



## WHO/IBP Implementation Stories Africa

2 June 2021



**Carolin Ekman, WHO/IBP Network, Moderator**

Carolin Ekman works for the IBP Network Secretariat, with a main focus on communications, social media and knowledge management. With 12 years across the UN system, NGOs and the private sector, Carolin has a multidisciplinary understanding of SRHR and its wider impact on sustainable development. Her experience spans across external/internal communications; advocacy; research dissemination; partnerships; corporate responsibility; and M&E. Focus areas include family planning; adolescent health; social norms; FGM; child marriage; prevention of unsafe abortion; and honor based violence. Carolin holds a MSc in Media Technology/Journalism from the Royal Institute of Technology, Sweden, as well as a MSc in Marketing from Stockholm University, and has also studied human rights, development and CSR in Australia and Switzerland.




# Today's Agenda




<b>Opening &amp; welcome</b>	Carolin Ekman
<b>World Health Organization Remarks</b>	Carolin Ekman
<b>Knowledge SUCCESS Remarks</b>	Alex Omari
<b>Implementation Stories</b>	
Kenya	Paula Tavrow
Nigeria	Olufunke Fasawe
Tanzania	Anna Temba
Uganda	Irene Mirembe
Zimbabwe	Taurai Bhatasara
<b>Questions</b>	Carolin Ekman
<b>Closing</b>	Alex Omari & Carolin Ekman


# Before we Begin




**Webinar will be recorded**




**Submit your questions anytime!  
Q&A after all presentation**



**Visit our website to read all the stories:**  
<https://ibpnetwork.org/page/implementation-stories>





**Download the handouts**



The screenshot shows a GoToWebinar interface in 'Practice Mode'. The main content area displays a slide titled 'Covid-19 and Implications for Family Planning Services' with the WHO logo and a network diagram. Below the slide are several small profile pictures of participants. On the right side, there is a sidebar menu with options: Sharing, Webcam, Audio, Dashboard, Attendees: 1 of 501 (max), Polls (0/0), Questions, Handouts: 1 of 5, and Chat. At the bottom of the sidebar, it says 'Covid-19 and Implications for Family Plann...' and 'Webinar ID: 641-168-603'.

## Implementation Stories from Africa



		
Author(s)	Organization	Country
Taurai Bhasara, Brian Nachipo	PSI/MoH	Zimbabwe
Giang Thi Huong Phan	Marie Stopes International	Vietnam
Irene Mirembe, Sam Cherop, Carol Karutu	Intrahealth International	Uganda
Olufunke Fasawe, Farahat Bello, David Adeyemi, Nneka Onwuasor, Owens Wiwa	Clinton Health Access Initiative	Nigeria
Anna Temba, John Gamaliel, Marina Njelekela, Ramadhan Mlange, Emeka Okechukwu, Prudence Masako, Carlton Jones	EngenderHealth	Tanzania
Deepti Mathur, Mukesh Sharma, Vivek Sharma	Population Services International	India
Dra. Andrea del Rosario Garcia, Dr. Kirsten Austad	Wuqu' Kawoq   Maya Health Alliance	Guatemala
Bethany Arnold, Yacouba Ouedraogo, Cheick Ouedraogo	Jhpiego	Burkina Faso
Irene Torres, Bernardo Cañizares	Fundación Octaedro	Ecuador
Shamiya Nazir	International Rescue Committee/Bangladesh Sheikh Mujib Medical University (BSMMU)	Bangladesh
Paula Tavrow, Collins Juma, Albert Obbuyi	UCLA Fielding School of Public Health	Kenya
Dr Onisoa Rindra Ralidera	Options Consultancy Services	Madagascar
Diana Carolina Moreno, Laura Ximena León	Asociación Profamilia	Colombia
Lorena Eutiquia Santos Zárate, Patricia Cala Barranco	Mexfam/ Fundación Mexicana para la PF	Mexico
Cyprien Ephrem Zinsou, Ando Tiana Raobelison, Beth Brogaard	Association Béninoise de Marketing Social (ABMS)	Benin



**WHO Remarks**  
Carolin Ekman, WHO/IBP Network, Moderator



**A global platform  
for local impact**



“Tell me the facts and I’ll learn.  
Tell me the truth and I’ll believe.  
But tell me a story  
and it will live in heart forever.”

Native American proverb



“Intelligence is not information  
alone but also judgment,  
the manner in which information  
is coordinated and used.”

Carl Sagan  
(American scientist, writer and science communicator)





### Alex Omari, Knowledge SUCCESS

Alex Omari is a Public Health Professional and the Technical Family Planning/Reproductive Health Officer at Amref Health Africa's Institute of Capacity Development. He works as the Regional Knowledge Management Officer (East Africa) for the Knowledge SUCCESS project. Alex has over 8 years' experience in adolescent and youth sexual and reproductive health (AYSRH) program design, implementation, research, and advocacy. He is currently a Technical Working Group member for the AYSRH program at the Ministry of Health in Kenya. Alex is the outgoing Kenya Country Coordinator for the International Youth Alliance for Family Planning (IYAFP) and he is also a website contributor/writer for Strategic Review Journal ; an online journal of leadership, policy, and global affairs from the School of Government and Public Policy Indonesia.


# IBP Implementation Stories

Process, Story Creation, & Dissemination

*2 June 2021 | Presentation by Alex Omari,  
Knowledge SUCCESS*

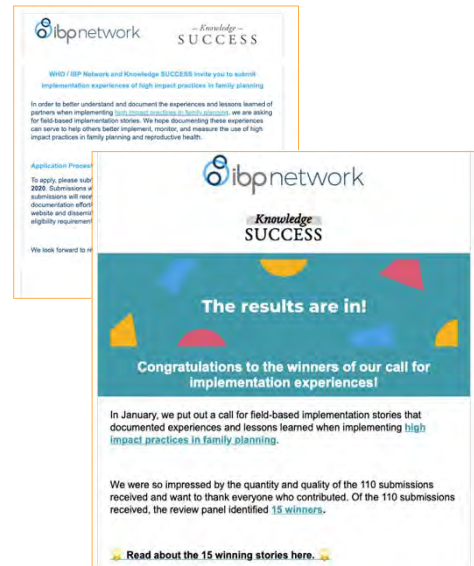


# Selection Process



## Submission and Selection

- Solicited stories in early 2020
- 110 total submissions
- 15 winning stories selected
- Announced winners in June 2020



