further.

Provision of depot medroxyprogesterone acetate

Most district health officers and district nursing officers (70 percent) were not aware of the current initiative to provide DMPA through CBD. However, the majority of district health staff interviewed (75 percent) supported the idea of using community health workers to provide DMPA and emphasized the need to adequately train and supervise them. See <http://www.fhi.org/en/RH/Pubs/booksReports/DepoCBDinAfrica.htm> to read a 2005 final report from the Ministry of Health, FHI, and Save the Children on the safety and feasibility of providing DMPA through CBD in Nakasongola. A follow-on scale-up and advocacy project is ongoing in two new districts in the country.

Evaluation

USAID-supported CBD programs involved in the mapping exercise have been evaluated, and best practices determined from these evaluations are available (Katende, Gupta, and Bessinger, 2003; MIHV and ADRA, 2004; Bowles, 1999; Putnam et al., 1996). The CBD programs supported by UNFPA have not been evaluated to-date, making it difficult to identify best practices from these programs.

District-level appreciation for the programs

According to the interviews, nearly all district health offices appreciated the concept of CBD. However, because of lack of adequate funding, these offices were not providing the programs with contraceptives and supervision. Some district health offices were not aware or informed about the CBD programs in their districts.

SECTION 4: CURRENT COMMUNITY-BASED DISTRIBUTION PROGRAMS

This section outlines detailed information on the five programs offering CBD of family planning in Uganda as of December 2006. These five programs offer CBD of FP in the 26 districts that have strong CBD programs, supported by development partners.

For all programs, outlined information includes their criteria for recruiting or selecting CBD workers, their training strategy, and their coverage (including what districts they serve, what services they offer, and their target groups). Payments or incentives they offer CBD workers, systems for supervising workers, supplies they keep, and other logistical information are also outlined for each program.

We have attempted to assess the relative strengths of the CBD programs according to the volume of contraceptives they provided. This information is presented in the table below for all programs except ADRA, for whom the data was not readily available.

<i>Program</i>	<i>Save the Children/USA</i>
Introduction	Save the Children/USA sponsors a community-based reproductive health and family planning program that complements clinic-based services. Support for the program is provided by USAID, through FHI and Save the Children.
Recruitment/selection criteria and process	One hundred fifty community reproductive health workers (CRHWs) recruited and selected at the parish level by the community.
Training	Two-week initial training for CRHWs. Developed a comprehensive, phased-in approach for a three-week training and practicum for CRHWs in each district for the safe provision of DMPA. CRHWs trained in reproductive physiology, contraceptive technology, counseling, client screening, injection technique, infection prevention, waste disposal, and other essential aspects of DMPA provision.
Coverage	Nakasongola, Luwero, and Nakaseke districts.
Payments/incentives	CRHWs are not paid a salary, but are given incentives by Save the Children. These incentives are monthly gifts of useful household items, such as raincoats and gumboots, that facilitate their work.
Supervision	Save the Children and nearby health center staff supervise the provision of contraceptive injections by CRHWs. However, because contraceptive injection by paramedical cadres is new to Uganda, district health officials also make special efforts to visit CRHWs in their home areas and ensure quality. Supervision, logistics, and safety systems were developed locally and are managed by district health officials and local staff of Save the Children.

Supplies/logistics	Raincoats and gumboots. Each CRHW is also affiliated with a health center where he or she is resupplied with free contraceptive commodities and to which he or she refers clients for clinic-based methods.	
Contraceptives issued (2006)	Type	Number issued
	Pills (cycles)	3,597
	Male condoms	41,926
	DepoProvera (Injections)	498
	TOTAL	30,600

