

# Christian Connections for International Health (CCIH) and Uganda Protestant Medical Bureau (UPMB)

## COMMUNITY-BASED FAMILY PLANNING PROJECT

**ENDLINE EVALUATION**

**From December 2017 through June 2019**



Reverend Canon Kabanda and Mrs. Kabanda talk about family planning with their congregation at St. Mark's Anglican Church of Uganda.

## **Christian Connections for International Health**

Christian Connections for International Health, Award No. APC-GM-0065, through Advancing Partners & Communities (APC), a cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-12-00047, beginning October 1, 2012. APC is implemented by JSI Research & Training Institute, Inc., in collaboration with FHI 360. The project focuses on advancing and supporting community programs that seek to improve the overall health of communities and achieve other health-related impacts, especially in relationship to family planning. APC provides global leadership for community-based programming, executes and manages small- and medium-sized subawards, supports procurement reform by preparing awards for execution by USAID, and builds technical capacity of organizations to implement effective programs.

Photo Credit: Mona Bormet/CCIH

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# TABLE OF CONTENTS

1. INTRODUCTION.....	6
2. HEALTH FACILITY DATA.....	7
Recommendations .....	11
3. CLIENT REFERRAL DATA.....	11
Recommendations .....	13
4. CONCLUSION .....	14
5. APPENDIX: ADDITIONAL FIGURES.....	15

# 1. INTRODUCTION

In December 2017, Uganda Protestant Medical Bureau (UPMB) was awarded a one-year cooperative funding agreement from the United States Agency for International Development (USAID) through Advancing Partners and Communities (APC) to implement a project to integrate community-based family planning (FP) into the Anglican Church of Uganda's health structures and health facilities. UPMB is the coordinating body for Protestant health services in Uganda, including health services provided through the Church of Uganda (COU), and oversees a network of 18 hospitals and 272 lower-level health facilities across the country. UPMB works in partnership with the Ugandan Ministry of Health (MOH) and through its 302 facilities provides an estimated 13% of health services in the country. For this project, UPMB worked in partnership with Christian Connections for International Health (CCIH), a United States-based network of faith-based organizations (FBOs) and individuals working in international health which has been a leader in promoting FBO involvement in FP. UPMB and CCIH affirm that voluntary FP services are a critical component of family and community health, and that religious leaders (RLs) and church-owned health facilities can be important partners in promoting and providing community-based FP services.

The project was implemented in the period December 2017 to June 2019 through four COU churches, each of which operates a health facility. Although project activities began in December 2017, training of religious leaders and health workers and subsequent outreach activities did not begin until April 2018. Of the four health facilities, two are in peri-urban Kampala and two are in rural areas in central and east central Uganda. Further information about the facilities is given in Table 1.

Table 1: Project health facilities

Facility	Diocese	Level
<b>Kyando</b>	Busoga (rural)	Level 2 Health Center
<b>Namutamba</b>	Mityana (rural)	Level 3 Health Center
<b>St. Apollo</b>	Namirembe (urban)	Level 3 Health Center
<b>St. Stephen's</b>	Namirembe (urban)	Level 5 Health Center

The project had two key objectives:

- *Objective 1: Improve the capacity of the COU to integrate FP into existing church health structures and facilities to improve community-based service delivery for FP.*
- *Objective 2: Expand the evidence base and create an enabling environment for Church of Uganda/UPMB churches and facilities to extend FP services and programming.*

In order to meet these objectives, the project held a project launch and provided training to RLs in each church and health providers in each health facility. A group of 12 RLs from the four churches participated in a 3-day training in April 2018 to educate them about the need for FP, various FP methods, and how to dispel myths about FP particularly from a Biblical viewpoint. This group included youth coordinators, parish priests, and chairpersons of mother's and father's unions and other church fellowships. Women and men were equally represented. These RLs also received "low literacy books", an education and communication tool which supported them in talking about various FP methods with the use of simple pictures and minimal text (with versions produced in the local languages of Luganda

and Lusoga). RLs were then tasked with raising awareness of FP in their communities and congregations. Over the life of the project, they reached a total of 4,335 people through 168 events. In addition, 8 health providers in the four health facilities received a refresher training on FP service provision including fertility awareness methods. These project activities are summarized in Table 2.

Table 2: Project activities by health facility

	Kyando	Namutamba	St. Apollo	St. Stephen's	Total
<b>RLs trained in key FP messaging</b>	3	4	2	3	<b>12</b>
<b>Health providers trained in FP service provision</b>	2	2	2	2	<b>8</b>
<b>FP awareness-raising events conducted by RLs</b>	63	41	28	36	<b>168</b>
<b>People reached by RLs with FP information</b>	1465	1149	641	1080	<b>4335</b>

In the first quarter of 2019, training was cascaded to an additional two church-health center pairs: Kaluuba Level 3 Health Center in Busoga Diocese and Kyanamugera Level 2 Health Center in Mityana Diocese. In March 2019, two health workers from each facility participated in a 5-day training on FP with health workers from the original four facilities, and religious leaders from these churches also received training. Data from these additional two facilities are not shown in the following graphs.

## 2. HEALTH FACILITY DATA

Data from the four health facilities showed a clear increase in client visits for FP over project implementation, particularly in the two rural facilities (Kyando and Namutamba). Figures 1-3 show new client visits for FP by quarter, beginning two quarters before project implementation. Project activities were initiated in April 2018, and a clear increase in new client visits is seen beginning in Quarter 3 (April - June 2018). This increase was particularly large in rural facilities, where total new client visits for FP increased sharply from less than 50 in Quarters 1 and 2 to over 100 in Quarter 3, over 200 in Quarter 5, and over 700 in Quarter 7 (the last quarter of the project). In the two urban facilities (St. Apollo and St. Stephen's), the increase in clients visits for FP was smaller, although new client visits increased 5-fold, from 120 in Quarter 1 to over 600 in Quarter 7. For all facilities, total new client visits for FP increased by more than 800%, from 148 in Quarter 1 to 1,356 in Quarter 7.

