ADVANCING PARTNERS & COMMUNITIES

ADVANCING FAMILY PLANNING IN LAST-MILE COMMUNITIES: **VOICES OF EXPERIENCE**

SOUTHERN SUN MAYFAIR HOTEL
NAIROBI, KENYA
25 & 26 SEPTEMBER 2019

USAID FROM THE AMERICAN PEOPLE

CCIH Christian Connections for International Health

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Advancing Partners & Communities

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BACKGROUND

In East Africa, faith-based organizations (FBOs) were among the earliest groups to understand the importance of family planning and healthy timing and spacing of pregnancies (HTSP) to ensure the health and welfare of women and families. FBOs also implemented some of the earliest and most effective community-based health, family planning, and HIV programs in Kenya, Tanzania, and Uganda, pioneering task shifting to community health workers (CHWs). These days, FBOs and community-based organizations (CBOs) continue to provide new methods (e.g., DMPA-SC), ensure access to a diverse contraceptive method mix (from the Standard Days Method to permanent methods) and partner with government and other stakeholders to advance family planning. Countries in this region are achieving impressive results in family planning access and use (Table 1). For instance, between 2012 and 2019, the contraceptive prevalence rate among all women increased from 35 to 43 percent in Kenya; 25 to 32 percent in Uganda; and 21 to 30 percent in Tanzania (FP2020).

Table 1. Key Family Planning Indicators, by Country

	Total fertility rate	Contraceptive prevalence rate (all women)	Teenage pregnancy
Kenya	3.7	43%	19%
Tanzania	4.9	32%	26%
Uganda	5.2	30%	25%

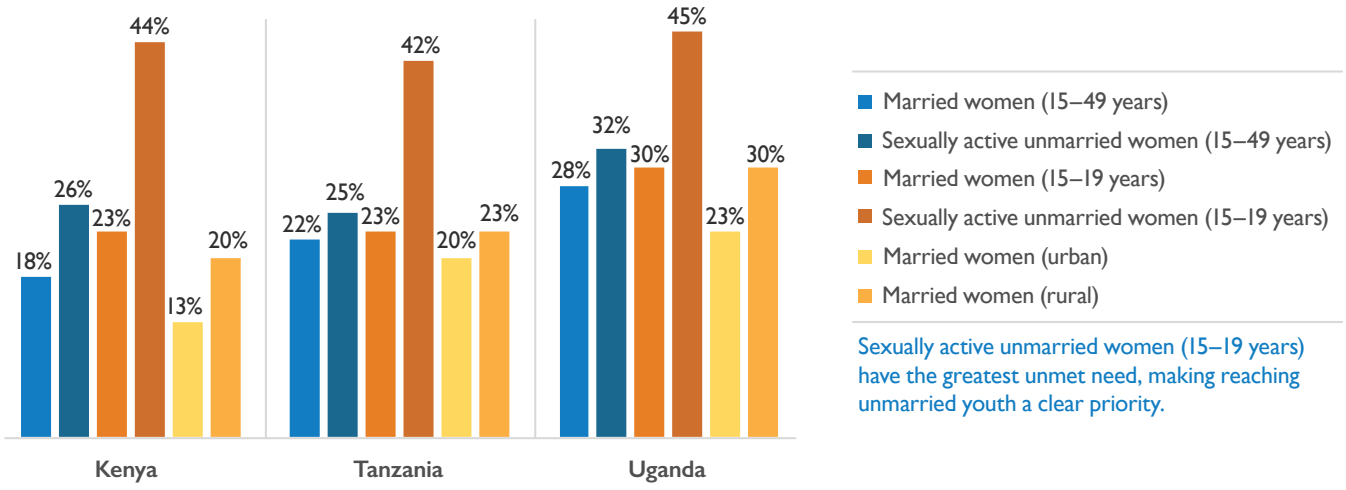
Data are from recent country Demographic and Health Surveys and FP2020. Teenage pregnancy refers to the percentage of women 15–19 years of age who have begun childbearing.

However, big challenges remain in reaching the communities at the "last mile" of health service delivery, where health knowledge and access are low. These last-mile communities are often located in isolated, poor, rural, and hard-to-reach areas, but may also occur in urban settings, such as slums. Another challenge is reaching huge swaths of East Africa's burgeoning youth population, which is in great need. Teenage pregnancy (women ages 15–19) is high, with one in four women having begun childbearing in Tanzania and Uganda, and one in five in Kenya (DHS 2015–2017).

Between 2012 and 2019, Advancing Partners & Communities (APC), a project funded by the U.S. Agency for International Development (USAID) and implemented by JSI and FHI 360, has worked closely with a number of East African FBOs and CBOs to advance family planning in last-mile communities. Along with colleagues from these organizations and USAID, in September 2019 the project held a consultative workshop, "Voices of Experience," to harvest the wisdom of individuals and groups working in this area and to inform new activities and possible funding going forward. The idea was to listen to seasoned, on-the-ground service providers and forward-thinking managers and thought leaders, and challenge them to think deeply and in a different way. APC gathered a diverse group from the three countries, from various faith traditions (Catholic, Protestant, Muslim, and Sikh), and from non-faith CBOs working in family planning for people of various ages and backgrounds.

Though this report highlights observations and recommendations, it only touches the surface of the rich and heartfelt reflections expressed. APC hopes new ideas and partnerships will result from what the group shared at the consultation.

Unmet Need for Family Planning in Kenya, Tanzania, and Uganda



Sexually active unmarried women (15–19 years) have the greatest unmet need, making reaching unmarried youth a clear priority.

WORKSHOP SUMMARY

Along with its partner and grantee of five years, Christian Connections for International Health (CCIH), APC organized the workshop to respond to three guiding questions:

1. What are three or four priority gaps in rolling out voluntary family planning and reproductive health care and programming in last-mile communities, where access and use remain low?
2. How can programs link the work of community health workers and other community-based champions to clinics providing family planning?
3. What can FBOs and CBOs (as part of their own faith entity and as part of interfaith national groups) do to be advocates in improving access to and utilization of services for last-mile clients, especially for youth?


Mona Bormet, CCIH

This workshop brought both a personal (faith) dimension and professional wisdom to consultations about improving services to clients in last-mile communities. The group of about 50 participants included seasoned medical service providers, program managers, family planning advocates, faith leaders, and youth leaders. Following greetings by the co-leaders (Liz Creel from APC and Mona Bormet from CCIH) and introductions, Reverend James Mlali from Tanzania set the tone for the workshop by invoking 1 Chronicles 4:9-10 with the exhortation to "enlarge my territory" and keep from causing pain. These themes were echoed throughout as participants stretched their minds on how to expand their work in family planning and reproductive health care and provide humanistic, compassionate services, especially to youth. Many different faith perspectives were represented at the consultation, but all participants were united in their support for family planning and reproductive health care and the need to expand services.