## Selection criteria



Diversity of partners



Clear description of the problem, intervention, and challenges faced



Availability of qualitative or quantitative evidence



Lessons learned clearly articulated



Unique experiences or use of the HIPs/WHO guidelines

## Selected Stories Represent a Range of:



Topics/experiences



Partners



Geographies



HIPs/WHO guidelines



# Winning Stories

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Title	Author	Organization	Country
An Integrated Approach to Increasing Postpartum Long-Acting Reversible Contraception in Northern Nigeria	Olufunke Fasawe, Farahat Bello, David Adeyemi, Nneka Onwuasor, Owens Wiwa	Clinton Health Access Initiative	Nigeria
“One Stop Shop” Mobile Family Planning Outreach and Service Integration in Southern Tanzania	Anna Temba, John Gamaliel, Marina Njelekela, Ramadhan Mlange, Emeka Okechukwu, Prudence Masako, Carlton Jones	EngenderHealth	Tanzania
Ensuring Access: How RHITES-E Improves Uptake of Voluntary Family Planning in Rural Eastern Uganda Through Partnerships and Collaboration	Irene Mirembe, Sam Cherop, Carol Karutu	IntraHealth International	Uganda
Providing Family Planning Services through the “Stop the Bus Model” for Adolescent Girls and Young Women in Six Districts in Zimbabwe	Taurai Bhatasara, Brian Nachipo	PSI/MoH	Zimbabwe
The After Hours Adolescent Project: Expanding Access to Sexual and Reproductive Health Services in Western Kenya	Paula Tavrow, Collins Juma, Albert Obbuyi	UCLA Fielding School of Public Health	Kenya

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# Dissemination and Follow Up

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## Dissemination and Next Steps



Final stories are available now as PDFs



Please help us share these stories with your networks



Looking into additional ways to tell these stories—and more stories like these

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## Knowledge SUCCESS Activities



The East Africa FP/RH CoP that strengthens knowledge exchange , collaboration and support to FP/RH programs



Working with KM Champions and youth networks such FP 2030 Youth Focal Points and IYAAP for dissemination



Building the KM capacity among youth-led and youth-serving civil society partners

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## Thank you!



Special thanks to all the authors, partners, and organizations who worked on the stories



Knowledge SUCCESS and IBP would love to hear from you, if you have additional ideas for stories or ways to disseminate this information!

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## Today's Presenters



**Paula Tavrow**  
Kenya



**Olufunke Fasawe**  
Nigeria



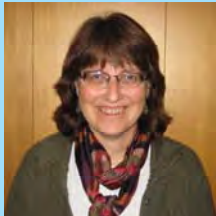
**Anna Temba**  
Tanzania



**Irene Mirembe**  
Uganda



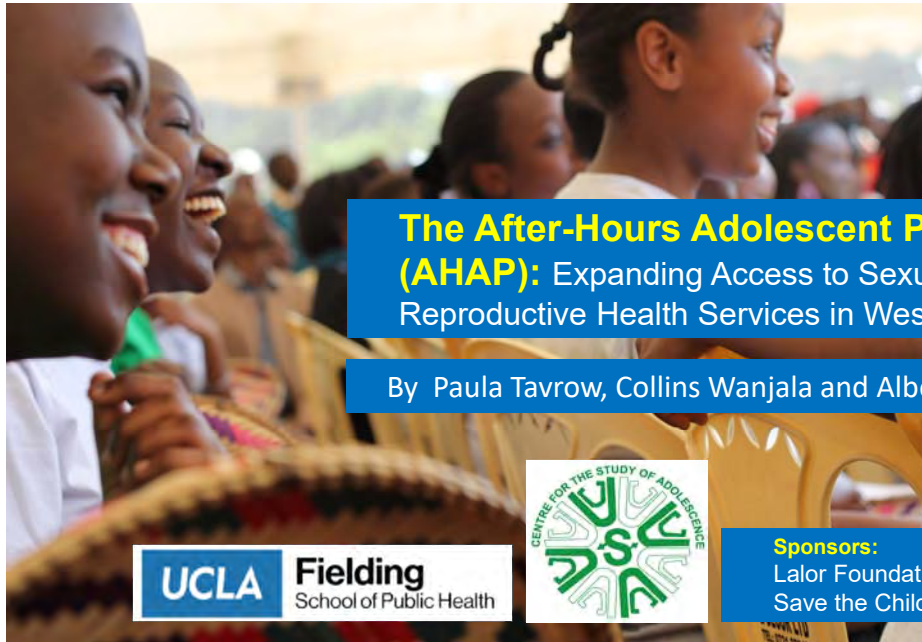
**Taurai Bhatasara**  
Zimbabwe



### **Paula Tavrow, UCLA**

Dr. Paula Tavrow is the Director of UCLA's Bixby Program in Population and Reproductive Health and Adjunct Professor in the Community Health Sciences Department at the UCLA Fielding School of Public Health. She was the founding Co-Director of Center of Expertise in Women's Health and Empowerment, at the University of California Global Health Institute. Her current research interests center on adolescent reproductive health, coerced sex, intimate partner violence, early marriage, and the quality of primary health care services. In Western Kenya, Dr. Tavrow has worked with the Centre for the Study of Adolescence (Nairobi) to launch several innovative projects to improve adolescent sexual and reproductive health, including Youth for Youth, End Violence on Campus, and After Hours Adolescent Project (AHAP). She received her AB (magna cum laude) from Harvard-Radcliffe College, her MALD from the Fletcher School of Law and Diplomacy at Tufts University, and her MSc and PhD from the School of Public Health at the University of Michigan in Ann Arbor.





**The After-Hours Adolescent Project (AHAP):** Expanding Access to Sexual and Reproductive Health Services in Western Kenya

By Paula Tavrow, Collins Wanjala and Albert Obbuyi

**UCLA Fielding**  
School of Public Health

**Centre for the Study of Adolescence**

**Sponsors:**  
Lalor Foundation  
Save the Children Sweden

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## Why don't more rural African youths use sexual and reproductive health (SRH) services?



1. **Not confidential.** Youths fear being seen by others who could report back to their parents.
2. **Not convenient.** Services are offered when students are in school.
3. **Not youth-friendly.** Youths worry about being humiliated or forced to wait long for services.