Whereas new client visits for FP may be the best measure of project impact, the number of returning client visits for FP (revisits) and total client visits for FP (new client visits plus revisits) also saw clear increases across all facilities (see Figures 9-11 in the Appendix). Steadily increasing numbers of revisits suggest that clients were being retained, and possibly that project activities such as FP messages from RLs were reminding women to regularly return for check-ups or for re-provision of FP commodities. As

with new client visits, client revisits and total client visits showed larger and more sustained increases in rural facilities than in urban facilities. (Total client visits are shown in Figures 12-14 in the Appendix.) Over the entire period of project implementation (April 2018 to June 2019), the four facilities recorded 3,942 new client visits, 1,551 revisits, and 5,493 total visits for FP.

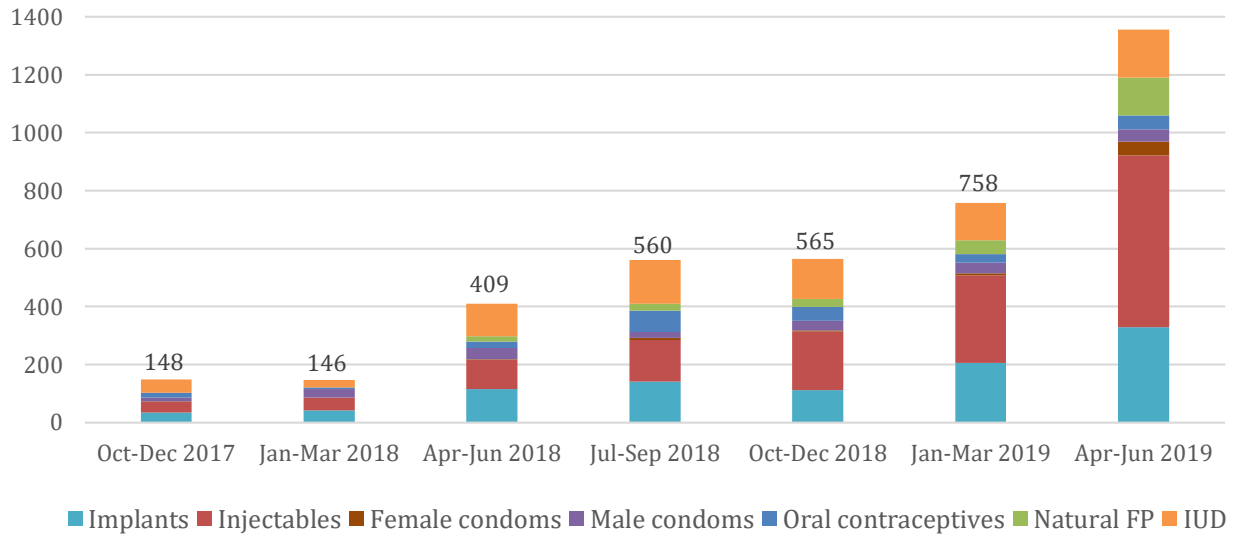


Figure 1: New client visits by quarter and FP method, all facilities

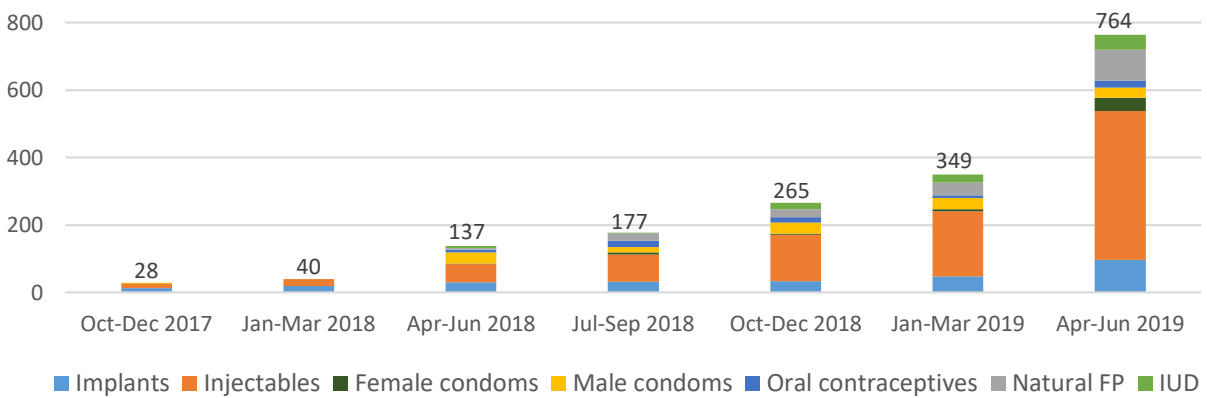


Figure 2: New client visits by quarter and FP method, rural facilities (Kyando and Namutamba)