The first day focused on challenges, though spirits were still high by its conclusion (see Annex A). The first of two "scene-setters," led by Jane Kishoyian of the Christian Health Association of Kenya, helped formulate the group's working definition of the meaning of last-mile communities after one participant pointed out that issues facing last-mile communities are "not just a matter of distance." These communities comprise other marginalized and vulnerable groups, such as the urban poor, physically and mentally disabled individuals, and people who are lesbian, gay, bisexual, transgender, and queer. Concerning the last group, one participant, a faith leader, pointed out that "None of us [the faith community] touch it"—a reality that he said needs to change. The second presentation, by Frederick Mubiru and Dennis Nsibambi of FHI 360, focused on church platforms as a way to reach youth, and the success of the Emanzi program, which engaged men as role models for family planning. Three activities looked at a definition of clients (focusing on youth), the characteristics of strong family planning facilities or programs, and the role of participants' personal faith and religious groups' beliefs in meeting clients' needs.

> *"Can we ask God to expand our territories over the next few days? The needs are far greater than the coverage that we have. We know that not doing something is doing something. Not doing the good, you know, is irresponsible. Not doing something to reduce maternal mortality, gender-based violence, etc. is causing pain or causing it to continue."*
>
> — Reverend James Mlali,
> Advance Family Planning Tanzania

Kristen Devlin, JSI

Perhaps the most moving part of the workshop was during the first session, where participants shared stories of youth facing challenges. The words "secrecy," "stigma," "shame," "fear," "rigid hierarchy," and "provider bias" dominated the often tragic stories of youth in crisis. The need for understanding, education, compassion, and youth-friendly services was underscored repeatedly, as was the need for inter-generational understanding and more youth-led programs. After the discussion about "my faith," some participants expressed a greater understanding of their personal responsibility—based on their faith—to ensure that clients' needs are met with compassion and competence.

The second day built on the first, starting with an interactive celebration of World Contraception Day and recognition of African pioneers in family planning, such as Dr. Fred Sai. A presentation on inter-faith actions supporting family planning in East Africa by Vitalis Mukhebi from the Faith to Action Network made a powerful case for joint planning, advocacy, and actions at the local, national, and donor levels to clarify and define the role of FBOs, and advocate for the financial resources needed to succeed. Participants repeatedly noted that changing social norms and strengthening health systems are long-term propositions, so FBOs need ongoing support.

The remainder of the day was spent formulating specific, measurable, attainable, relevant, and time-bound (SMART) recommendations. These included increasing the availability of services for boys and men, offering youth-friendly services everywhere, advocacy (especially to solve chronic supply chain challenges), tackling the lengthy and expensive task of spreading knowledge and adopting healthy behaviors, and most importantly, going into communities and listening. In the last session, teams from Kenya, Tanzania, and Uganda defined their highest priorities and actionable aspirations.

This report provides a detailed look at key areas of discussion and recommendations from the workshop.

"The role of faith is to deal with your own ego."

— Sheikh Lattif Shaban, Supreme Council of Kenya Muslims

Kristen Devlin, JSI

FINDINGS

Participants worked in groups to discuss overarching questions about several facets of providing family planning and reproductive health care to last-mile communities, first characterizing the service environment, then examining specific questions about improving services.

Activity 1: Our clients

Irene Nakiriggya from the United Protestant Medical Bureau led the workshop's first activity. She invited people to think about some of the critical issues that young people face regarding their family planning and reproductive health needs, focusing on those living at the last mile. Participants relayed stories from their experiences as health providers, program managers, and family planning advocates. These rich discussions laid the groundwork for the rest of the workshop. Their key challenges are summarized below.

- **Harmful cultural and religious beliefs and practices.** These included anti-family planning sentiments, because many people believe large families signify wealth and good fortune. This was a very common theme. In some instances, thought leaders believed that certain family planning methods were okay to use and others were not, per cultural beliefs and/or interpretations of religious texts. Anti-family planning sentiments among men result in their wives using family planning in secret. They also shared anecdotes of women having to "prove" their virginity, and of female genital cutting/mutilation.
- **Poor information.** Both young people and adults lack knowledge about their bodies, sex, pregnancy, infections, family planning, and where to access reproductive health information and services. Lack of information prevails in underserved communities, where health services and education are typically weaker. Myths and misconceptions about reproductive health prevent youth from practicing family planning (or practicing it correctly) and undermine their ability to care for themselves (e.g., in the case of becoming pregnant or contracting a sexually transmitted infection). For example, in some contexts, people do not seek contraceptives because they think they cause infertility.
- **Stigma, secrecy, and shame.** Sex is often a taboo topic, and is particularly sensitive as it relates to young people. For example, the Church of Uganda accepts family planning for married couples only—and yet unmarried couples are sexually active. Participants said that parents are often unlikely to discuss sex with their children, and many stories of girls and young women becoming pregnant involved elements of shame and secrecy. As a result, many girls try to hide their pregnancies, seek services only when their lives are in jeopardy, or have unsafe

> *"There is a lot of ignorance about reproductive health. There is a lot of poverty. ...we are here to see how we are going to break that cycle of poverty. Because when people are equipped with the right knowledge they're empowered with the right tools and then we are able to have the best leaders in the world."*
>
> — Margaret Aturo
> JENGA Community Development Outreach, Tanzania


Kristen Devlin, JSI.

abortions. In some stories, girls did not even know that they were pregnant or what was happening to their bodies. Discussions followed about how parents, families, and the larger community disproportionately place blame on girls (and their mothers), and less on the boys or men who impregnated them, even in cases of rape and coercive sex. Participants also talked about cases of rape, incest, and other instances of violence in which young girls and women were made to feel ashamed. Stigma surrounding young people and sex makes it difficult for them to come to education or outreach sessions.[1]

- **Poverty.** Many stories were rooted in poverty and poor reproductive health, whether due to poor financial access to health services or socioeconomic factors (e.g., low education, fewer skills, few available jobs, poor health). Young people are less likely to have financial access to family planning and reproductive health care. Anecdotally, where poverty is high, girls find themselves in situations where they may be "cared" for by older men (e.g., for financial support, love, affirmation) who expect sex in return. This prompts a host of other concerns, such as violence, coercion, early childbearing, dropping out of school, and mental health problems. Poverty was linked with alcoholism as well, which in some cases contributed to violence. Some participants discussed a lack of child protection in their own homes; in these cases, children would be subject to violence and rape within their own households. Participants also discussed the cycle of poverty, particularly in the context of young, impoverished parents being unable to care for their children.