## Purpose of Adolescent After Hours Project (AHAP)

To test whether making SRH services **more convenient, confidential, and youth-friendly** increased young people's use of rural government health facilities in Bungoma County, Kenya



## Main components of AHAP

- **Extended clinic hours into evening/weekend to enhance confidentiality for youths**
- **Hired and trained newly-graduated nurses to be youth-focused, friendly, and supportive**
- **Investigated whether having some nurses teach comprehensive sexuality education (CSE) part-time helped demystify services**
- **Ensured facilities had adequate supplies of condoms and basic lighting**
- **Set up clinic youth space with board games and informational materials**
- **Introduced youth client satisfaction cards and after-hours registers**



Training of AHAP nurses

## AHAP was a **randomized controlled trial**



AHAP facility: Khalumuli Dispensary

- **13 rural public facilities randomized to:**
  - **5:** after hours with AHAP nurse, who also taught CSE part-time in schools and community
  - **4:** after hours with AHAP nurse, who stayed in clinic
  - **4:** comparison (no change)
- **Hired and trained 10 new, young nurses (ages 23-29, M & F)**
  - Recruited CSE rovers (high school graduates) to assist AHAP nurses to do CSE in schools and communities
- **Encouraged intervention facilities to be open at least until 6 PM on weekdays, and one half-day of weekend**

## Evaluation methods

- **Review facility registers:**
  - April 2018 (before AHAP began)
  - April 2019 (near end of AHAP)
- **Focus group discussions:**
  - AHAP nurses
  - Youths in facility catchment area
- **Collect and analyze:**  
Youth client satisfaction cards at AHAP facilities



AHAP facility: Matisi Dispensary

## Key Results -1

Youth SRH visits to public facilities **increased 77-97% in one year.**

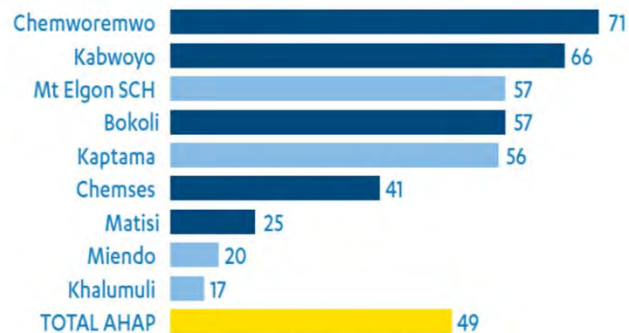
	No. of SRH youth client visits (April 2018)	No. of SRH youth client visits (April 2019)	Change (%)
AHAP			
AHAP plus nurse doing CSE in community (5 facilities)	532	1047	96.8%
AHAP plus nurse staying in clinic (4 facilities)	499	884	77.2%
Comparison (4 facilities)	337	337	0%

## Key Results -2



Youth space in AHAP clinic

Nearly half (49%) of youth SRH clients came to the AHAP facilities after hours.



Percentage of youths who came after hours to clinics.

Dark blue: AHAP + nurse taught sex education part-time.

Light blue: AHAP only.



## Key Results -3

Youth client cards revealed very high levels of satisfaction with services at AHAP facilities.

1. Felt comfortable with provider: 97.7%
2. Received information wanted: 97.6%
3. Had enough privacy: 95.8%
4. Received supplies wanted: 95.4%
5. Provider was not harsh: 93.6%
6. Comfortable coming here again: 96.7%

*From 1987 youth client cards (53% female, 44% male).*



AHAP nurse with youth client

## Comments from the community



AHAP nurse educating on CSE

- “Since AHAP was started one year ago, we have not had one pregnancy in our school. This has never happened before.”  
--Assistant Principal, Bungoma county
- “Youths themselves are very particular. If it is an AHAP nurse, they come. If it is someone else, they won’t come.”  
--In-charge at AHAP facility

## Lessons learned



- **After-hours works!** To increase rural youths' SRH use, it is vital that services be more convenient and confidential. Having services open until 6-7 PM helped youths overcome fears and embarrassment.
- **Demystify nurses.** Having nurses give CSE talks in the schools and community helped youths feel more comfortable with coming to the facilities. Youths like being able to ask for AHAP nurse by name.
- **Re-train nurses.** Even newly-graduated nurses harbor harmful misconceptions about contraception, such as that it increases infertility. Training nurses in SRH and CSE, plus clarifying their values is important.
- **End stock-outs and fees for youths.** Major deterrents to youth are SRH commodity stock-outs and fees for STI/HIV or pregnancy tests. Guaranteed condoms is not enough.

## Recommendations

1. Prior to launch, **get commitment that MOH** will continue to cover AHAP nurses' salary once concept has proven successful.
2. Ensure nurses feel **comfortable giving CSE talks**, and give them ample "practice time."
3. Ensure that essential SRH commodities are **adequately stocked** at all times. Train in stock management if necessary.
4. Consider creating **AHAP posters and brochures** to help advertise the program.
5. Encourage **community meetings** to discuss AHAP.



You can do it! For more information, contact Paula Tavrow (ptavrow@ucla.edu) or Albert Obbuyi (obbuyi@csa.kenya.org)





### **Olufunke Fasawe, Clinton Health Access Initiative**

Dr. Olufunke Fasawe is a Senior Director, Primary Health Care (Global), Director of Programs (Nigeria) and Technical Lead for the Sexual, Reproductive, Maternal, Newborn and Child Health Program (Nigeria), at the Clinton Health Access Initiative (CHAI) based in Nigeria. She joined CHAI in February 2012 and has worked across different program areas including Early Infant HIV Diagnosis laboratory strengthening, Routine Immunization & vaccine financing, Nutrition, Cervical Cancer. Prior to starting her career with CHAI, she worked with the Joint United Nations Programme on HIV/AIDS in Geneva as a health economics consultant conducting economic modeling for HIV programs and initiatives in high-burden mother-to child transmission of HIV (MTCT) countries. Olufunke holds a Master's degree in International Health Management, Economics and Policy from SDA Bocconi, Milan, Italy; she earned her Bachelor of Dental Surgery degree from the University of Lagos, Nigeria.