Program	<i>Family Planning Association of Uganda (FPAU)</i>				
Introduction	FPAU operates in 29 districts (branches) and has more than 3,500 volunteers. The program's activities include advocacy of sexual and reproductive rights; IEC on sexual and reproductive health; and sexual and reproductive health services through static clinics and outreach. FPAU is supported by many partners including the International Planned Parenthood Federation, UNFPA, Plan International, and Pathfinder International.				
Recruitment/selection criteria and process	Volunteer members recruited by the branches and community-based organizations through sensitization and provision of services.				
Training	Two-week initial training for volunteer members. Program curriculum used.				
Coverage	Targets adolescents, youth, and adults in 13 districts. These districts are Arua, Bushenyi, Hoima, Mbale, Mityana, Luwero, Tororo, Iganga, Fortportal, Mbarara, Moyo, Kampala, and Lira.				
Payments/incentives	No payments, but nonmonetary incentives in the form of supplies.				
Supervision	Supervised by FPAU staff at the branch level.				
Supplies/logistics	Equipment, bags, IEC materials, gumboots, bicycles, and umbrellas.				
Contraceptives issued (2006)	Type	Clinics	Outreach	Community Based Reproductive Health	Total
	Pills	21,339	5,257	5,204	31,800
	Intrauterine devices	360	1	5	366
	Male condoms	155,326	99,453	147,271	402,050
	Female condoms	401	2,195	---	2,596

	Injectables (three-month)	11,856	1,265	3	13,124
	Injectables (two-month)	79	29	---	108
	Injectables (one-month)	1,171	170	8	1,349
	Emergency contraceptives	1,565	78	59	1,702
	Tubal ligation	13	9	---	22
	Vasectomy	2	2	---	4
	Implants (five-year)	293	3	---	296
	TOTAL	192,405	108,462	152,550	453,417

Program	Marie Stopes Uganda (MSU)	
Introduction	MSU is providing family planning services through its centers and outreach components. Twelve centers now serve more than 86,025 clients each year. MSU provides a range of center-based and outreach sexual and reproductive health services. These include family planning and contraceptive services, contraceptive social marketing, ante- and postnatal care, female sterilization, vasectomy, primary health care, and youth services. They also focus on the prevention, diagnosis, and treatment of sexually transmitted infections; initiatives to raise awareness of HIV/AIDS and other sexually transmitted infections; and voluntary, confidential counselling and testing for HIV/AIDS clients.	
Recruitment/selection criteria and process	Volunteer members recruited by the branches through sensitization. Clients who are satisfied with their services agree to work as volunteers.	
Training	Two-week initial training for community health workers. Program curriculum used. Workers create awareness and refer clients to the centers for services.	
Coverage	Amuru, Apac, Gulu, Iganga, Kabale, Kampala, Lira, Mbale, Mbarara, Oyam, and Tororo districts.	
Payments/incentives	No payments, but nonmonetary incentives in the form of supplies.	
Supervision	MSU and health center staff supervise the provision of injectables by community health workers.	
Supplies/logistics	Equipment, bags, IEC materials, gumboots, bicycles, t-shirts, caps, and rain coats.	
Contraceptives issued (2006)	Type	Number issued
	Pills	6,992
	Intrauterine devices	630

	Male condoms	79,170
	Female condoms	0
	Injectables (three-month)	5,485
	Injectables (two-month)	0
	Injectables (one-month)	0
	Emergency contraceptives	155
	Tubal ligation	18,913
	Vasectomy	1,054
	Implants (five-year)	1,009
	TOTAL	113,408

<i>Program</i>	<i>Christian Children's Fund (CCF)</i>	
Introduction	CCF receives support from UNFPA to undertake CBD in three districts of northern Uganda.	
Recruitment/selection criteria and process	Volunteer members recruited by CCF branches through sensitization and provision of services.	
Training	Two-week initial training for volunteer members. Program curriculum used. Trained to provide COCs, condoms and refer for DMPA	
Coverage	Pader, Kitgum, and Lira districts.	
Payments/incentives	No payments, but nonmonetary incentives in the form of supplies.	
Supervision	CCF and health center staff supervise CBD workers.	
Supplies/logistics	Equipment, bags, IEC materials, gumboots, and bicycles.	
Contraceptives issued (2006)	Type	Number issued
	Pills	600
	Male condoms	30,000
	TOTAL	30,600