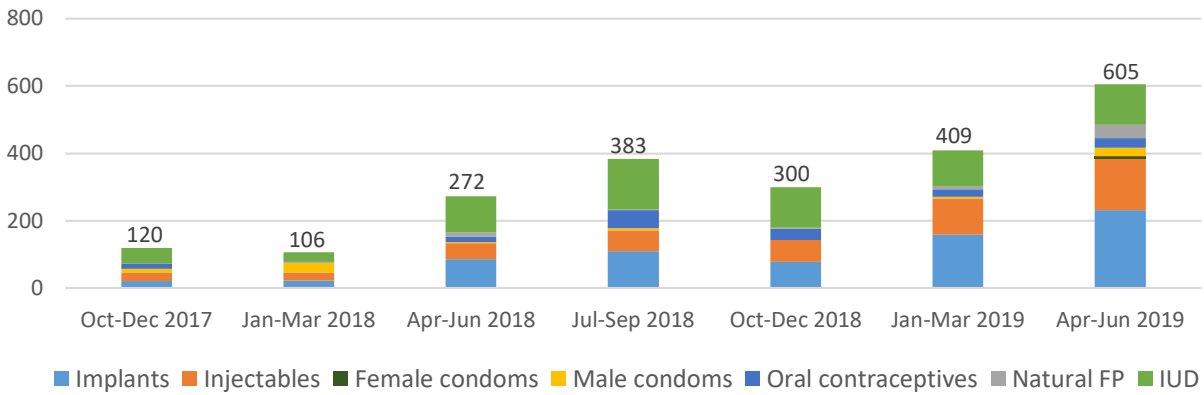


Figure 3: New client visits by quarter and FP method, urban facilities (St. Apollo and St. Stephen's)

Facility data also show differences in FP method between facilities, and particularly between rural and urban facilities. At rural facilities, a full half of new client visits for FP were for injectables, whereas only 21% of new client visits for FP at urban facilities were for injectables (Figure 4). Intrauterine devices (IUDs) were much more popular in urban facilities compared to rural facilities (35% versus 5% of new client visits), as were implants (30% versus 17%) and oral contraceptives (9% versus 5%). Nearly 1 in 10 new client visits at rural facilities was for natural (NFP), whereas only 2% of new clients at urban facilities requested NFP, and no women at urban facilities requested female condoms. Differences in FP uptake were also seen between age groups, with injectables being much more popular among young women ages 10-19 years, compared to older women (Figure 5). Revisits and total visits by age are shown in Figures 15-16 in the Appendix.