- **Provider attitudes.** Across countries and settings, participants relayed how negative health worker attitudes and behaviors affect adolescent reproductive health. In some instances, and despite government policies, health workers do not provide reproductive health services to youth, whether married or not. Some, providers will provide only certain methods to married youth. Poor treatment and the fear of being judged prevents young people from returning to these facilities for information and services. Anecdotes elaborated the harmful and even deadly effects of girls and young women delaying or avoiding care due to provider attitudes.

- **Poor social support and communication.** Lack of social support, poor communication about sex from parents (or lack of parental involvement), and low levels self-esteem, skills, and confidence—in addition to incorrect information from peers—exacerbates young people's inability to understand and navigate their reproductive health. Peer pressure can also influence decisions.

- **Political and social considerations.** Cases of violence and rape were discussed in the larger context of conflict, whether between communities, tribes, or families.

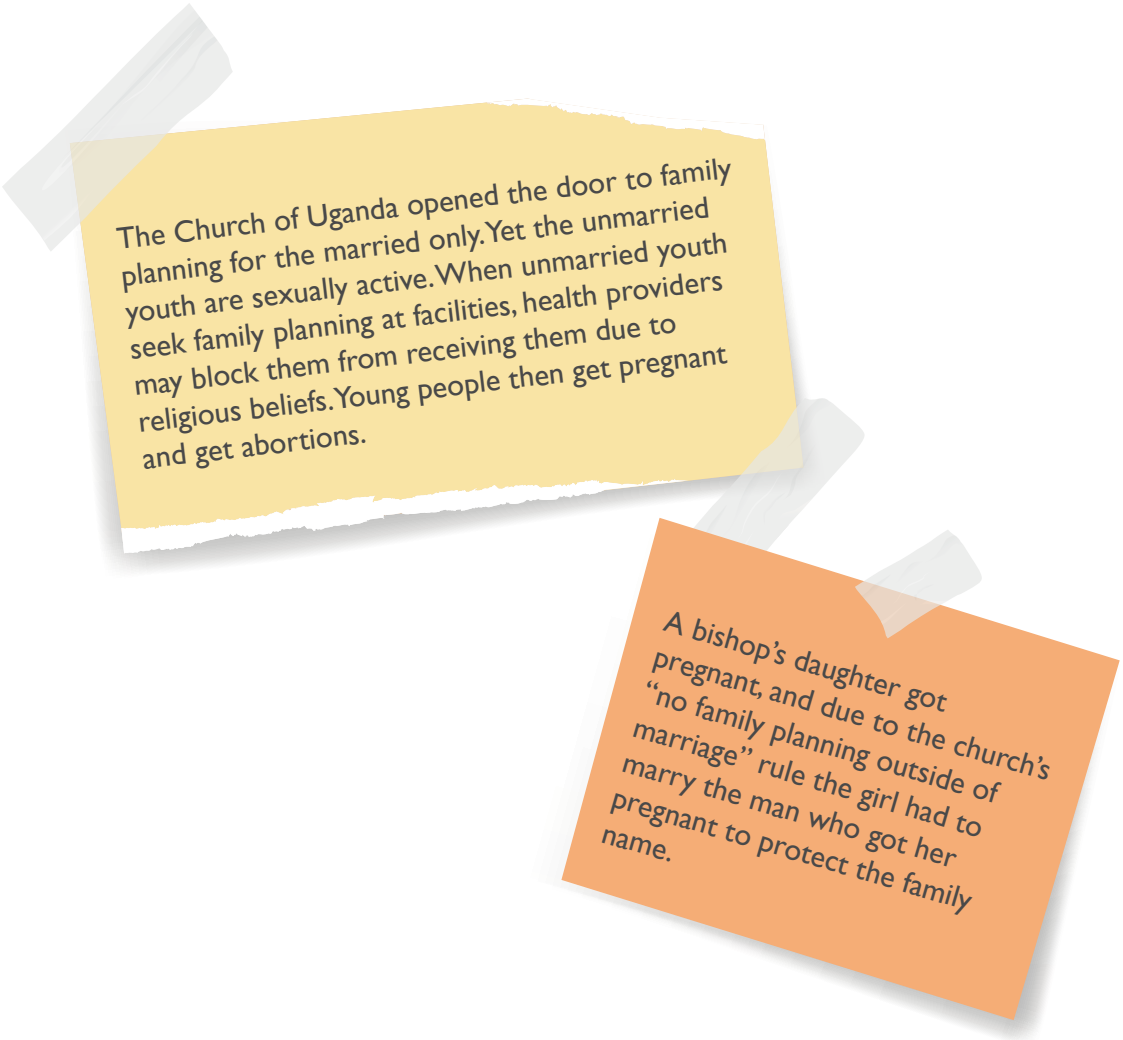
1 Note that many studies have suggested that youth are reluctant to come to "traditional" clinics, where their mothers or aunts attend, but respond well to "youth-friendly" environments, where service providers have special training and positive attitudes. (Adolescent-Friendly Contraceptive Services: Mainstreaming Adolescent-Friendly Elements Into Existing Contraceptive Services: https://www.fphighimpactpractices.org/briefs/adolescent-friendly-contraceptive-services/)

- **Devolution.** An important related area of discussion was the devolution of political spaces (e.g., in Kenya) and how it contributes to subnational political leaders or policies discouraging family planning to increase the population. The reasoning is that more people means more votes and resources allocated to the subnational entity or redistricting. Devolving the government can have the positive effects it was designed for (e.g., bringing financial resources and program decisions closer to clients), but it also can have negative consequences when it isolates poorer or less-developed districts and their inhabitants. Devolution increases the number of people on the public payroll, and only improves things when corruption is reduced and there is strong local leadership. Civil society groups, including FBOs, can be strong civil society voices.

Shano Guyo, World Vision

Example Stories

The participants relayed the following stories of youth who have encountered difficulty related to their reproductive health, including accessing family planning. Discussion of these issues provided an important backdrop for the rest of the workshop.



Solutions

Participants then brainstormed ways to address the problems they identified. Some strategies included more detailed recommendations.