<i>Program</i>	<i>Adventist Development and Relief Agency (ADRA) Uganda</i>
Introduction	ADRA Uganda is a national NGO serving vulnerable communities across the country. Through Bunya Integrated Health Project, ADRA is implementing CBD of family planning in two subcounties of Mayuge district.
Recruitment/selection criteria and process	CRHWs are recruited by communities to educate communities, visit homes, provide counseling, distribute contraceptives, and refer clients.
Training	Training of traditional birth attendants includes client history-taking, physical examinations, screening and referring mothers to

	health units for family planning services and maternal health care, and use of the lactational amenorrhea method. Training of CRHWs includes the rationale for family planning, client counseling on informed choice, client education, home visits and follow-up, screening and referring clients to health units, and anatomy and physiology. Training sessions also address the benefits of family planning services in relation to general community development, family development, and economic growth. Training manuals have been developed.	
Coverage	ADRA Uganda targets women of reproductive age, adolescents, and sexually active men in Mayuge district.	
Payments/incentives	No payments, but nonmonetary incentives in terms of supplies.	
Supervision	Health center staff supervise CBD workers.	
Contraceptives issued (6 months)	Type	Number issued
	Pills (cycles)	81
	Male condoms	25,901
	Implants (through referral)	25
	Depo Provera (through referral)	637
	Tubal Ligation (through referral)	22
	TOTAL	26.666

SECTION 5: CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusions

CBD of family planning has been practiced for the last 26 years in Uganda. Based on reports evaluating selected CBD programs, some of the programs have been generally successful and increased contraceptive prevalence. CBD activities have been implemented in 66 (82.5 percent) of the 80 districts in Uganda at some point in time. However, the CBD programs appeared not to have adequately benefited from community networks and partnerships in terms of planning and implementation.

Based on interviews with district health officers and representatives of NGOs involved in CBD of family planning, 14 districts have never had a CBD program, and 30 districts have only weak programs. The districts in the Karamoja region where the contraceptive prevalence rate is zero and there is no family planning program (Abim, Kaabong, Kotido, Nakapiripirit, and Moroto) need special programs with strong sensitization, mobilization, and advocacy to change the negative attitudes of their communities toward family planning.

Each program provided its own guidelines, materials, and other tools for selecting CBD workers, training them, and supervising them. However, these resources differed among the different programs. A standard package of guidelines and other resources has not been created to be used across the CBD programs.

5.2 Recommendations

- A national strategy for CBD of family planning needs to be developed to guide and harmonize CBD programs and projects in Uganda.
- Existing CBD guidelines for selecting CBD workers, training manuals, supervision checklists and tools, and other materials should be harmonized.
- The feasibility and effectiveness of using existing community networks and partnerships to implement CBD of family planning should be investigated. Existing networks to explore include traditional birth attendants, the Church of Uganda and its agencies, the Uganda Muslim Supreme Council, and the Uganda Private Midwives Association (UPMA). UPMA, for example, has a membership of more than 500 midwives through which more than 500 community contraceptive depots can be established at clinics.
- Using CBD workers to provide reproductive health, HIV/AIDS, and other services needs to be studied to determine whether providing integrated services marginalizes family planning services. Integration of services could, on the other hand, potentially motivate community health workers for FP if the other programs are providing incentives for services offered.
- An appropriate incentive plan needs to be designed for CBD programs.

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APPENDIX A - Assessment Tools

**Mapping of Community-Based Distribution of Family Planning in Uganda
Rapid Assessment Tool for DDHSs**

Name of respondent

Designation of respondent:

Name of District:

Population of district:

Health sub districts:

Sub counties:

Presence of district / government affiliated CBD programme. Yes
 No

Name of the programme:

Development partners supporting the programme

Year Programme Started:

Programme End Date:

Level of Funding:

Coverage of NGO CBD programme
(# sub counties / parishes)

Estimate of population covered by CBD programme

CPR for district (if known)

Aware of CHW provision of DMPA initiative? Yes
 No

Willing to be involved in scale up of CHW of DMPA initiative? Yes
 No

Mapping of Community-Based Distribution of Family Planning in Uganda
Rapid Assessment Tool for NGO