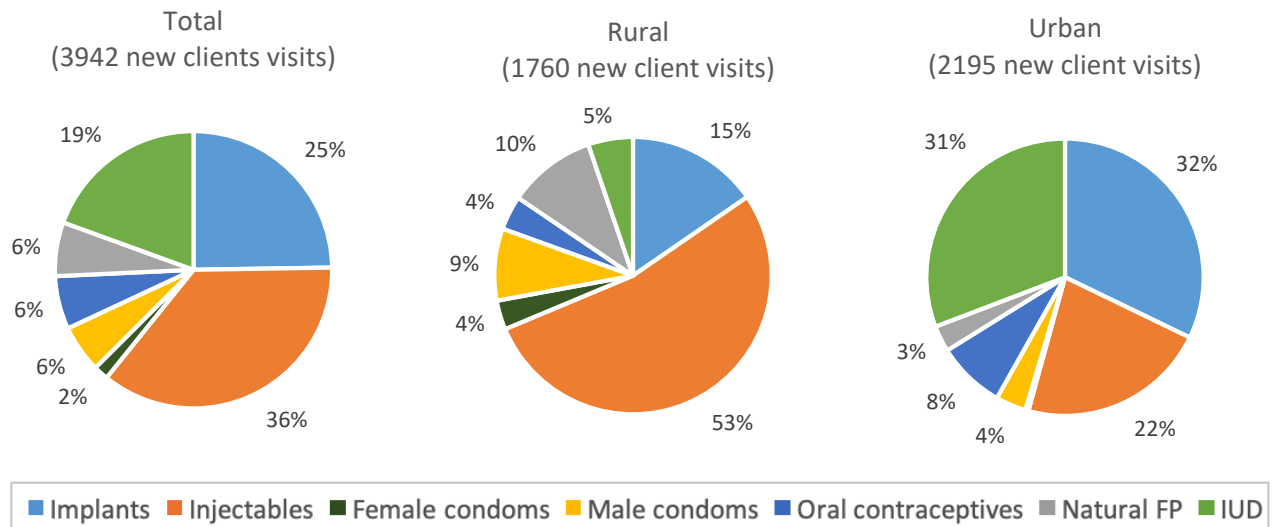


Figure 4: New client visits, revisits, and total visits, by FP method

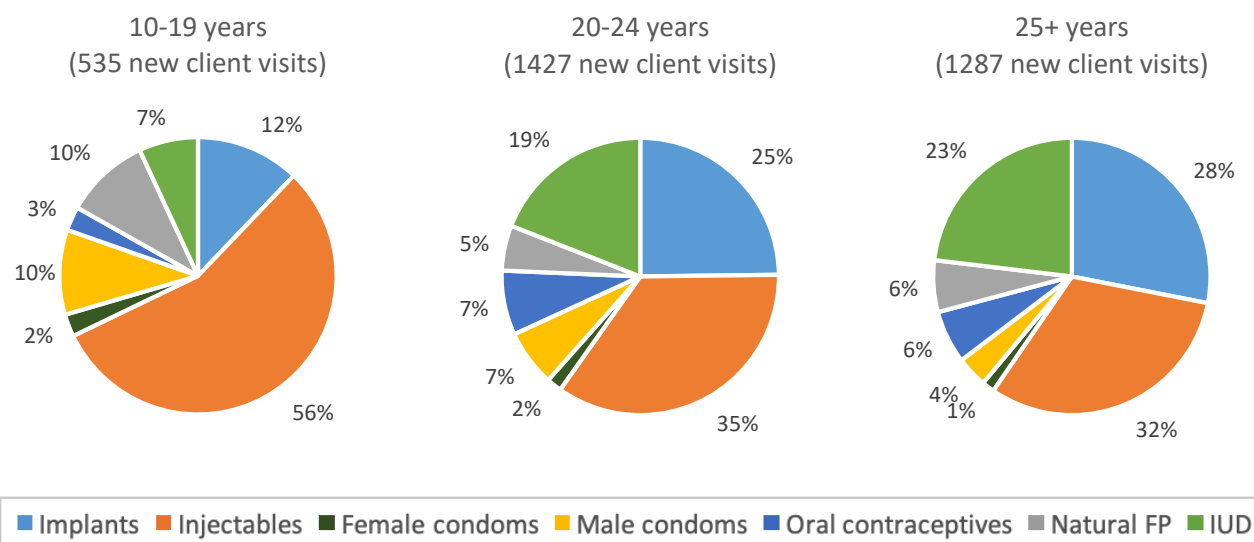


Figure 5: New client visits for ages 10-19 years, 20-24 years, and 25+ years, by FP method

A possible explanation for the greater popularity of injectables among rural women and young women ages 10-19 years is that these women wanted a FP method which could be used without the knowledge of a sexual partner (or parents, in the case of young women). Rural women may have feared a negative reaction from a husband or partner if he detected that they were using an implant or IUD against his wishes. Younger women and rural women may have also been less likely to request long-acting methods because they desired a pregnancy in the near future, which would account for the greater popularity of NFP, condoms, and injectables among these groups, compared to older and urban women. Conversely, urban women may have preferred long-acting methods such as IUD and implants for their convenience and because they did not desire another pregnancy. Different uptake by FP method between urban and rural facilities may have also been partly due to availability. Kyando did not distribute IUDs and Namutamba distributed IUDs only beginning in June 2018, meaning that IUD distribution at the two rural facilities was limited. There was also anecdotal evidence of stock-outs, particularly of oral contraceptives, although this information was not systematically documented.<sup>1</sup>

Regardless of the reasons for women's varied preferences by age and rural or urban residence, these differences suggest that diverse populations may require tailored and specific approaches, information, and services. UPMB should continue to work with facilities and the MOH to ensure consistent supply of FP commodities, and to monitor and ameliorate stock-outs when they occur. Notably, the Joint Medical Stores (JMS), which is co-owned by UPMB and the Uganda Catholic Medical Board (UCMB), began to stock FP commodities in September 2018. The JMS receives free FP commodities for all private facilities (including private not-for-profit facilities) through Uganda's Alternative Distribution System, and receives support from the United States Agency for International Development (USAID) to serve as the supply chain store. This development has served to stabilize FP commodity supply chains. The impact of increased FP supplies on FP uptake at the four facilities after September 2018 cannot be known, but it is

<sup>1</sup> CCIH staff making a February 2017 visit to Kyando documented stock-outs of many FP commodities. Although this visit was before project implementation, it seems likely that similar stock-outs may have continued during project implementation at this or other facilities.

likely that some of the increased FP uptake seen in the last three quarters (September 2018 to June 2019) is due to increased supply. For this reason, the increase in FP uptake seen over project implementation should not be attributed solely to the project's impact.

## RECOMMENDATIONS

UPMB should attempt to regularly document FP commodity stock-outs at member facilities, such as through monthly reporting or through documenting FP commodity availability during supervisory visits. In the absence of such data, it is impossible to know to what degree FP uptake is affected by demand and to what degree by supply, meaning that it is difficult to claim that increased FP uptake was due to demand creation due to project or facility activities. More importantly, consistently monitoring FP supplies and stock-outs would help UPMB to effectively coordinate with the JMS and MOH to make sure that stock-outs do not occur, that supply meets demand, and that a full range of FP methods is consistently available to every woman who seeks FP at a UPMB facility.

## 3. CLIENT REFERRAL DATA

FP clients who were referred to health facilities by RLs were tracked using a paper referral form. The RL filled out the top half of the form, specifying what FP services he or she was referring the client for: FP method, side effect management, care for an injection site reaction, and/or management of sexually transmitted infections (STIs). The client then presented the form to the health provider upon visiting the health facility, and the health provider filled out identical fields on the bottom of the form: FP method, side effect management, care for an injection site reaction, and/or STI management. Completed forms were retained by the health facility, and copies of the forms were returned to UPMB for analysis. The referral form also captured the date of referral and date of visit to the health facility, as well as other identifying information (such as patient name and identification number) which was not included in this analysis.

A total of 313 referral forms were returned to UPMB over the course of the project; these 313 referrals were considered completed referrals. The majority of the completed referrals (84%) were for clients seen at Kyando (Figure 6), although the rate of referrals varied widely over the project period (Figure 7).