ADVOCATE FOR POLICIES THAT SUPPORT YOUTH

ENGAGE MEN IN REPRODUCTIVE HEALTH

INVOLVE RELIGIOUS AND COMMUNITY LEADERS

- Disseminate educational booklets on family planning and religion
- Coordinate interfaith participation in family planning technical working groups
- Educate high-level religious leaders
- Engage religious groups to improve reproductive health access for unmarried youth
- Help FBOs and leaders advocate for evidence-based reproductive health policies and practices
- Encourage leaders to prevent teenage pregnancy through dialogue (e.g., counseling, adolescent clubs)

INVOLVE YOUTH IN PROGRAM DESIGN

SUPPORT YOUTH EDUCATION AND CAPACITY

- Intensify youth outreach on reproductive health
- Implement entrepreneurship and life-skills development strategies to empower youth
- Train positive role models, youth leaders, peer educators, and adolescent reproductive health champions
- Establish youth-run 'safe spaces' to talk about adolescent reproductive health
- Work with young parents to discuss youth issues

WORK WITH PARENTS

- Prepare parents to talk to their children about reproductive health
- Train parents on parenting skills

STRENGTHEN YOUTH SERVICES

- All facilities should have youth-friendly reproductive health services
- Integrate youth-friendly reproductive health services within routine medical care
- Overcome provider bias, especially around youth
- Ensure informed choice in family planning
- Offer a comprehensive package of family planning and reproductive health care to youth

Activity 2: If I ran a facility planing facility or program...

Lilian Chebon from World Vision Kenya led participants in a discussion about how they would run an ideal family planning clinic and/or program, how reality differs, and steps to take to remedy this situation.

Ideal family planning clinic or program

An ideal program or clinic comprises interlinking and complementary interventions and other elements within four main areas, outlined below:

Facility

- Accessible
- Affordable
- Good working conditions (water, electricity, privacy, play areas, computers)
- Legally registered
- Managed by a board
- Includes at least one male and one female youth leader in its management

Services/program

- Provides friendly services for all, including married and unmarried youth
- Offers privacy
- Ensures family planning commodities
- Collects and uses data for decision-making
- Links to health management information system
- Systematically determines and fills service delivery and programmatic gaps
- Offers ongoing capacity-building opportunities for providers and communities
- Has a clear referral system

Providers

- Trained and knowledgeable, especially about adolescent reproductive health
- Available, motivated, and passionate about youth-friendly reproductive health services
- Able to ensure privacy and confidentiality
- Conduct outreach
- Mentor and involve CHWs, peer educators

Community

- Whole communities—parents, men, religious leaders, opinion leaders, committees, and community groups are involved in reproductive health discussions
- CHWs and religious and community leaders receive basic education and training on family planning

What will it take to get there?

- Consistent funding and other resources to run programs
- Commitment at all levels, from communities and health providers to faith leadership and government
- Use of multi-sectoral approaches
- Dissemination of accurate information
- Involvement of young people
- Consistent, wide availability of family planning commodities

Activity 3: My faith, our faith

In this session, led by Sheikh Lattif Shaban from the Supreme Council of Kenya Muslims, participants reflected on the concept of responsibility—their own, the faith community's, and the government's—in meeting clients' family planning needs. One participant noted never having reflected on their personal responsibility for family planning before. Examples of the types of responsibility are provided below.

My faith (individual responsibility)	Our faith (my faith community's responsibility)	My government's responsibility
Cause no harm ▪ Cause no harm and do not refuse to do the right thing **Be a good partner and parent** ▪ Talk about reproductive health as a parent and raise children's awareness ▪ Ensure open communication about family planning in the home **Be a role model** ▪ Be responsible in planning my family ("walk the talk") ▪ Advocate for the voiceless and vulnerable (especially youth) **Raise awareness** ▪ Create family planning awareness in the community ▪ Share information with others **Embrace compassion** **Provide a safe place for family planning and reproductive health care**	**Break the silence and promote openness and sharing** ▪ Create a platform within one's faith community to convey messages and advocate for healthy, manageable families ▪ Host outreach sessions, medical camps ▪ Address spiritual needs ▪ Reduce stigmatization ▪ Integrate family planning counseling into marriage counseling **Change the hierarchy and attitude of faith communities toward reproductive health** **Educate** ▪ Empower religious leaders on healthy timing and spacing of pregnancy ▪ Teach the truth about biblical and Quranic interpretations (e.g., separate culture and religion) ▪ Educate about the implications of unplanned births **Offer family planning at faith-based health facilities** **Advocate for better incorporation (and proper use) of natural family planning among modern methods**	**Commit to working with FBOs** **Engage in private/public partnerships** **Design and implement family planning policies, guidance, regulations** **Be accountable to citizens** **Participate in technical working groups related to reproductive health** **Ensure high-quality services** ▪ Train staff and CHWs ▪ Fund health centers ▪ Monitor and evaluate implementation ▪ Ensure that commodities are available

> *"Family planning should be a part of everything."*
>
> — Douglas Nsibambi, FHI 360

Kristen Devlin, JSI.

Activity 4: Improving family planning access and uptake

The group engaged in a brainstorming session facilitated by Mona Bormet from CCIH, completing an exercise to identify and prioritize the gaps in services to last-mile communities. Participants voted on these gaps as top priorities:

1. Poor knowledge and/or information (among women, men, and youth) about family planning/HTSP
2. Social and cultural barriers to using family planning
3. Availability of skilled, unbiased, and supportive health workers
4. Leadership for family planning by political and religious leaders

The group mentioned numerous other challenges, including limited access to family planning and reproductive health care (especially for youth), poor male involvement, conflict and violence, supply chain problems, pastoral lifestyles, poverty, and contraceptive side effects.

The next several pages list the recommendations for how policymakers, program managers, donors, health workers, and FBOs can minimize these gaps.