## **INTEGRATED APPROACH TO INCREASING POSTPARTUM LONG-ACTING REVERSIBLE CONTRACEPTION IN NORTHERN NIGERIA**

Presented at the Anglophone Africa WHO/IBP Implementation Stories Webinar | 02, June 2021  
Authors: Olufunke Fasawe, Farahat Bello, David Adeyemi, Nneka Onwuasor and Owens Wiwa

#### *Contact*

Olufunke Fasawe, Clinton Health Access Initiative (CHAI)  
ofasawe@clintonhealthaccess.org



## BACKGROUND

A major contributor to the low contraceptive prevalence rate in Nigeria is poor access to family planning services, which is more pronounced in rural areas. In 2015, only 19% (5,500) of the country's 29,000 primary health facilities offered family planning and only about 3% (1,000) offered long-acting reversible contraceptives.<sup>3</sup>

Nigeria is the second largest contributor to the global burden of maternal deaths, with **58,000** maternal deaths annually.<sup>1</sup>



The unmet need for family planning among married women of reproductive age is **19%**<sup>2</sup>, and only **3%** of postpartum Nigerian women use contraception within six months after delivery.

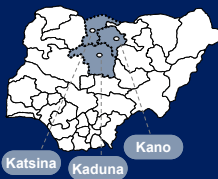
Only **17%** of married women of reproductive age use contraception and just **12%** use a modern method. An average of **82%** of births reportedly occurred outside of the health facility (home births) in the three program states in 2018.<sup>2</sup>



Sources: (1) Trends in Maternal Mortality: 1990 to 2015 by WHO, UNICEF, World Bank and United Nations Population Fund, (2) Nigeria Demographic Health Survey Final Report 2018, (3) Nigeria Family Planning Dashboard

## IMPLEMENTATION OF THE PRACTICE

CHAI implemented a post-partum family planning (PPFP) program from 2016 to 2019 in partnership with the Federal and State Ministries of Health of Kaduna, Kano, and Katsina states to address the low contraceptive prevalence rate and high unmet need for FP.



*The aim of the project was to address key barriers to access for long-acting, reversible contraceptives (LARCs) among post-partum women - lack of competent trained health providers for PPFP, limited availability of FP commodities and equipment, poor integration of FP and MNH services, lack of awareness of PPFP among pregnant women.*

### THE INTEGRATED APPROACH

Increased access points for quality PPIUD services from 30 to 682 facilities

Trained and mentored 1,454 qualified health care providers on immediate PPFP

Increased the proportion of women receiving ANC that are counselled on and referred for PPFP



- Strengthened commodity security and ensured availability of key commodities, equipment, and consumables
- Reorganized client workflows to link ANC, maternity, post-natal care, immunization services with FP
- Incorporated PPFP into guidelines and healthcare worker protocols in ANC, L&D, PNC



- Updated national training and mentoring curriculum for LARC to include PPFP
- Trained and mentored health workers at health facilities to provide PPFP
- Worked with the Society of Obstetricians and Gynecologists and Nursing to ensure quality standards in PPFP mentoring approach
- Instituted quality of care framework for optimizing PPFP service delivery



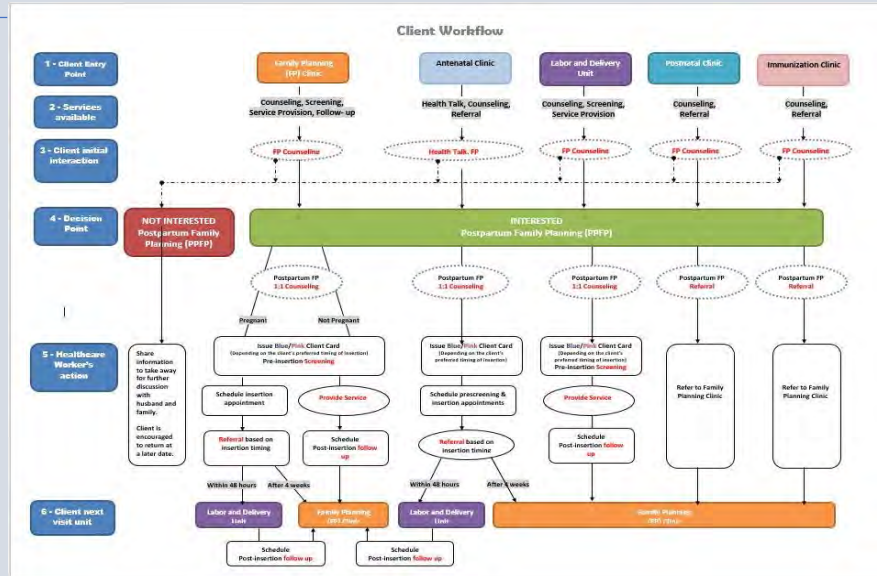
- Worked with traditional community leaders to increase acceptability of child spacing
- Trained and mentored TBAs to counsel and refer women for PPIUD and other FP services; focusing on home births
- Leveraged the network of Motorbike Ambulances (MBAs) to provide transport support for women in labor, earlier counseled, who want immediate PPIUD

## CLIENT WORKFLOW

The program worked with the SMOHs in Kaduna, Kano, and Katsina to reorganize the client workflow for facilities between the FP unit and other units in 374 facilities.

The approach integrates FP counseling and services, particularly LARC, into the MNH cascade to reach women during pregnancy-related interactions within the health system.

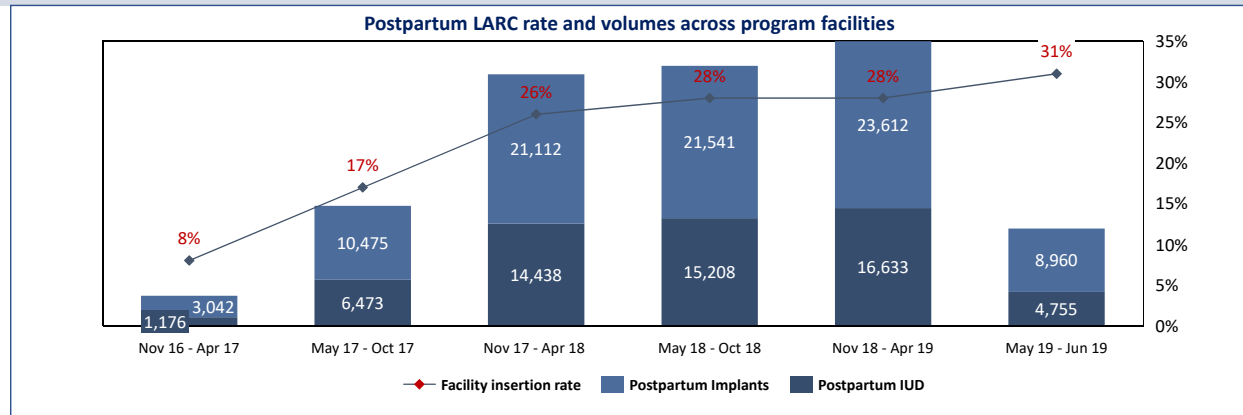
Clients now have access to FP and PFP information and services via ANC, Labor and Delivery, Postnatal and Routine Immunization units. The reorganization ensures that there are multiple access points for PFP so women already in the facility for other health services can receive their postpartum method of choice.