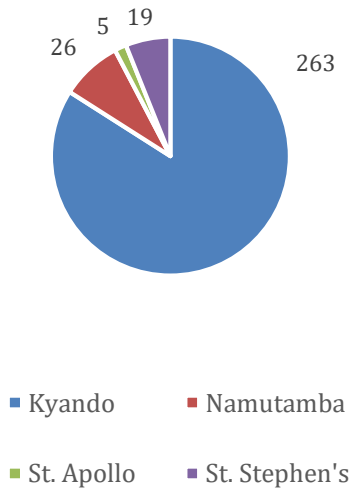


Figure 6: Completed referrals for FP services, by facility (N = 313)

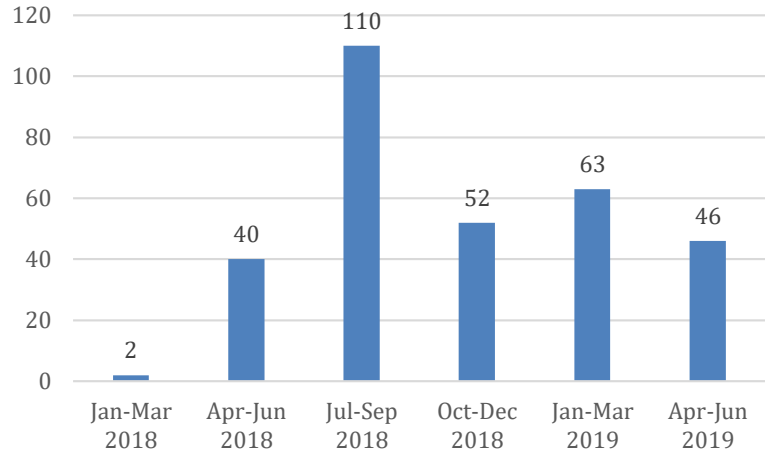


Figure 7: Completed referrals for FP services, by quarter

Note: Referrals are counted in the quarter in which the RL made the referral. The figure for April-Jun 2019 include referrals made through 17 May only.

Figure 8 shows the FP methods and service RLs referred clients for (the information entered on the top half of the referral form) and the FP methods and services clients received when they visited the health facility (the information entered on the bottom half of the form). As can be seen, the number of referrals fluctuated throughout the year. UPMB conducted support supervision during the period July to September 2018, which may have contributed to a larger number of referrals during this time. In addition, churches have an increased emphasis on teaching during this period, before harvest begins in October, which may have also increased the number of referrals.

Many forms had incomplete information, such as failing to specify a FP method or service on one or both parts of the form. In a few cases, a client was referred for or received multiple services, such as being given condoms and moon beads (for natural FP). Therefore, the figures in Figure 8 do not add up to the number of complete referrals. For a full quarter of the forms (N = 78), no method or service was specified on the referral (top) part of the form, and in many of the remaining forms, it appeared that the health provider had filled in both the top and the bottom of the form. Thus data on type of referral provided by RL should be interpreted with caution, as it is likely that for many of these referrals the RL did not actually provide a referral for a specific FP or service and was referring to the health facility only.

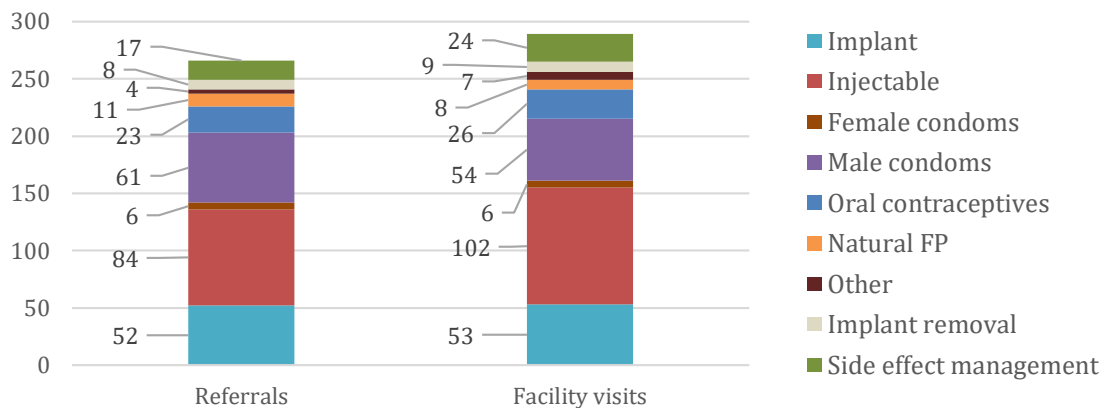


Figure 8: Referrals and facility visits by FP method or service, among completed referrals

Injectables were the most common FP method among referrals (N=84) and facility visits (N=102), followed by male condoms (N=61 and N=54) and implants (N=52 and N=53). Fewer clients received referrals for oral contraceptives, natural FP, and female condoms, or received these FP methods at the health facility. Some women received referrals for side effect management (N=17) or visited the health facility for the same (N=24), and a small number received referrals for implant removal (N=4) or visited the health facility to have an implant removed (N=5). The “other” category of referrals includes 1 referral each for an IUD, tubal ligation (not available at the project facilities), vasectomy (also not available), and care for an injection site reaction. Clients who received an IUD (N=1), STI treatment (N=2), care for an injection site reaction (N=1), counseling only (N=1), or referral for services not available at the facility (such as a tubal ligation or vasectomy, N=3) were classified as “other” under facility visits.

Whereas the referral forms show that RLs successfully referred several hundred women to health facilities for FP, these referrals account for only a small proportion of women who sought FP services at the four project facilities during project implementation. This was particularly true for urban facilities, where approximately 1% of women coming for FP services brought a referral form, compared to approximately 10% of women at rural facilities. Some women may have received referral forms and taken them to other facilities not included in the project, particularly in urban areas (where women have many more choices about where to seek FP services). The rural RLs may also have been more effective in referring women for FP and filling out forms.

## RECOMMENDATIONS

Referral forms are a critical tool for linking program activities, particularly RL efforts to educate clients and refer them for FP, with facility-level data showing FP uptake. Data from referral forms can be used to monitor which RLs are most actively referring clients, how many clients are being brought to facilities through RL referrals, and how long clients wait between referral and coming to a health facility. UPMB should regularly collect referral form data from facilities and use these data to evaluate how referral systems between RLs and facilities function and could be improved.