*What can **policymakers** do to fill gaps?*

INCREASE RESOURCES

- Increase family planning budgets, especially for youth-friendly reproductive health services
- Invest in a supportive environment to reach last-mile communities (schools, health centers, roads, water, staff, supplies)

PASS RESPONSIVE, ENABLING POLICIES

- Prioritize youth-friendly reproductive health services & family planning
- Incorporate community voices in policy design process
- Streamline and consolidate information and budgets to reduce duplication (especially at subnational level)

LET DATA GUIDE INVESTMENTS

- Make evidence-informed statements
- Use data for decision-making
- Include indicators that document *who* makes referrals (CHWs, religious leaders, friends, no one) in health information systems

TAILOR MESSAGES TO AUDIENCE

INVEST IN HEALTH WORKERS

- Strengthen practical components of family planning curricula
- Incorporate CHW motivation schemes in strategies
- Ensure adequate staffing for high-quality services

IMPROVE SERVICE DELIVERY

- Expand health and other social services to remote areas
- Ensure adequate stock of family planning commodities
- Strengthen referrals


Martin Ndichu, World Vision

*What can **program planners** do to fill gaps?*

TARGET HARD-TO-REACH AND UNSEEN COMMUNITIES

INVOLVE YOUTH AT ALL STAGES, FROM PROGRAM DESIGN TO EVALUATION

DESIGN PROGRAMS THOUGHTFULLY

- Understand the context before designing interventions
- Listen to communities about what they need and want
- Make programs flexible, especially those for youth. Every day they are changing!

PRIORITIZE HOLISTIC PROGRAMMING

- Mitigate sociocultural barriers
- Include behavior change communication and methods
- Engage couples and the whole family in interventions
- Link family planning to livelihoods and other aspects of health
- Integrate advocacy

TRAIN RELIGIOUS AND COMMUNITY LEADERS AS FAMILY PLANNING CHAMPIONS

TARGET HEALTH WORKERS

- Understand the location's context before the intervention
- Listen to communities and avoid implementing something they do not need or want

DESIGN HOLISTIC PROGRAMS

- Recruit more health workers, especially women
- Give health workers scopes of practice
- Train health workers to:
  - Offer family planning methods and make referrals
  - Reduce bias, especially toward youth
  - Accommodate diversity in religions, cultures, etc.
  - Include men
- Strengthen pre-service training
- Provide on-the-job training, especially on contraceptive side effects and risks
- Include group quality improvement sessions
- Offer routine coaching and mentoring
- Build in motivation schemes
- Involve health workers in district family planning technical working groups

FOCUS ON EDUCATING

- Establish family planning outreach
- Dispel myths and misconceptions about family planning
- Train youth on life and parenting skills
- Educate girls on health and body literacy at school
- Learn from other successful programs

STRENGTHEN MONITORING & EVALUATION

*What can **donors** do to fill gaps?*

UNDERSTAND THE CONTEXT

- Conduct needs assessments to target funding for sustainability
- Be aware that the context and social and cultural barriers differ in each community
- Ask communities what to address, and what to address first
- Use existing infrastructure

MAKE EFFICIENT INVESTMENTS

- Target remote, hard-to-reach, and 'unseen' communities
- Work with partners who have existing and trusting relationships with these communities
- Provide resources directly to the organizations directly providing family planning
- Prioritize funding to integrated rather than siloed programs
- Add family planning and reproductive health into existing successful programs

SUPPORT HEALTH WORKERS

- Train health workers to provide the range of family planning methods
- Strengthen skills in long-acting removable contraceptives
- Fund education on natural modern methods in line with demand

BE FLEXIBLE AND SENSITIVE TO CHANGES

- Assess funding needs
- Be aware of timeframes
- Adjust as needed

INVEST IN FAMILY PLANNING COMMODITY PURCHASING, MANAGEMENT, AND AVAILABILITY

WORK ALONGSIDE CULTURAL CHANGE

- Appreciate the process of change, and who needs to suggest and lead change (e.g., community members)
- Integrate behavior change programming where possible
- Fund programs that integrate reproductive health information into cultural practices

EMPHASIZE SUSTAINABILITY

- Fund programs with sustainability in mind
- Consider longer-term programs rather than shorter-term
- Partner with groups that will remain in communities (e.g., churches, mosques, grassroots organizations)

ENCOURAGE EFFECTIVE LEADERSHIP

- Limit development tourism (e.g., only invite country leaders to international conferences based on their record of accomplishment)
- Develop a reading list (see Annex B)

*What can **health workers** do to fill gaps?*

PROVIDE COURTEOUS SERVICES TO ALL

- Be courteous. Do not withhold services from clients, no matter their socioeconomic status and age.
- Accommodate unity and diversity in health services by recognizing different religions and cultures and including men
- Recognize your own bias and follow protocols to determine the services to offer; follow clear referral system from one facility to another

CONDUCT OUTREACH AND UNDERSTAND THE COMMUNITY

- Improve services and sustain the benefits of family planning. Make services accessible for every kind of client—not just at health facilities, but also during outreach
- Visit households
- Act as a bridge between the facility and communities
- Sensitize the community regularly
- Increase regular outreach to communities
- Partner with religious leaders/lay faith leaders for community sensitization and programming

INTEGRATE FAMILY PLANNING COUNSELING

- Provide integrated family planning and reproductive health care
- Identify opportunities for a woman to be counseled more holistically (e.g., after giving birth, during breastfeeding consultation)

BE PROACTIVE

- Ensure that you are competent and knowledgeable
- Learn to access digital information (WhatsApp, internet) to update yourself about family planning methods

Mona Bormet, CCIH

*What can **FBOs** do to fill gaps?*

SUPPORT AND INCLUDE YOUTH

- Accept that some youth are having sex
- Encourage dialogue about reproductive issues, even with children
- Identify and engage adolescent reproductive health champions
- Involve young people in leadership structures (e.g., health facility boards)
- Encourage religious leaders to involve young people in problem-solving
- Mentor young people

EDUCATE

- Educate the faith community on family planning and clarify misconceptions and misinterpreted scriptures
- Help thought leaders and communities separate culture and religion from family planning
- Raise community awareness on the effects of population increase and family planning benefits and considerations

ENGAGE RELIGIOUS LEADERS AND STRUCTURES

- Train religious leaders on family planning
- Help religious leaders integrate family planning and reproductive health topics into their work and sermons
- Support religious leaders to lead dialogue on reproductive health with congregants at various points of contact (e.g., Sunday school, marriage counseling)
- Use religious texts to help communicate family planning messages
- Integrate family planning information into theological schools where religious leaders are trained
- Pass internal resolutions that support family planning and reproductive health

STRENGTHEN ADVOCACY

- Advocate for comprehensive family planning and reproductive health care in faith-based facilities
- Encourage internal advocacy within religious organizations to influence politicians
- Create spaces for policymakers to receive evidence-based strategies from people they respect
- Share information in ways that benefits policy-makers, and tailor messages to them
- Encourage dialogue about family planning among policymakers, religious leaders, and communities and help them find areas of agreement
- Build religious leaders' advocacy skills and include them in policy development
- Make religious leaders champions in the process of developing local-level family planning budgets

SUPPORT HEALTH WORKERS TO IMPROVE ATTITUDES, KNOWLEDGE, AND SKILLS

> *"We need to be proactive... If we wait for trainings, it will take a while"*
> — Participant

"How do we find a point of convergence where young people and people of faith do not feel isolated?"