## PROGRAM RESULTS







The goal of the program was to expand access to long-acting, reversible contraceptives (LARCs), particularly PPIUDs during the postpartum period and increase uptake of FP in order to reduce unintended pregnancies and associated negative health outcomes.

Over the course of the program, 147,425 women chose and received PFP immediately after delivery (58,683 PPIUDs and 88,742 PP implants). The proportion of women delivering at facilities who received postpartum LARC increased from 8% in the first year of the program to 31% in the final months of the program.



By the end of the program 36% of the PPIUDs and PP implants provided were to women who delivered at home but came to the facility after delivery for PFP compared to 7% at the beginning of the program.

LESSONS LEARNED			
<p>Understanding the local context and barriers that affect uptake of postpartum family planning, and tailoring program interventions to address them, can improve uptake.</p>	<p><b>Sequencing supply and demand interventions, creating enabling environment at the facility, and ensuring equipment and commodity availability</b></p> <ul style="list-style-type: none"> <li>• Work closely with the state MOHs to ensure timely and consistent distribution of FP commodities to the facilities</li> <li>• Revise mentoring timelines to prioritize community mobilization and demand generation</li> <li>• Space out activities to allow lag time between community awareness, acceptance and uptake of PFP</li> </ul>	<p><b>Mentorship, supervision, and feedback to HCWs are critical for the provision of high quality voluntary PFP</b></p> <ul style="list-style-type: none"> <li>• Tailor <b>bespoke mentoring model</b> to health care providers to improve the provision of health care</li> <li>• Use <b>cluster mentoring approach</b> to pool health workers to reinforce counseling and insertion skill</li> <li>• Enable health care providers to learn best practices from staff in other facilities and foster healthy competition between facilities to improve family planning service provision</li> </ul>	<p><b>Community engagement and ownership is crucial in the acceptance and sustainability of interventions</b></p> <ul style="list-style-type: none"> <li>• Involve community leaders including traditional leaders, village heads, and key community influencers such as traditional birth attendants and male stakeholders.</li> <li>• Foster participation of key beneficiaries in program design and implementation to increase ownership and obligation, ensure the success and continuity of the intervention, and build trust in the formal health care system</li> </ul>

RECOMMENDATIONS		
 <p><b>1. Strengthen the capacity of the government</b> to manage postpartum family planning integration through strengthened monitoring and evaluation and quality data management.</p>	 <p><b>2. Ensure commodity security</b> and strengthen last mile distribution of FP commodities (including to L&amp;D wards), and consumables to enable service provision.</p>	 <p><b>3. Identify and fill equipment and instrument gaps</b> at facilities and build inventory management systems to ensure consistent availability of key equipment and instruments.</p>
 <p><b>4. Update and modify clinic flow</b> to integrate postpartum family planning at all points of care including antenatal care, routine immunization, and postnatal care units.</p>	 <p><b>5. Engage and train community influencers, including traditional leaders and male stakeholders,</b> to create community demand and increase awareness about the benefits of postpartum family planning.</p>	 <p><b>6. Expand the use of existing referral networks</b> to include postpartum family planning support and link clients to health facilities providing postpartum family planning.</p>



### Anna Temba, EngenderHealth

Dr. Anna Temba is a Medical Doctor and Public Health Specialist. She has over 10 years of practical experience as Clinician, Program Manager, and Technical Advisor in areas of MNCH, Family Planning, Youth, Comprehensive Post Abortion Care (PAC) and HIV/AIDS. Anna works with EngenderHealth where she serves as Senior Technical Advisor for FP/RH at USAID Boresha Afya Southern Zone Program. She has previously worked with various renowned FP organization including Pathfinder International and PSI and also served as a secretariat of the Tanzania National FP technical Working Group.

## Deloitte.



### USAID Boresha Afya - Southern Zone "One Stop Shop" Mobile Family Planning Outreach and Service Integration in Southern Tanzania



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FROM THE AMERICAN PEOPLE

**Deloitte.**

**fhi360**  
THE AGENCY OF INNOVATING LIVES



**EngenderHealth**  
ip - women's life



## Our Program

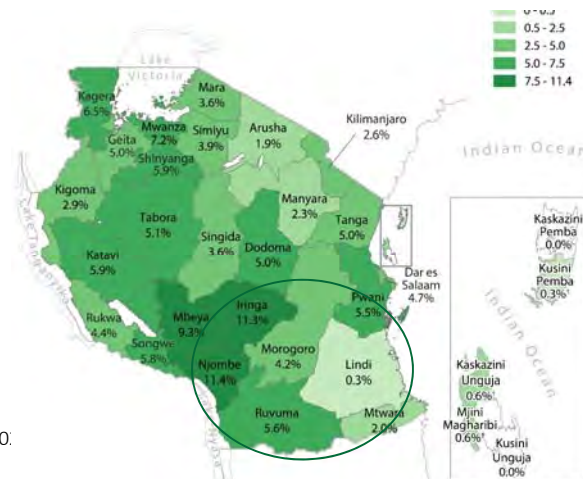
- **Title:** USAID Boresha Afya – Southern Zone Program
- **Goal:** Improved health status for all Tanzanians
- **Vision:** To create a dynamic, integrated platform for delivery of health services that emphasizes strong collaboration between government, health facilities and communities
- **Duration:** Five years program (October 1, 2016 to December 31, 2021). Currently in Q3 of the 5<sup>th</sup> year of implementation.
- **Supported services:** HIV, FP, MCH , TB and Malaria **Funded by :** USAID
- **Managed by** Deloitte Consulting Ltd in partnership with FHI360, EngenderHealth (EH), and Management and Development for Health (MDH).
- **Implemented by** LGA/Councils; Health Facilities; district based CSOs, CBOs and FBOs
- **Coverage:** Iringa, Lindi, Morogoro, Mtwara, Njombe and Ruvuma

## Background and Context

### Tanzania Context

- Contraceptive prevalence rate - **32%**
- Unmet need for Contraception - **22- 24%**
- Contraceptive knowledge - **99%**
- HIV prevalence rate **4.9% (6.3% among women)**
- **60%** of people know their HIV Status
- TB case notification – **49%**
- Human Resource for Health shortage is at **52%**

### HIV prevalence in supported regions



Source: TDHS 2015/2016, THMIS 2018, NTL, HRH strategic plan 20.