UPMB can also use these data to evaluate the referral form itself, and whether changes to the form might be advisable. For example, it may be beyond the RL’s role and expertise to advise a client on which FP method to choose. The fact that many RLs chose not to specify a FP method on the referral

form suggests that many RLs did not feel comfortable making such a recommendation. UPMB could make the form easier to use by printing available FP methods and services on the health provider portion of the form, so that the provider could tick off methods or services rather than writing them in. This would also standardize responses and make them much easier to tabulate. Finally, UPMB might consider removing portions of the form that are rarely used (such as responses for injection site reaction and STI treatment), in order to make the form simpler and more streamlined.

## 4. CONCLUSION

Based on the available data, there is convincing evidence that the project successfully increased FP uptake at the project health facilities, with the largest increases seen at the rural sites. Urban facilities saw client visits for FP increase more than 5-fold (from 144 in Quarter 1 to 793 in Quarter 7), while rural facilities saw client visits increase by more than 16-fold (from 66 in Quarter 1 to 1102 in Quarter 7). However, another important change also occurred during project implementation, in that FP commodity provision through the JMS beginning in September 2018 ensured a steadier supply of commodities and may have increased availability and uptake. Without better data on FP commodity supplies and stock-outs at the project facilities before and after September 2018, it is impossible to say how the supply of commodities may have impacted uptake. However, increases in client visits for FP after April 2018 (when the project was launched) and before September 2018 (when JMS began to supply FP commodities) suggest that the project was responsible for increased FP uptake, and continued increases in client visits after September 2018 also suggest that the project continued to increase demand even as supply stabilized. UPMB should continue to collect, monitor and triangulate key data (including facility data on client visits for FP, referrals forms, and FP commodity supplies and stock-outs) in order to support effective community-based family planning through its network of facilities and their affiliated churches.