— Mustafa Asman Ismail,
Kenya Muslim Youth Development Organization


Kristen Devlin, JSI.

Activity 5: Meeting the family planning needs of young people

Mustafa Asman Ismail, Kenya Muslim Youth Development Organization co-led the activity with Nancy Pendarvis Harris from JSI. Mr. Ismail raised a thought-provoking question to guide the session: "How do we find a point of convergence where young people and people of faith do not feel isolated?" Participants discussed a range of reproductive health challenges that youth face, drawing from previous discussions and the concepts in the diagrams on the following page. They developed recommendations to address them, and sought to make these recommendations SMART.

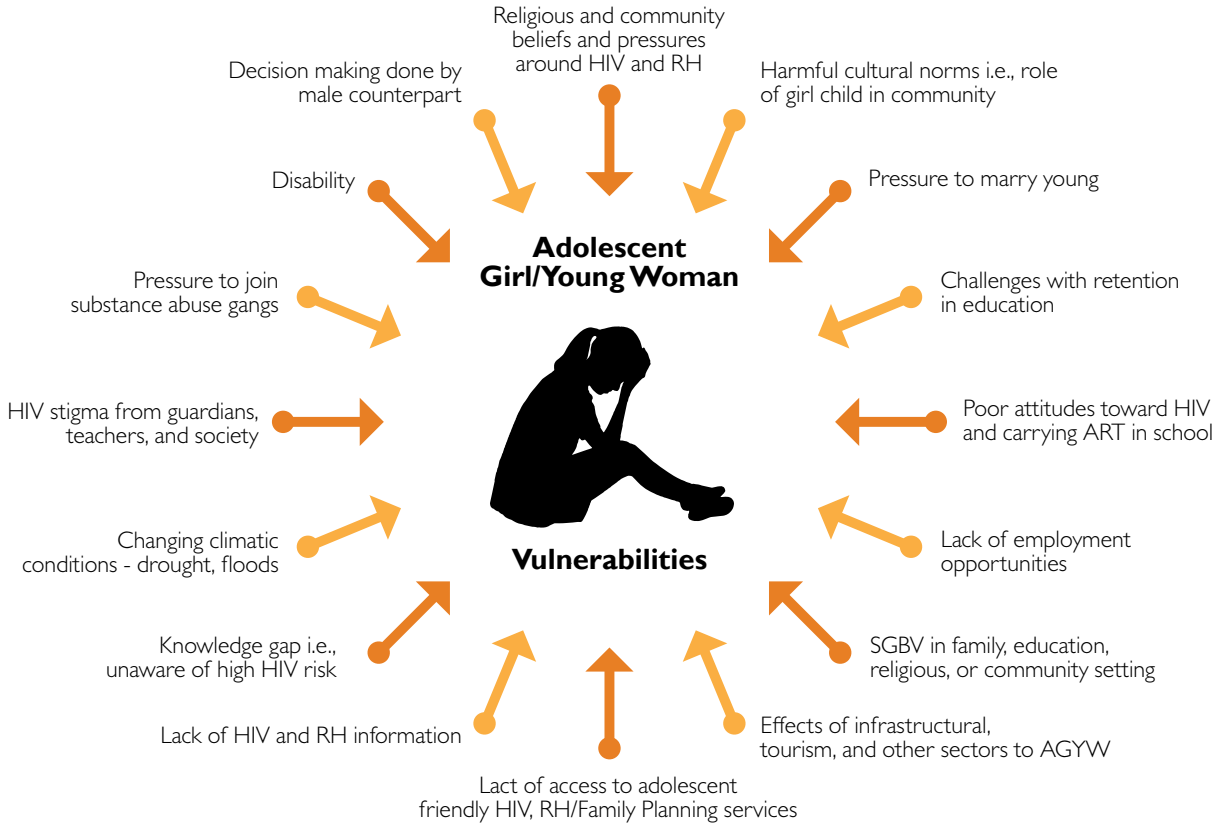
Top recommendations for improving adolescent reproductive health