## Rationale for selecting HIP

### Mobile Outreach and integrated care have a potential to:

- Increase access and uptake of FP services including LARCs/PM
- Contribute to country's HIV identification efforts
- Improve maternal /neonatal health outcome through PPF
- Maximize Human Resource for Health through capacity building, retention and bridging service gaps created by HRH shortages



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## Integrated Outreach Approach

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## Integrated FP/HIV/ TB Outreach

- **Entry point service:** Family planning
- **Integrated services :** HIV Screening, testing and linkage; TB screening and linkage
- **Target population:** All WRA and Men
- **Location:** Facility based
- **FP method provided:** Short Acting, LARCs and PM
- **Team formation: 5 HCW**
  - Surgeon
  - Assistant surgeon
  - 2 FP nurses
  - 1 nurse – client flow, commodities and IPC
- **Frequency:** 5 days every quarter in each council
- **Client mobilization strategy:** Public announcement



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USAID Boresha Afya - Southern Zone Program 51

## Integrated FP/Immunization Outreach

- **Entry Point service:** Immunization services
- **Integrated services :** Family Planning
- **Target population:** Post Partum Women
- **Location:** Community
- **FP method provided:** Short Acting, Implant and referral for IUCD and PM
- **Team formation: 2/3 HCW**
  - Immunization nurse
  - FP nurse
- **Frequency:** 3 days every month in each council
- **Client Mobilization strategy:** CHW and Village leaders



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## FP outreach day at CTC

- **Entry Point service:** HIV antiretroviral refills
- **Integrated services :** Family Planning services and cervical cancer screening
- **Target population:** Women Living with HIV
- **Location:** HIV Care and Treatment Centers
- **FP method provided:** Short Acting, LARCs and referral PM
- **Team formation: 2/3 HCW**
  - FP nurse
  - Cervical cancer nurse
  - Host facility HCW
- **Frequency:** 5 days every month in each council
- **Client Mobilization strategy:** Community Based HIV Services providers (CBHS) and HCW



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USAID Boresha Afya - Southern Zone Program 53

## Results

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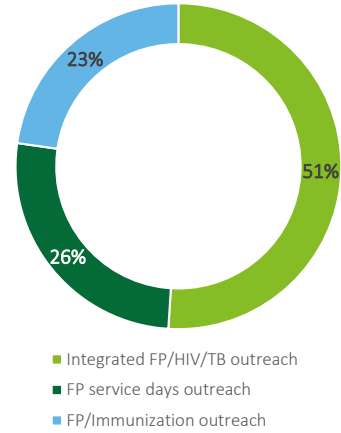
## The Impact

FP uptake by outreach type

	Minilap	NSV	Implant	IUCD	DMPA	Pills	condoms	Total
Integrated FP/HIV/TB outreach	6656	5	68719	24187	33701	13269	27578	<b>174115</b>
FP service days outreach	572	1	13625	3212	10187	6014	56178	<b>89789</b>
FP/Immunization outreach	1046	0	33792	4414	11262	7953	19132	<b>77599</b>
<b>Total</b>	<b>8274</b>	<b>6</b>	<b>116136</b>	<b>31813</b>	<b>55150</b>	<b>27236</b>	<b>102888</b>	<b>341503</b>

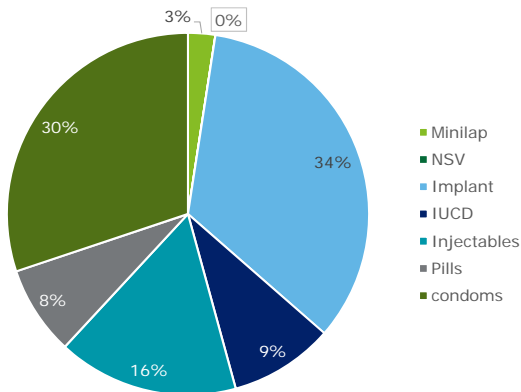
- 31,914 clients were tested for HIV, 194 tested positive and linked to CTC
- 21518 clients were screened for TB, 325 presumptive cases were linked for further testing

Clients served by outreach type

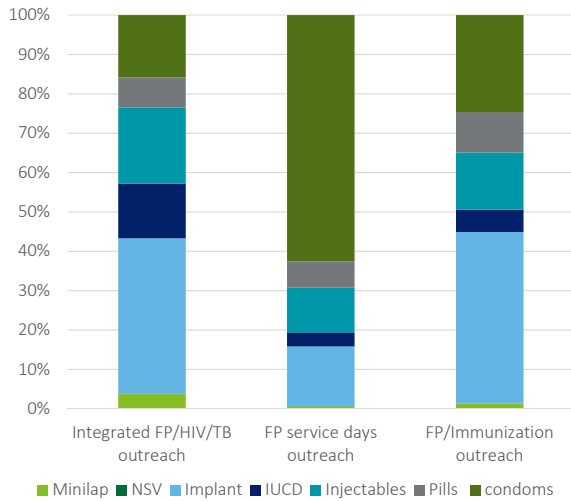


## The Impact

Method Mix During Outreach



Method Mix by Outreach type



## Lessons Learned & Recommendation

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### Lessons learned

- Training providers to multi task and provide multiple services
  - effective use of both financial and human resources
  - Maintain clients' privacy and confidentiality
- Strategic selection of outreach facilities to minimize outreach dependency for LARCs
  - Graduate facilities that have attained desired competency
- Supportive policies and guidelines increased provider buy in and supported capacity building initiatives
- Integrated program from design stage offer more opportunities for coordination and ownership



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## Recommendations

- Integrated service should be layered on already established and accepted service eg
  - High coverage of immunization services
  - High CTC attendance for ART refills
- Build in capacity building initiatives for clients' continuum of care eg. Management of side effects and removals
- Ensure service sustainability beyond outreach days
  - Supply equipment (IUCD, implant removal kits etc)
  - Ensure commodity security
  - Continuous clinical mentorship
  - Accountability - supportive supervision



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# Asante Sana

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**Irene Mirembe, IntraHealth**

Irene Mirembe is a multi-skilled strategic health communication professional, authentic storyteller with progressively responsible experience in health Communication, knowledge management, Learning, Reporting, documentation, and collaboration. Particularly experienced in implementing strategic health communication strategies/campaigns and sharing knowledge and best practices to empower underrepresented population to be part of the solution rather than the problem in their journey for healthier lives. She holds various certificates from strategic health communication trainings from John Hopkins University/Center for Communication Program to writing and media relations. She completed a bachelor's degree in Mass Communication from Makerere University and a master's degree in the same field.