Name of Respondent

Designation of respondent:

Name of NGO

Name of CBD Programme:

Development partners supporting the programme:

Year Programme Started:

Programme End Date:

Level of Funding:

District(s) of operation

Health sub districts of operation in each district

Sub counties of operation in each district

Coverage of CBD programme (# sub counties / parishes)

Target Group of programme: (Adolescents, married men and women, etc)

Number of CBD agents per district by gender

Name given to CBD agents:

Average level of education of CBD agents

Facilitation given to CBD agents?

- A. Salary (*mention how much*)
- B. Transport Allowance
- C. Lunch Allowance
- D. Bicycle
- E. Uniforms, boots, and kits
- F. Bag
- G. Commission from sale of contraceptives
- H. Other (*please mention*)

Activities undertaken by CBD agents

- A. Distribution of contraceptives
- B. FP education and counselling
- C. STD and HIV/AIDS information and counseling
- D. Information on maternal and child health
- E. Distribution of malaria medicines and products (e.g. bed nets)
- F. Basic curative health care
- G. Others (*please mention*)

Contraceptives provided

- H. Condoms
- I. Pills
- J. Others (*please mention*)

Charges of contraceptives (free or sold at reduced prices). For those sold, give the price per unit

- A. Condoms
- B. Pills
- C. Others (*please mention*)

Implementation strategies

- A. Door to door services
- B. Depots where clients access services
- C. Both

Availability of guidelines for selection of CBD agents

- Yes
 - No
-

Availability of CBD agents' supervisors in the community

- Yes
 - No
-

Availability of training tools and manuals

- Yes
 - No
-

Period of training CBD agents

IEC/BCC materials CBD agents use (flip charts, pamphlets, visual aids, etc)

Aware of CHW provision of DMPA initiative?

- Yes
 - No
-

Willing to be involved in scale up of CHW of DMPA initiative?

- Yes
 - No
-

APPENDIX B

List of Respondents

No.	Name	Designation	District/organization	Contact
1.	Kyokuhair betty	DHV	Masindi	0772-268196
2.	Cuciri Alice	DNO	Adjumani	0772-510857
3.	Dr. Anguzu	DHO	Arua	0772-696200
4.	Sr. Nsubuga Beatrice	DNO	Bugiri	0772-432918
5.	Dr. William Sikyewunda	DHO	Bundibugyo	0772-534149
6.	Dr. Owundo	DHO	Busia	0772-507510
7.	Ms. Getrude Irumba	DHV	Hoima	0772-513230
8.	Sr. Namusaabi	DNO	Iganga	0772-665679
9.	Sr. Naziwa	NO	Iganga	0772-665679
10.	Isiko Joy	RHC	Jinja	0772-386836
11.	Sr. Najjemba	DNO	Mayuge	0772-420338
12.	Dr. Bitakalamire	DHO	Kalangala	0772-590851
13.	Dr. Mutebi Edirisa	MO	Kampala	0772-425109
14.	Dr. Shaban Mugerwa	DHO	Kaliro	0782-701525
15.	Dr. Kaseewa	DHO	Kamwenge	0772-553408
16.	Dr. Ssebudde Stephen	DHO	Kanungu	0772-900138
17.	Dr. Boyo Mashandich	DHO	Kapchorwa	0772-984947
18.	Dr. Zefa Kalyabakabo	DHO	Rukungiri	0772-681785
19.	Dr. Musisi	DHO	Kayunga	0772-447832
20.	Sr. Tofasi Muhereza	DNO	Kibaale	0772-328923
21.	Dr. Muluta Allan	DHO	Kiboga	0772-460297
22.	Dr. Assye Ndizihwe	DHO	Kisoro	0772-665948
23.	Sr. Allen Amono	RHC	Kitgum	0772-903052
24.	Dr. Talamoi	DHO	Kotido	0772-381451
25.	Sr. Kimara	DNO	Kyenjojo	0772-563041
26.	Dr. Kusolo P.M.	DHO	Lira	0782-726199
27.	Dr. Okware	DHO	Luwero	0772-405094
28.	Sr. Trecy Namisango	DHV	Masaka	0772-601586
29.	Sr. Nampeera Edith	DNO	Rakai	0772-571500
30.	Dr. Kaguna Amooti	DHO	Mbarara	0772-521846
31.	Dr. Owiny	DHO	Moroto	0772-614641
32.	Dr. Ndibako S.	DHO	Moyo	0772-507245
33.	Dr. Nasanga R.	DHO	Mpigi	0772-503088
34.	Dr. Mubiru Wilson	DHO	Mubende	0772-670556
35.	Dr. Elly Tumushabe	DHO	Mukono	0782-414189
36.	Sr. Nakityo Justine Kajura	DHE	Nakasongola	0782-828769
37.	Hellen Brijaru	DNO	Nebbi	0772-666772
38.	Jancita Oboke	DNO	Pader	0772-873419
39.	Sr. Otim Dorothy	DNO	Pallisa	0772-492046