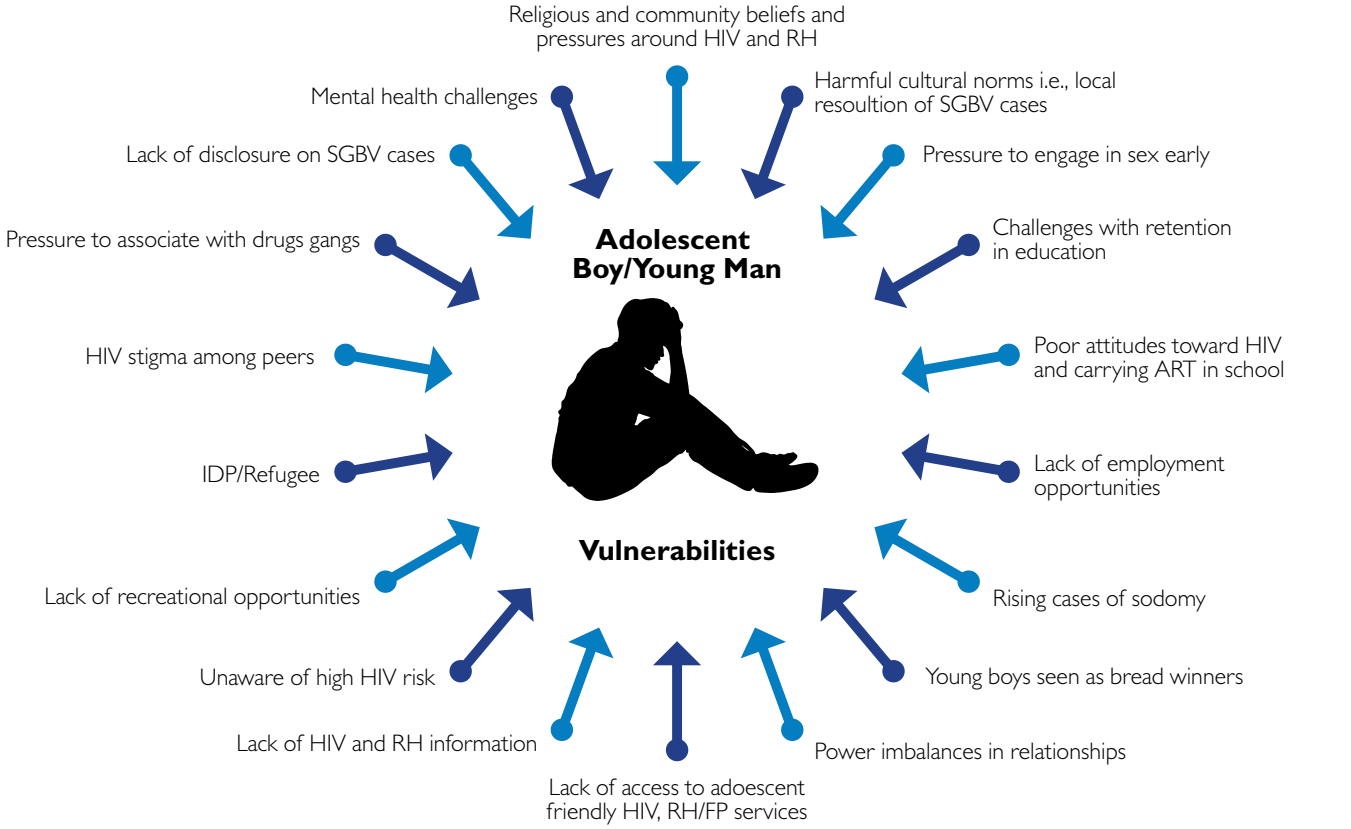
1. Within one year: Ensure that the health facility governance structure includes one male and one female youth champion who are trained to mentor and refer other youth for counseling and services
2. By end 2020: Adopt and test context-specific reproductive health curricula that train religious leaders and provide religious instruction for young people
3. By 2021: Advocate for and achieve at least a 2 percent increase in funding for family planning in the country's health budget
4. By 2024: Create a youth-friendly family planning program at the community and facility levels[2]
5. By 2024: Implement holistic (including economic, health, spiritual, and other concerns) family planning and reproductive health care for youth at all levels of contact

Other recommendations included developing strategies to empower youth and building capacity in reproductive health and life skills.

2 Participants determined the timeframe based on their country context and rough estimation of how long each action would take.

Vulnerabilities that Young Women and Men Face:





* Adapted from the Adolescent and Young Person Sexual Reproductive Health Rights and HIV Strategy, 2019-2022 for Kilifi County, Kenya

Activity 6: What can we do?

Each of the three East African countries with representation in the workshop has a unique faith and family planning landscape. Reverend James Mlali from Advance Family Planning, Tanzania moderated a discussion about issues affecting family planning and helped participants recommend ways to advance the family planning agenda in their countries, including for donors. Key recommendations are outlined below, following a quick synopsis of the context.

Kenya

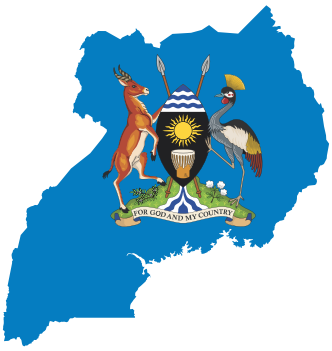
Kenya has experienced dramatic economic, educational, and social progress in the last 20 years. Kenya has a diverse and proactive faith community, and many FBOs are paired with district ministries of health. There is a potential for a stronger cadre of faith leaders to support family planning. Contraceptive prevalence is high, at 43 percent among all women (and 59 percent among married women), but there is still high teenage pregnancy and pockets of very low family planning knowledge and use. The Kenya group developed these goals for 2021:

- Synthesize family planning data from faith-based facilities and ensure that they contribute to decision-making at the policy level
- Advocate to form family planning and adolescent reproductive health county technical working groups
- Integrate family planning into every health program (maternal, newborn, and child health, HIV, tuberculosis, etc.)
- Prioritize capacity building (assessment, mapping, religious leaders, community health volunteers) and county technical working groups on family planning and adolescent reproductive health

Tanzania

Tanzania's faith community is a major provider of health services, and its faith hospitals and clinic networks are among the best in the region. These FBOs have CHW networks, and the country has had a national CHW program for many years. But unlike its neighbors, CHWs in Tanzania cannot provide injectable contraceptives. Contraceptive prevalence is slightly higher in urban areas than rural ones (35 percent versus 31 percent [DHS 2015–16]) but much less in last-mile communities. An important challenge is the need to educate senior politicians about the benefits of family planning. The group outlined the following priorities:

- Advocate for donors to provide funding to engage FBOs directly to the existing structures, denominations, and networks, rather than going through other faith or secular international NGOs, by the end of September 2020
- Identify champions in denominations/FBO settings to help disseminate family planning strategies by the end of 2020
- In the spirit of unity, advocate for family planning and promote issues with various religious denominations in Tanzania, with emphasis on defining, discussing, and adopting acceptable practices in each denomination by September 2021
- Empower religious leaders with family planning knowledge, advocacy tools, and religious texts in their respective denomination by September 2021



Uganda

Uganda is developing rapidly. It has a well-coordinated faith community for family planning; for example, the Uganda Muslim Medical Bureau, Uganda Catholic Medical Bureau, and the Uganda Protestant Medical Bureau meet regularly and have outstanding advocacy for HTSP at all levels. As in other East African countries, urban contraceptive availability is good, but lower in rural communities (41 versus 33 percent [DHS]). Uganda has high teenage pregnancy. The Uganda group had specific objectives and timeframes:

- Establish an inter-faith technical working group or community of practice by 2020
- Strengthen the role of FBOs by training religious leaders to increase awareness of family planning by 2021
- Develop and disseminate faith-appropriate information, education, and communication materials and trainings on family planning by 2021
- Document family planning success stories by 2021
- Conduct research on the use of contraceptives within faith-based health facility catchment areas among young people by 2021

Participants formed country-specific WhatsApp groups to remain in contact with and help each other accountable. They agreed that if various faith groups work together and speak with one voice, they can influence policies at all levels and gain traction with government and donors.