USAID REGIONAL HEALTH INTEGRATION TO ENHANCE SERVICES IN EASTERN UGANDA (USAID RHITES-E)

**Ensuring Access: How RHITES-E improves Uptake of Voluntary Family Planning in Rural Eastern Uganda Through Partnerships and Collaboration.**

**Authors:** Sam Cherop, Irene Mirembe and Carol Karutu

Mirembe Irene, Knowledge Management Manager-RHITES-E



## Overview of the USAID RHITES-E Activity

- Five year Activity: Start date 22 May 2017
- Purpose: To support the Government of Uganda and key stakeholders to increase availability and utilization of high quality health services by;
  - Strengthening Health Systems
  - Improving the Quality, Access, and Demand for health services
  - Attention to equity and underserved populations.
- Catchment: **25 districts** in Eastern Uganda and **5 in Karamoja** sub-region
- Consortium members: CDFU, TASO
- Sub grants: 7 local community organization

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## National Context

- Uganda has one of the highest fertility rates in the world, at five children per woman (World Bank, 2018).
- Attributed to several factors: low awareness & demand for FP services.
- Overall modern contraceptive prevalence rate is still relatively low, at **35%**—and is higher in urban areas (41%) than **rural areas (33%)** (Demographic and Health Survey [DHS] Uganda, 2016).

## SEBEI Context

- The Sebei Cluster in mid-Eastern Uganda contains three districts: **Kapchorwa, Kween, and Bukwo.**
- This region has had relatively **low contraceptive uptake (13 %)** compared with the rest of Uganda
  - RHITES-E implemented by IntraHealth International, became the main implementing partner for both family health and HIV in this region.

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## SEBEI Context

- Baseline survey **findings** conducted by RHITES-E in June 2017 indicated that the **low use** was due to several factors:
  - **Low demand** for voluntary family planning and reproductive health care;
  - Influence of **cultural norms**, such as the association of bearing many children with a lot of wealth;
  - **Myths** about family planning (for example, that it causes cervical cancer, infertility, or high blood pressure);
  - Frequent **stockouts** of family planning commodities; and inadequate skills among health workers.

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## The Collaborative Intervention

- To address the issue of low contraceptive use and voluntary family planning access barriers in the Sebei Cluster, the RHITES-E team spearheaded a collaborative using principles of [community group engagement](#)
  - This **approach** was adopted to **foster intentional and continuous learning** to ensure **access to voluntary family planning through partnerships of stakeholders** such as health facility leads, cultural leaders, government leaders, and other implementing partners



A health facility lead counseling a couple about voluntary family planning

USAID RHITES-E

## Activities at District Level

**Mapped** out key activities per implementing partner and co-funded additional activities to reduce strain on resources.

Held **district-based advocacy meetings** and **budget conferences** to encourage local governments to allocate voluntary family planning funding in health budgets.

Supported districts to **engage the private sector** by encouraging private practitioners to provide a range of affordable contraceptive methods.

To ensure **consistent availability of methods**, we strengthened district logistical and information systems through trainings and mentorships

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## Activities at Community level

- Developed **radio talk shows and dramas** and distributed educational materials to enhance mobilization among community members.
- Held **dialogue meetings** among selected community leaders to encourage them to advocate for voluntary family planning. We conducted a stakeholder mapping matrix to guide teams on the most influential and appropriate leaders to include.
- Engaged **with satisfied family planning users to provide appropriate information** to potential users (for example, information on contraceptive mechanisms of action, administration of different methods, and side effects).



*A community mobilizer discussing voluntary family planning with a couple.*

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## Challenges

- Gaps in health workers' capacity,
- Lack of systems linking communities and health facilities,
- Inadequate resources, and
- Resistance from some community leaders.

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## Activities at Facility Level

1. Using World Health Organization guidelines and the [Training Resource Package for Family Planning](#), we **addressed learning and performance gaps by conducting facility-based training** to enhance the technical capacity of health workers to deliver high-quality care (USAID, WHO, and UNFPA, 2020).

2. We adopted blended learning approaches, such as presentations on best practices during **quality improvement sessions**, which then connected providers to mentors and supervisors through additional peer-to-peer sessions. Mentors and mentees often communicated via WhatsApp to improve competency without disrupting health service provision.

3. We conducted **skills building for provider-initiated discussions about voluntary family planning**—that is, asking every woman and girl about her needs for contraception to space or limit pregnancies.

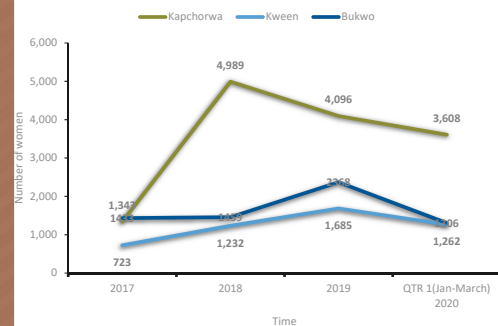
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## Impact

- The collaborative allowed partners to **align activities** and pool resources for greater impact
  - The modern contraceptive prevalence rate **increased** from **13%** in the Sebei Cluster in 2016–2017 to **16%** in 2019–2020 (DHIS2 FY 2019/2020).