# 5. APPENDIX: ADDITIONAL FIGURES

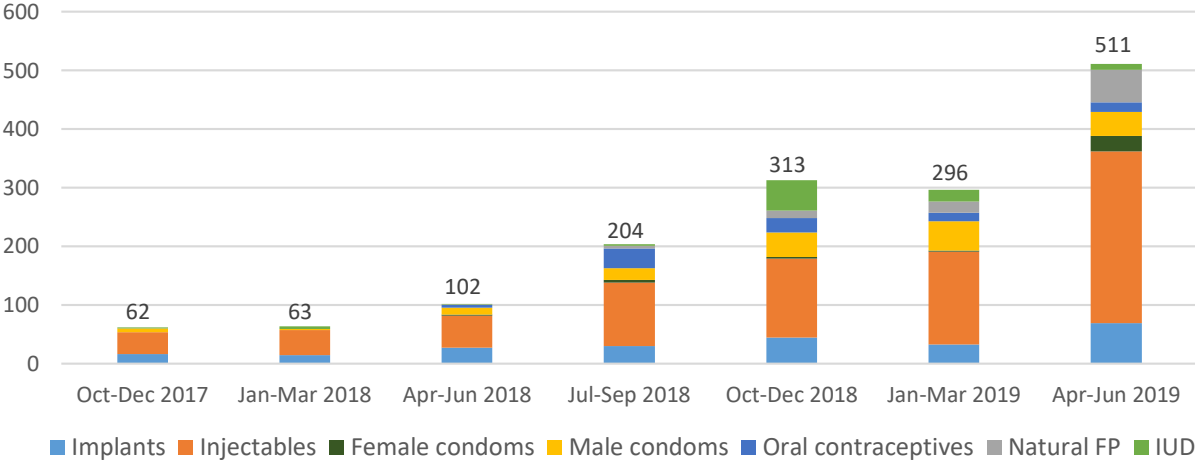


Figure 9: Client revisits by month and FP method, all facilities

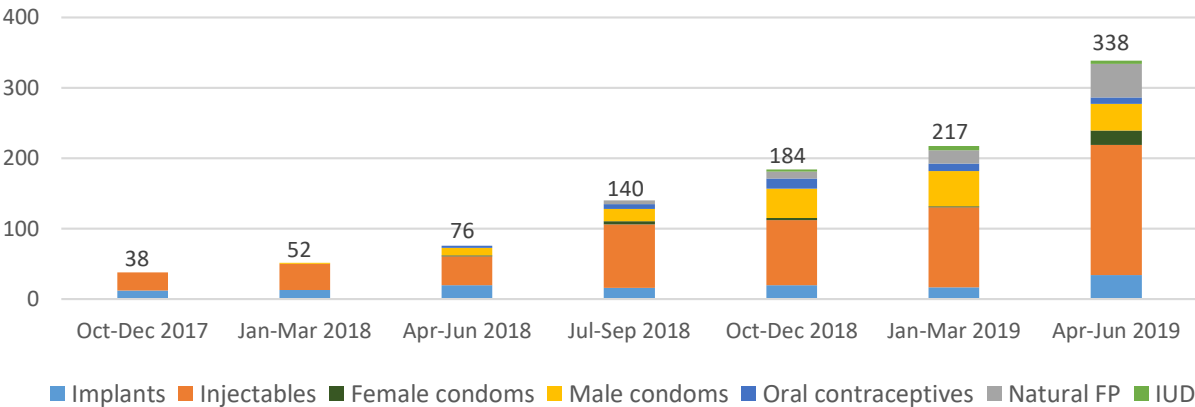


Figure 10: Client revisits by month and FP method, rural facilities

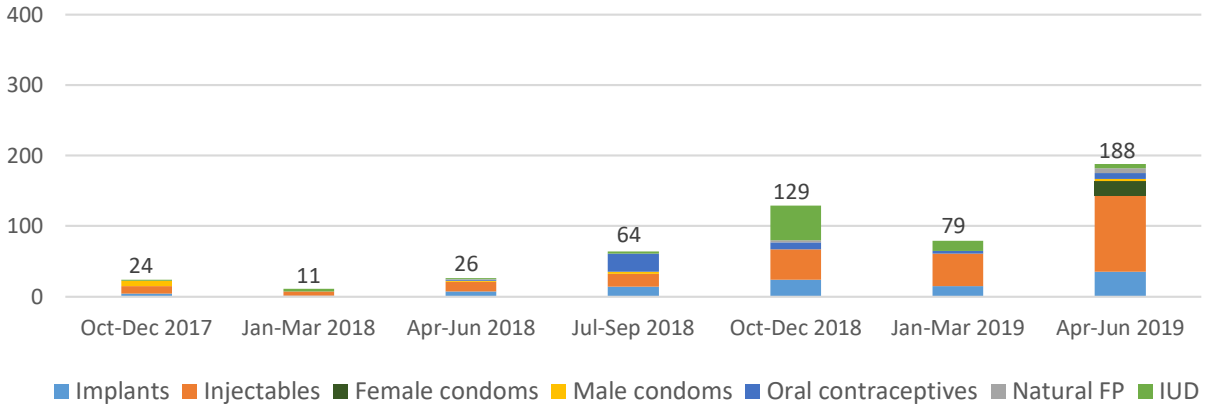


Figure 11: Client revisits by month and FP method, urban facilities

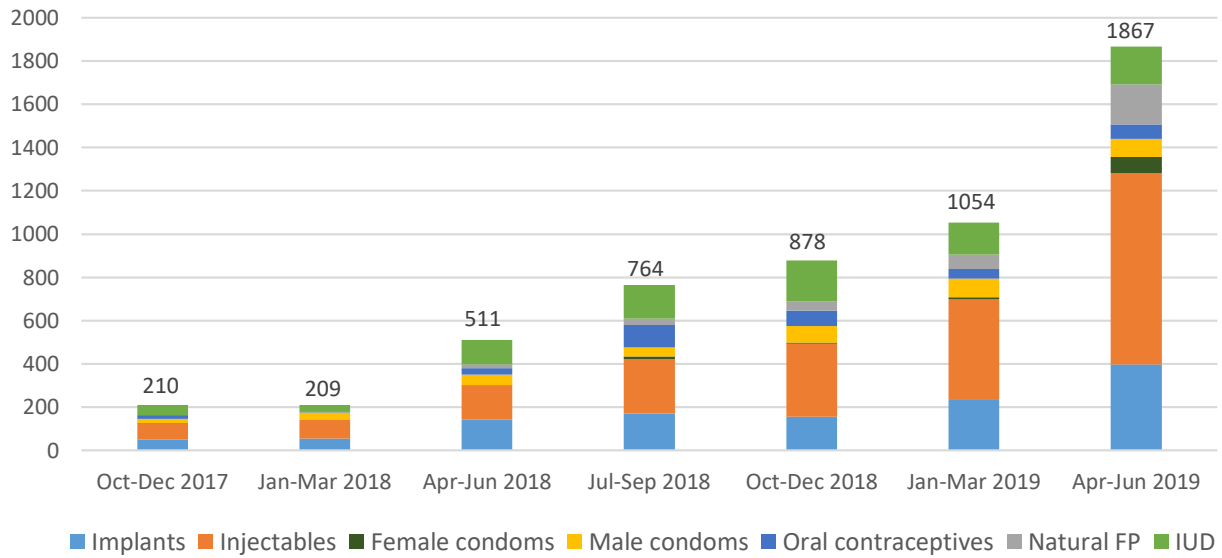


Figure 12: Total client visits by month and FP method, all facilities