For donors

- Ensure FBO representation at national and subnational family planning technical working groups
- Train and strengthen the family planning technical working group and the interfaith subgroup (in Uganda)
- Provide funding to engage FBOs directly to FBO networks, rather than going through international NGOs
- Coordinate to ensure that funding streams support integration of family planning into other areas

CONCLUSION: "FALLING FORWARD"

> *"Fall forward, not backward.*
>
> — Lilian Chebon, World Vision

Lilian Chebon from World Vision Kenya summarized the group's thoughts on how to succeed, recommending "falling forward, not backward." Falling backward means blaming others for failure, repeating the same mistakes, expecting to never fail again, and even quitting. Falling forward means taking responsibility, accepting and learning from past mistakes, persevering, and taking new risks. It also encompasses questioning tradition while recognizing its importance, listening to communities, and working "alongside cultural change." For instance, in some settings, traditional healers provide care during illness but do not have medical training. A falling forward approach recognizes the cultural significance of these community figures and finds a way to involve them while ensuring that trained health providers attend medical needs.

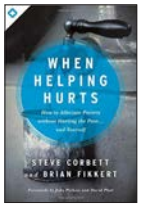
In the spirit of "falling forward," what have we learned?

- The faith community is concerned about how to reach youth. Involving young people right from the start in designing family planning and reproductive health care policies and programs is important for identifying their diverse needs, and reaching them. To do this, it will be necessary to examine one's own beliefs and biases and replace stigma and blame with knowledge and compassion. Equally critical is helping parents discuss family planning and reproductive health care with their children.
- Adopting more holistic approaches to reach last-mile communities with family planning is also a priority. Family planning access and adoption are interconnected with broader health and social issues. Incorporating interventions designed to reduce gender-based violence, engage boys and men, give young people life skills (e.g., the ability to manage stress), and break the cycle of poverty will improve health outcomes.
- Programs must adapt to changing social conditions, community priorities, and timeframes, and respond with thoughtful, evidence-based adjustments during implementation. Social change takes time, and flexibility and patience are of utmost importance.
- FBOs and other longstanding CBOs working at the community level are among the biggest underused resources for transforming social norms and improving health programming. Many of these organizations have significant experience and capacity to manage resources and work with new partners. Giving more direct funding to FBOs of all sizes could be a cost-effective investment.
- Engaging the interfaith community is another way to harness the power of the full faith spectrum. Doing so will extend family planning to those who need it most.

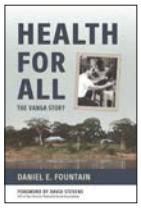
ANNEX A. WORD CLOUD

At the end of Day 1, participants summarized their feelings in one word.

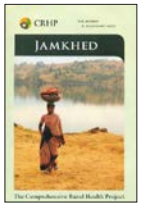
ANNEX B. SUGGESTED READING ON FBOS AND DEVELOPMENT



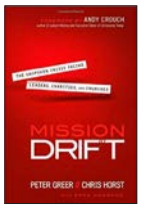
- **When Helping Hurts | Steve Corbett.** Poverty is much more than a lack of material resources, and it takes much more than donations and handouts to solve it. When Helping Hurts shows how some alleviation efforts, failing to consider the complexities of poverty, have actually (and unintentionally) done more harm than good.



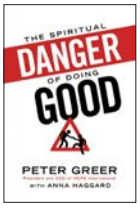
- **Health for All: The Vanga Story | Daniel E. Fountain.** When Dan Fountain and his wife arrived in the Congo in 1961, the challenges to effective medical missions seemed overwhelming. As the only doctor for a quarter of a million residents of the Vanga Health Zone, and with nothing but a dilapidated mission hospital and an undertrained staff to run it, Dr. Fountain turned to prayer, innovation, and local partnerships to meet the vast needs of his area.



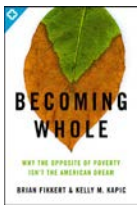
- **Jamkhed: A Comprehensive Rural Health Project | Mabelle Regi Arole and Rajanikant Arole.** The Jamkhed Comprehensive Rural Health Project (Jamkhed CRHP) was established in central India in 1970. The Jamkhed CRHP approach, developed by Rajanikant and Mabelle Arole, was instrumental in influencing the concepts and principles embedded in the 1978 Declaration of Alma-Ata. The Jamkhed CRHP pioneered provision of services close to people's homes, use of health teams (including community workers), community engagement, integration of services, and promotion of equity, all key elements of the declaration. The extraordinary contributions that the Jamkhed CRHP has made as it approaches its 50th anniversary need to be recognized as the world celebrates the 40th anniversary of the International Conference on Primary Health Care and the writing of the declaration.



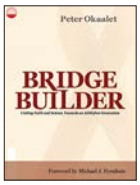
- **Mission Drift: The Unspoken Crisis Facing Leaders, Charities, and Churches | Peter Greer and Chris Horst.** Why do so many organizations—including churches—wander from their mission, while others remain Mission True? Can drift be prevented? In Mission Drift, HOPE International executives Peter Greer and Chris Horst tackle these questions. They show how to determine whether your organization is in danger of drift, and share the results of their research into Mission True and Mission Untrue organizations. Even if your organization is Mission True now, it's wise to look for ways to inoculate yourself against drift. You'll discover what you can do to prevent drift or get back on track, and how to protect what matters most.



- **The Spiritual Danger of Doing Good | Peter Greer and Anna Haggard.** What happens when Christian ministry and social justice lead to burnout, pride, or worse? Peter Greer knows firsthand how this can happen. Using stories from his own life and the lives of others in ministry, Greer shows everyone from CEOs to weekend volunteers how to protect themselves from the unseen hazards of doing good work and how to keep the flame of passionate ministry burning brightly. Includes end-of-chapter questions for personal reflection or group discussion.



- **Becoming Whole: Why the Opposite of Poverty Isn't the American Dream | Brian Fikkert and Kelly M. Kapic.** Fikkert and Kapic look at the true sources of brokenness and poverty and uncover the surprising pathways to human flourishing, for poor and non-poor alike. Exposing the misconceptions of both western civilization and the western church about the nature of God, human beings, and the world, they redefine success and offer new ways of to achieve it. Through biblical insights, scientific research, and practical experience, they show you how the good news of the kingdom of God reshapes our lives and our poverty alleviation ministries, moving everybody involved toward wholeness.



- **Bridge Builder: Uniting Faith and Science Towards an AIDS-free Generation | Peter Okaalet.** This book is the story of the remarkable journey of a shoeless village boy who became a global advocate for the poor and the those suffering the reality of the HIV and AIDS pandemic. It is the story of a youngster who once prodded his family's cows to move from one field to another and now guides church leaders, politicians, development professionals and other towards a deeper understanding and action to support those infected and affected by the virus and AIDS.

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