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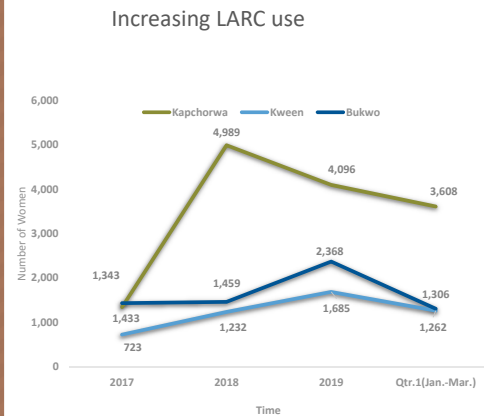
Women Who Voluntarily Initiated LARCS Across Sebei Cluster, 2017–2020



## Impact

- This shows that all three districts are increasing LARC uptake, particularly Kapchorwa. The focus of program implementation is now concentrated in Kween and Bukwo, where we are applying key learnings for scale-up from Kapchorwa.

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## LESSONS



**Collaboration** with implementing partners and other stakeholders is **efficient**. Stakeholders can leverage funding, share donor interests, and divide responsibilities. This helped avoid duplication and maximize funding.



The collaborative provided **a conducive environment for stakeholders** to nurture relationships, share experiences, and improve voluntary FP outcomes.



**Quarterly meetings** provide important **moments to pause and reflect**, where all stakeholders come together to share progress and challenges.



**Consistent data review** guides decision making among implementing partners and stakeholders. It **allows them to focus activities**. It allows them to focus activities in areas that may be lagging.



Focused **community-based interventions play key roles in challenging cultural practices** and addressing myths and misconceptions—for example, rumors about contraceptives causing infertility or high blood pressure or about bleeding while using contraception causing bad luck.

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# Recommendations

1

**Hold regular Meetings** (monthly or quarterly) -helps identify opportunities for synergy and enables the collaborative to adapt as needed.

2

**Define expectations** and roles for each partner. This encourages proper coordination and accountability for each activity.

3

**Review donor interests** consistently and keep scouting for partnerships with other implementing partners who have similar donor interests.

4

**Advocate for district leaders to be accountable for specific family planning activities** and programs. This goes a long way to ensure sustainability of programs after the collaborative has ended.

5

**Use stakeholder mapping to identify and prioritize** which stakeholders and cultural leaders to engage.

6

**Integrate voluntary family planning with other health areas within the community.** This enhances voluntary family planning uptake, especially in communities where access to FP Services

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Thank you

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**Taurai Bhatasara, FHI 360**

Taurai Bhatasara is currently a Technical Lead Adolescent Girls, Young Women (AGYW) and Prevention Services with FHI 360. He is passionate about AGYW and currently pursuing a PhD in Child Sensitive Social Policy focusing on AGYW. Taurai has been coordinating the DREAMS, PrEP and Key Populations program in Zimbabwe for past five years with the Zimbabwe Ministry of Health and Child Care. He had been instrumental in developing various strategies to reach out to AGYW in Zimbabwe.





## Providing Family Planning through “Stop the Bus Model” in Zimbabwe.

Presented by: Taurai Bhatasara  
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### Background

Zimbabwe has one of the high unmet needs of family planning sitting at 10%.

Young people continue to face challenges in accessing SRHR services resulting in high teen pregnancies, low condom knowledge and limited access.

Health facilities remain one of the barriers to access SRHR services by young people due to unfriendly environment regardless of Youth Friendly Service provision training.

Apart from service delivery barriers Adolescent Girls and Young Women continue to face other structural challenges such religious and traditional practices including long distances to health facilities.





## About the Stop the Bus Model



This is a model that started in 2016 under the DREAMS program and has since been adopted to other HIV prevention programs.

The model involves the use of the physical bus to offer services to AGYW in their localities.

The intervention includes working with communities and drumming up support, buy in and mobilization for services.

In the Bus Youth friendly trained nurses offer services such as STI screening and treatment, cervical cancer screening, Short and long term family planning services.

The model was designed to address challenges related to access, affordability, and availability of voluntary family planning among adolescent girls and young women.

It was also adopted to increase access to safe spaces for family planning, improve the client experience by reducing the time spent seeking care, and remove user fees, which are often cited as a barrier for adolescent girls and young women.

### Services provided through Stop the Bus includes;

- Youth-friendly health counseling Short-acting contraceptive methods
- Male and female condoms
- Long-acting reversible contraceptives; support for any adverse reactions to family planning methods
- Postabortion counseling and integrated voluntary contraceptive counseling referrals Cervical cancer screening
- Referral and documentation of sexual abuse; HIV testing (including provision of HIV self-test kits);
- Pre-Exposure Prophylaxis
- Syndromic management of STIs
- Referral to other DREAMS partners for additional follow-up activities

## Successes

In the 6 districts a total of 8,570 adolescent girls and young women were reached with different voluntary family planning methods from 2016 to 2019.

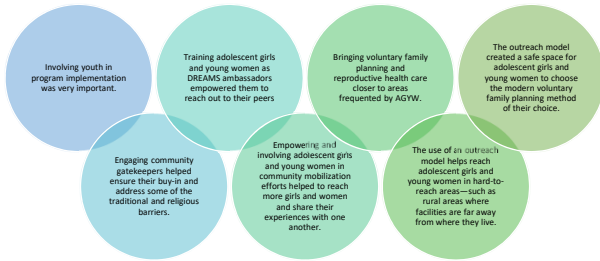
Reduced distances traveled to access services to facilities.

Provided safe space for AGYW to access Family Planning and other SRHR services.

Addressed stigma associated with visiting local health facilities by young people to access FP services



# Lessons learnt



# Recommendations

During program rollout, involve adolescent girls and young women who can reach out to their peers in the community and increase voluntary uptake and use of voluntary family planning and reproductive health care.

While engaging adolescent girls and young women is important, it is also critical to engage other members of the community—for example, parents often affect their access to health care.

Think beyond voluntary family planning and reproductive health. Mobile services can be a good opportunity to integrate a range of health areas into voluntary family planning and reproductive health programs, such as cervical cancer screening, STI/HIV testing, and pre-exposure prophylaxis.

Use entertainment education—these approaches are generally effective in mobilizing young people in rural communities.

# Acknowledgements

Ministry of Health and Child Care, Zimbabwe

DREAMS Implementing partners

FHI360

World Education Incorporation/ Bantwana

DREAMS Ambassadors

Community Gate Keepers

# Thank you



Now it's time for a poll!



Questions & Answers



“No story lives unless someone wants to listen.

So thank you, all of you.”

J.K. Rowling  
(Author of Harry Potter)



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