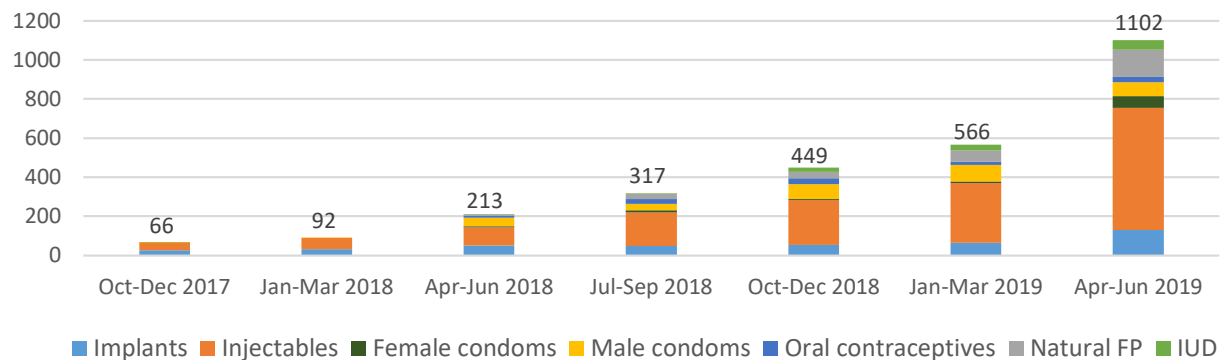


Figure 13: Total client visits by month and FP method, rural facilities

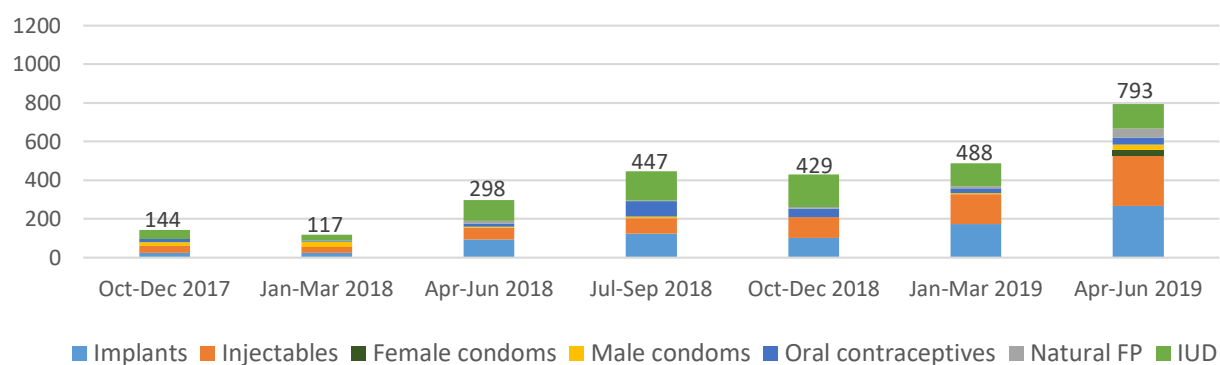


Figure 14: Total client visits by month and FP method, urban facilities

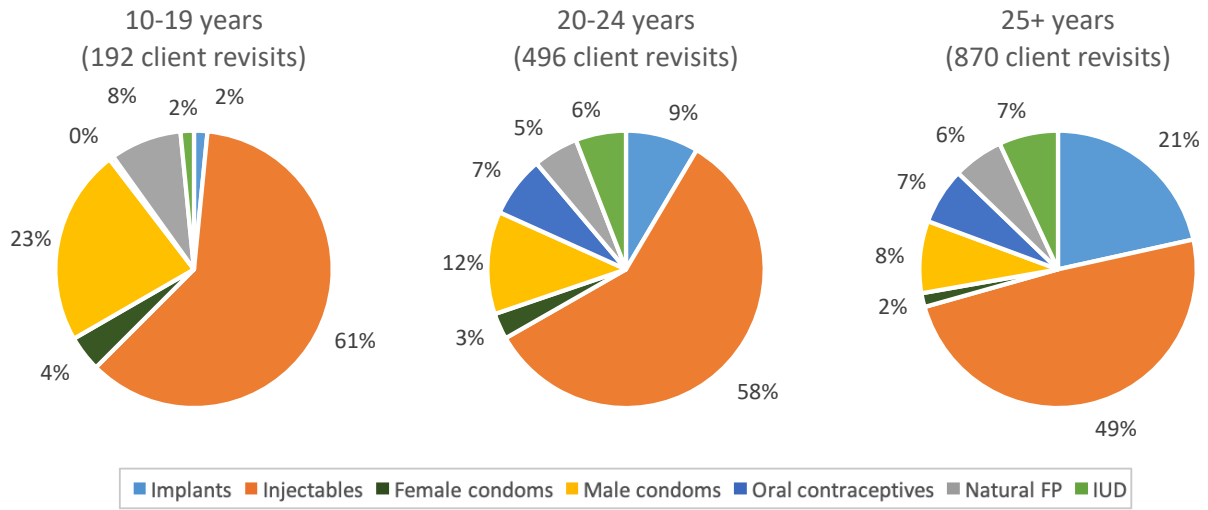


Figure 15: Client revisits by age

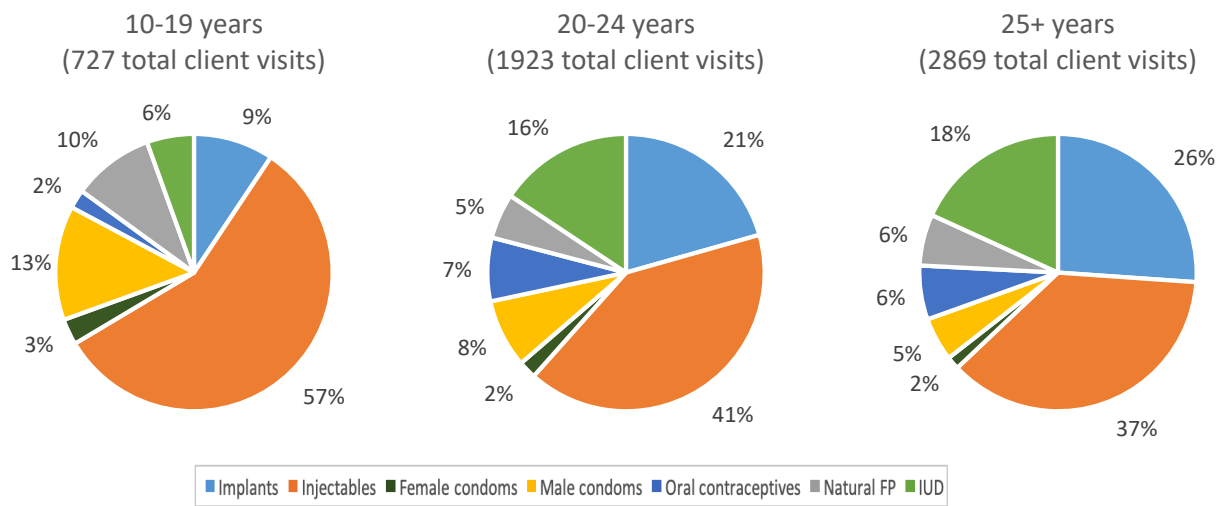


Figure 16: Total client visits by age

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