No.	Name	Designation	District/organization	Contact
40.	Dr. Binta Monica	DHO	Sembabule	0772-305626
41.	Dr. Nabende	DHO	Sironko	0752-818474
42.	Dr. Mukisa E.	DHO	Wakiso	0782-455889
43.	Sr. Grace Drabu	DHV	Yumbe	0772-301694
44.	Dr. Mugweri	DHO	Nakapiripirit	0772-457343
45.	Dr. Kaligwiza William	DHO	Ntungamo	0782-521787
46.	Dr. Okware Joseph	DHO	Luwero	0772-405094
47.	Dr. Mukobi Peter	DHO	Kasese	0774-408225
48.	Dr. Emer Mathew	DHO	Apac	0772-406695
49.	Ms. Marjorie Rugwiza	DHV	Kabaale	0772-674440
50.	Mr. Tukwasibwe Francis		UNFPA	0772-645440
51.	Dr. Sentongo Miriam		Ministry of Health	0772-413433
52.	Dr. Kakande Henry		ACQUIRE Project	0752-692159
53.	Alex Bagora	Training officer	Marie Stopes	041-347129
54.	Mr. Musoke	Manager	ADRA, Mayuge	0772-771109
55.	Mr. Jackson Chekweko	Acting Manager	FPAU	041-540658
56.	Dr. Caroline A. Abeja	Director	Pathfinder	041-255939
57.	Priscilla Muyindi	Field Coordinator	Christian Childrens' Fund, Kitgum	0782 852282

Abbreviations: DHE = District Health Educator; DHO = District Health Officer; DHV = District Health Visitor; DNO = District Nursing Officer; NO = Nursing Officer; MO = Medical Officer; RHC = Reproductive Health Coordinator.

APPENDIX C

Mapping of Activities by District

Current Status of Community-Based Distribution Programs

No.	District	Supported/Active	Unsupported/Inactive	Integrated Program	No Program
1	Abim				
2	Adjumani				
3	Amolatar				
4	Amuria				
5	Amuru				
6	Apac				
7	Arua				
8	Budaka				
9	Bududa				
10	Bugiri				
11	Bukedea				
12	Bukwa				
13	Buliisa				
14	Bundibugyo				
15	Bushenyi				
16	Busia				
17	Butaleja				
18	Dokolo				
19	Gulu				
20	Hoima				
21	Ibanda				
22	Iganga				
23	Isingiro				
24	Jinja				
25	Kaabong				
26	Kabale				
27	Kabarole				
28	Kaberamaido				

62	Mubende				
63	Mukono				
64	Nakapiripirit				
65	Nakaseke				
66	Nakasongola				
67	Namutumba				
68	Nebbi				
69	Ntungamo				
70	Oyam				
71	Pader				
72	Pallisa				
73	Rakai				
74	Rukungiri				
75	Sironko				
76	Soroti				
77	Ssembabule				
78	Tororo				
79	Wakiso				
80	Yumbe				